Child Protection Reader

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Royal College of Paediatrics
and Child Health

CHILD PROTECTION READER
RECOGNITION AND RESPONSE IN CHILD PROTECTION

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&
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Preface

We are delighted to introduce this Reader in child protection. It is designed to accompany the child protection course "Safeguarding Children : Recognition & Response in Child Protection" which is a basic course in safeguarding children aimed at paediatricians in the early stages of their training. Learning how to be a good paediatrician in child protection has many aspects. Not only must doctors be alert to the signs and symptoms that may suggest a child is in need of safeguarding, but also they must know how to approach the parents, raise these sensitive issues and seek appropriate help. They must be aware of the multi-disciplinary nature of the team that will be involved and how important it is to maintain good communication. Many of these aspects are taught in the one day course or are demonstrated in the accompanying DVD which is an essential component of the course package.

This Reader is one of two books that accompany the course, the other being the Child Protection Companion. The latter provides practical guidance, but this Reader provides more information about many aspects of child protection for those who wish to read more widely and more deeply around the subject. We recommend that everyone looks at this Reader and we feel confident that they will be drawn into the various chapters to learn more about differing perspectives on the historical, ethnic and cultural, legal and other aspects of this complex topic.

Many experts have contributed to the Reader and we are grateful to them, as well to the editors Janet and Leon Polnay, Margaret Lynch and Neela Shabde who have put in an enormous amount of work to produce this invaluable document. Our two organisations are proud to have been sponsors of this project and look forward to seeing many paediatricians benefit from it.

Patricia Hamilton, President RCPCH
Mary Marsh, Chief Executive NSPCC

Foreword

This document will contribute to children staying safe, one of the five outcomes that are key to well-being in childhood and later life. It supports health professionals in undertaking their statutory responsibilities to safeguard and promote the welfare of children whilst they are carrying out their professional responsibilities.

Health professionals, together with colleagues from other disciplines, are on the front line in the identification and management of children who may have suffered physical, sexual, or emotional abuse or neglect. There can be few more stressful clinical scenarios for a junior or a senior paediatrician than to be asked to assess such a child, and to distinguish between abuse and other reasons for the child's signs and symptoms. The stakes are very high. On the one hand is the risk of failure to detect abuse or manage the situation correctly, leaving a vulnerable child at risk of further injury or death. This has been tragically demonstrated in high profile cases. On the other, the distress caused by an accusation of abuse which later proves to be groundless is incalculable.

We recognise, too, the need for continued scholarship, research, and audit in this area, so that new knowledge is gained and disseminated to improve the outcome for abused or neglected children.

This educational programme is warmly to be welcomed. It is a major step towards equipping paediatricians in training to deal with children who may have been abused or neglected, and to do so with expertise, knowledge and sensitivity. The Royal College of Paediatrics and Child Health (RCPCH), the National Society for the Prevention of Cruelty to Children (NSPCC) and the Advanced Life Support Group (ALSG) are to be congratulated on these high quality educational materials. We are confident they will not only improve the management of cases where, sadly, abuse or neglect has occurred, but by raising awareness of safeguarding issues in paediatric trainees, make it more likely that appropriate support is provided for the child at risk of suffering harm and their family.

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The core reasons for failure of child protection processes are reviewed and the progress and development of the Acts of Parliament for children starting from 1883 up to the present Children Act, 2004 are charted. Current definitions of abuse and neglect are also provided.

Chapter 2

Extent of child abuse and neglect
This chapter discusses statistics of child abuse and neglect - looking at difficulties in interpretation of figures and analysing trends.

Chapter 3

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Children's rights
This chapter outlines the meaning of children's rights as contained in the UNCRC. Their application in the UK is discussed. The articles relevant to health care and paediatricians specifically are documented.

Chapter 11

Safeguarding children and the law
The legislation (public and private law) appertaining to child protection relevant to medical practitioners is described, including the philosophy underlying the Children Act 1989. The chapter points out the use of specific terminology relating to child protection in the legal context.

Topics such as parental responsibility, domestic violence and the Human Rights Act are included. Guidance on correct history taking and court appearances is given.

Chapter 12

Working together to safeguard children
This reproduces the Executive Summary of the government guidance on Working Together to safeguard children 2006. It summarises the content of each chapter of this document.

Suggested reading

The College recognises that the terminology referred to throughout this document is based on English Law and practice. Those working in Scotland, Wales and Northern Ireland should refer to their country specific legal terminology and legislation.

Suggested reading for paediatric trainees in Scotland

- Protecting Children. A shared responsibility. Guidance on inter-agency co-operation. The Scottish Office, 1999
- Protecting Children. A shared responsibility. Guidance for Health Professionals in Scotland. SEHD, 2000
- Protecting Children and Young People: Framework for Standards. Scottish Executive, 2004
- Protecting Children and Young People. Child Protection Committees, Scottish Executive, 2005
- Protecting Children living in families with problem substance use. Guidelines for agencies in Edinburgh and the Lothians. August 2005

Suggested reading for paediatric trainees in Wales

- Children and Young People: Rights to Action. Safeguarding Children: Working Together under the Children Act 2004, WAG August 2006

- Cooperating to safeguard children: Department of Health, Social Services and public safety, Belfast 2003, ISBN: 0946932093
- Keeping Us Safe'. Report of the Safeguarding Vulnerable Children Review. WAG May 2006
- All Wales Child Protection Procedures July 2002 (currently being re written)
- Good Practice Guidance on Domestic Abuse. Safeguarding Children and Young People in Wales. WAG March 2004
- Too Serious a Thing.The Review of Safeguards for Children and Young People treated and cared for by the NHS in Wales. The Carlile Review. National Assembly for Wales(NAfW) March 2002

Suggested reading for paediatric trainees in Northern Ireland

- Cooperating to safeguard children: Department of Health, Social Services and public safety, Belfast 2003, ISBN: 0946932093
- Department of Health, social services and Public Safety
- Belfast: Department of Health, social services and Public Safety, 2003
  ISBN: 0946932093
- NI Area CP Committees' Regional Child Protection Policy and Procedures: April 2005 -
- The Children (NI) Order, 1995

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What is child abuse and neglect?

History of child abuse

Until the 18th century, society viewed children as possessions of their parents, who were at liberty to treat children in any way they wished. In fact legislation was introduced to protect animals before children were afforded the same 'privilege'. Lynch (1985) examined evidence produced throughout the centuries on the recognition of physical abuse, and found that many of the early references were medical and that physicians easily accepted that those caring for children might injure them.

However, values started to change around the time of the 17th century. Incest was seen as a crime under church law (De Mause 1974) and by the time the 18th century arrived, children were being punished for touching their genitals. Also, in the 18th century children's 'inherent badness' was still noted to need discipline, but by the 19th century, children's maltreatment was observed, but denied and more obscure diagnoses were being sought to explain the lesions. However, even during the time some physicians were pursuing ‘scientific’ aetiologies, there were publications that demonstrated a continuing acknowledgement of the problem of child abuse (Lynch 1985).

Around the turn of the 20th century, social denial of abuse continued. Freud’s work in which patients reported that they had been sexually abused by their parents, was not accepted at the time and he changed his interpretation to imply that it was fantasy (Reder *et al* 1993). Sexual abuse of children was still thought to be a rare occurrence, however, incest was made a criminal offence when the Punishment of Incest Act was passed in 1908.

The 20th century saw the beginnings of an acknowledgement of the problem of child abuse and the recognition that children needed protection, though society was slow to accept that carers could deliberately harm children for whom they were responsible. In 1946 Caffey, a paediatric radiologist in the US, described bone lesions and sub-dural haematomas resulting from trauma, and Kempe (a US paediatrician) in 1962, described the 'battered child syndrome' (Kempe *et al* 1962).

The term 'non-accidental injury' (NAI), became the medically accepted label for this syndrome in the UK, and doctors became increasingly involved with social workers and the police in its diagnosis. Medical evidence was necessary for proof, and the traditional medical model methods of history, examination, investigation and diagnosis were appropriate for this initial stage.

The British Paediatric Association (BPA) published a memorandum on the *Battered Baby* in 1966 giving advice to doctors on the nature of the injuries seen in babies and young children and how to handle the resultant problems. The Department of Health and Social Security (DHSS) in England and Wales also circulated advisory documents about the benefits of collaboration between all the personnel involved. By the 1970s, physical abuse of children had been established as a common occurrence and the beginnings of its management by the medical, social work and police professions had begun.

In the 1980s many papers appeared in the medical press on child sexual abuse. Mrazek *et al* showed that professional recognition of child sexual abuse was at a similar stage as that of physical abuse 20 years ago (Mrazek *et al* 1983). Sexual abuse of children was just not talked about so there was a lack of diagnosis and inadequate treatment. Thus, in society and in the medical profession, only in the mid 1980s was the problem of child sexual abuse beginning to be seriously highlighted. The actual confirmation of sexual abuse was still seen to be based on the medical model and the role of the doctor seen as the primary one. To compound the problem, society's level of acknowledgement lagged behind that of professionals.

Despite the progress made on recognising child abuse, defining what constitutes child abuse remains a matter of debate. Until recently, corporal punishment at school was deemed by society not only acceptable, but necessary. Yet nowadays widely accepted and almost universal practices such as caning of school children have been incorporated within the widening spectrum of child abuse. Even today, the debate continues as to the appropriateness of smacking children by parents who seek to enforce discipline.

Key Message
Child abuse has existed for centuries but society has been slow to recognise it and acknowledge it as a problem.

Current definitions of child abuse and neglect

The definitions are taken from Working Together to Safeguard Children (HM Government 2006).

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger. They may be abused by an adult or adults or another child or children.

Physical abuse
Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms or deliberately induces illness in a child.

Emotional abuse
Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and normal social interaction. It may involve seeing or hearing the ill treatment of another. It may involve serious bullying causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse
Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (for example, rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Neglect
Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing, shelter including exclusion from home or abandonment, failing to protect a child from physical and emotional harm or danger, ensure adequate supervision including the use of inadequate caregivers, failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

History of child protection

The earliest organised professional response to child abuse in the UK was the British Society against Cruelty to Children in Liverpool in 1883 (Reder *et al* 1993), which led to the National Society for Prevention of Cruelty to Children (NSPCC) being established in 1890. However, there has always been debate as to how much the state should interfere with family life. The history of state intervention where there has been concern for a child's welfare has swung between authoritarian state control and overriding concern for family rights (Reder *et al* 1993). In 1904, the implementation of the Prevention of Cruelty to Children Act gave local authorities the power to remove children from their parents for the first time.

A further factor to help in the protection of children was the development of the educational system in 1870. This meant that children were gathered together on a daily basis and their condition could be seen, especially when the school health service was later established. Those that were absent were identified and truancy officers could investigate the reasons (DoH 1995a).

Initially, professionals focused on identification and how best to protect children at risk of harm. As more knowledge has been gained and the profound effects that abuse has on children has been recognised, appropriate therapeutic interventions have begun to be explored and developed (Barker and Place 2005, Romano and De Lucca 2005). Moreover, appreciation of the intergenerational cycle of abuse has offered an opportunity to intervene to try to prevent further harm (Dixon *et al* 2005).

Lessons learnt from landmark child protection cases

Maria Colwell
The death of Maria Colwell in 1974 from physical abuse gave rise to public outcry and the committee of enquiry that followed stated that:

'*Certain local authorities and agencies in Maria's case cannot escape ... because they must accept responsibility for the errors and omissions of their workers*' (DHSS 1974).

Child protection systems had failed Maria and professionals were blamed for not having done enough. Following this, child protection agencies (all organisations whose work brings them into contact with children and families including health services, social services, police, probation, education and voluntary organisations) were urged to take more effective action and to improve communication to protect children from physical abuse.

Area Review Committees were established following the Maria Colwell enquiry to review practice, look at inter-agency co-operation and training issues. Child protection agencies were urged to take more effective action and improve communication to protect children from physical abuse.

The Cleveland crisis

In 1987, a crisis arose in Cleveland in the UK resulting in an official enquiry which was carried out by a senior family judge, Dame Butler Sloss (DHSS 1988). Two consultant paediatricians were criticised for diagnosing sexual abuse on the basis of a physical sign of anal dilatation, and splitting up families by admitting many children who were considered to be at risk of sexual abuse, to hospital. The DHSS circular of 1976 had stressed that if a child was suspected of being at risk of a non-accidental injury, that the child should be admitted to hospital and the paediatrician would be responsible for the assessment. These guidelines had enormous implications for the way the children in Cleveland were managed – explaining the multiple hospital admissions.

The Cleveland affair was heavily reported in the press, and for the first time, sexual abuse was talked about publicly. Issues causing problems included poor medical and police co-operation, families being torn apart, and social services being unable to cope. From the public's point of view, it was forced to admit to the occurrence of sexual abuse in our society, and to make matters worse, the perpetrators were usually those stalwarts of family life – the bread-winning males.

The report of the Cleveland enquiry had profound implications on the Children Act 1989 (HMSO 1989), which was being formulated at the time. Different procedures to be undertaken when children are physically or sexually abused were developed and Area Child Protection Committees (ACPC) were set up. The Children Act 1989 remains the key legislation for the protection of children. It again emphasised the importance of different professions working together and that the interests of the child are paramount.

Victoria Climbié and others

There have been several other high profile reports on the deaths of children – those of Jasmine Beckford (London Borough of Brent 1985) and Kimberly Carlile (London Borough of Greenwich 1987) are two of the most well known. The tragic death of Victoria Climbié in 2000 and the subsequent report by Lord Laming have brought child protection issues to the fore again – both to the public and to professionals involved in the care of children. It was commented in Lord Laming's report:

'Perhaps the most painful of all the distressing events of Victoria's short life in this country is that even towards the end, she might have been saved' (HMSO 2003).

At post mortem examination, Victoria was found to have 128 injuries. Lord Laming made 108 recommendations, 27 of which relate to healthcare. The repercussions and recommendations from this report have re-shaped organisational and individual practice in child protection. The Children Act 2004 (HMSO 2004) and the replacement of ACPCs with Local Safeguarding Children Boards (LSCB) (HM Government 2006) were two such results.

Key Message
The development of legal and professional strategies and systems to safeguard children is an ongoing process. Each tragic case highlights the complexity of the process and reveals more potential loopholes in any system designed to protect those most vulnerable. Hence, there can never be complacency in child protection.

Doctors are well used to, and accept, the format of presenting difficult cases to one another so lessons can be learned and new management plans formulated. In child protection, the same model is just as valuable, but much more difficult to implement, not only due to the number of different professionals involved, but also due to the sensitive nature of the problem. This is where the vital role of the serious case review (previously known as part 8 review) comes in to play.

LSCBs and social services (renamed as children's social care) (HM Government 2006) have the power to call a serious case review when there has been a suspicious child death or a case of serious injury where abuse or neglect is thought to be a contributory factor. When such case reviews are called, reports are required from all professionals and agencies that have had anything to do with the child and his/her family.

The purpose of these reviews is to learn from experience – to see if the tragedy could have been prevented, or if current procedures need to be altered to try and prevent such incidents in the future. Many lessons have been learned from these reviews, and whilst it is appreciated that it can be impossible to prevent a parent who is really determined or sufficiently disturbed from harming a child, four areas are recurrently identified where professional practice could be improved:

Recognition
Failure to recognise abuse may be due to several reasons ranging from psychological barriers to gaps in clinical skills. For example, a professional may not actually recognise that a child has been abused due to an uncommon presentation. This leads to inappropriate management, and a subsequent postponement in diagnosis. Delay in recognition may also occur if health visitors or social workers who are carrying out home visits are denied access to a child, and excuses such as 'the child is asleep', are accepted. However, a heightened awareness of the occurrence of child abuse, can lead to its more frequent recognition.

Communication
As many professionals tend to be involved with families where children are at risk, it can be a real problem to enable those involved to have access to all the relevant information. Different professionals coming from different training backgrounds and often speaking in different jargon is a further complicating issue, which must not be underestimated. Any referral made to children's social care because of child protection concerns (or indeed any other) must be followed up in writing, as indeed is the case when referrals are made to medical colleagues. When writing reports, care must be taken not to use abbreviations and to explain clearly the implications of test results, observations and all medical information.

All verbal referrals to children's social care must be followed up in writing within 24-48 hours according to agreed local guidelines. This is not only good practice, and is no different from

that which is expected in a medical setting, but also protects the doctor should there be any queries made at a later date.

Procedures
All paediatricians should be aware of, and have access to, their local child protection procedures. It may be that a child at risk of harm has been recognised but the correct procedures have not been adhered to, and the case not correctly followed through, thus leaving the child in a vulnerable situation. This can particularly occur when there is lack of clarity as to who is responsible for actually making a referral to children's social care, or adequate discharge arrangements for a vulnerable child from hospital have not been made.

Note keeping
Doctors are reminded time and time again, by the defence societies, how crucial good note keeping is – every set of notes should be kept as if it might need to be viewed in court. Child protection is no exception. Failure to keep adequate notes can mean that a child's life may be put at risk of harm. It can also mean that clinical competence may be open to question.

Summary

Over the years, the recognition and handling of child abuse has come a long way. Many lessons have been learnt from tragedies leading to public enquiries, local case reviews and research (DoH 1995b). The document *Working Together to Safeguard Children* (DoH 1999) recognised that if families can be supported at a stage where they may be 'in need', there may be less requirement for child protection action, as potential crises may be averted. A revised *Working Together to Safeguard Children* was published in April 2006 (HM Government 2006) (see chapter 12). There is now much evidence-based information on how children can be prevented from suffering abuse and it is up to the professions to put into action the knowledge which has been gained.

Child abuse is always distressing; children are highly vulnerable members of society. It is also a form of activity peculiarly hard to combat, because its existence is difficult to discover. Babies and young children are unable to complain and older children too frightened. If the source of abuse is a parent, the child is at risk from his/her primary and natural protector within the privacy of his/her home. This both increases the risk of abuse and means that investigation necessitates intrusion into highly sensitive areas of family life, with the added complication that the parent who is responsible for the abuse is likely to give a false account of the child's history.

References

Barker, R, Place, M. 2005. Working in collaboration – a therapeutic intervention for abused children. *Child Abuse Review* 14: 26-39.

De Mause, L. 1974. *The history of childhood.* London: Bellew Publishing.

Department for Education and Skills and the Home Office. 1989. *The Children Act 1989.* London: The Stationery Office.

Department for Education and Skills and the Home Office. 2004. *The Children Act 2004.* London: The Stationery Office.

Department of Health. 1995a. *Child protection practice: private risks and public remedies.* London: HMSO.

Department of Health. 1995b. *Child protection: messages from research.* London: HMSO.

Department of Health. 1999. *Working together to safeguard children.* London: The Stationery Office.

Department of Health and Social Security. 1974. *Report of the Committee of Enquiry into the care and supervision provided in relation to Maria Colwell.* London: HMSO.

Department of Health and Social Security. 1988. *Report of the enquiry into child abuse in Cleveland.* London: HMSO.

Dixon, L, Browne, K, Hamilton-Giachristsis, C. 2005. Risk factors of parents abused as children: a mediational analysis of the intergenerational continuity of child maltreatment (Part 1). *Journal of Child Psychology and Psychiatry* 46:(1): 47-57.

HM Government. 2006. *Working together to safeguard children.* London: The Stationery Office.

HMSO. 2003. *The Victoria Climbié Inquiry. Report of an Inquiry by Lord Laming.* London: The Stationery Office.

Kempe, CH, Silverman, FN, Steel, BF. 1962. The battered child syndrome. *Journal of the American Medical Association* 18: 17-24.

London Borough of Brent. 1985. *A child in trust. The Report of the Panel of Inquiry into the circumstances surrounding the death of Jasmine Beckford.*

London Borough of Greenwich. 1987. *A child in mind: The protection of children in a responsible society. The Report of the Panel of Inquiry into the circumstances surrounding the death of Kimberley Carlile*.

Lynch, MA. 1985. Child abuse before Kempe: A historical literature review. *Child Abuse and Neglect* 9(1): 7-15.

Mrazek, PJ, Lynch, MA, Bentovim, A. 1983. Sexual abuse of children in the United Kingdom. *Child Abuse and Neglect* 7: 147-151.

Reder, P, Duncan, S, Gray, M. 1993. *Beyond blame.* London: Routledge.

Romano, E, De Lucca, RV. 2005. An individual treatment programme for sexually abused adult males: description and preliminary findings. *Child Abuse Review* 14: 40-56.

Further reading

Farmer, E, Owen, M. 1995. *Child protection practice: private risks and public remedies.* London: HMSO.

HMSO. 2003. *The Victoria Climbié Inquiry. Report of an Inquiry by Lord Laming. Summary and Recommendations.* London: The Stationery Office.

Parker, R. 1995. *A brief history of child protection (chapter 1).* In E. Farmer and M. Owen eds. 1995. *Child protection practice: private risks and public remedies.* London: HMSO.

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Polnay, J. Ed. 2001. *Child protection in primary care.* Oxford: Radcliffe Medical Press. (Reproduced with the permission of the copyright holder. Updated and amended).

Polnay, L. Ed. 2002. *Community paediatrics.* Edinburgh: Churchill Livingstone.

2

Extent of child abuse and neglect

Difficulties in assessing the extent of child abuse

The true incidence of child abuse is difficult to ascertain for several reasons. A problem must first be defined before it can be quantified – the perception as to what actually constitutes child abuse varies not only according to the era and society in question (see chapter 1), but from family to family. There are international differences in the acceptability of physical chastisement as a form of punishment as well as huge variations in the level of protection in societies across the world (see chapter 4). In all countries a great deal of what, if it came to the attention of child protection professionals, might be considered child maltreatment remains unreported (Cawson *et al* 2000). Severe physical chastisement that is family-based but not known to others will not be accounted for in figures for physical abuse. Despite international moves to protect children over the past century, the problem remains significant and includes child labour and children who are actively engaged in armed combat. Today's more global society has also led to the emergence of new aspects of child exploitation and abuse such as the international trafficking of children and internet child pornography.

Surveys and studies of the incidence of abuse

The first national survey of all types of abuse and neglect, using computer-assisted personal- and self-interviewing, was conducted in the UK for the NSPCC (Cawson *et al* 2000). In the study, which was carried out between September 1998 and February 1999, 2,869 young adults between the ages of 18 and 24 years were interviewed. There were no definitions of abuse and neglect but respondents were asked if they had experienced specific behaviours. The prevalence figures obtained were as follows:

- Serious physical abuse (violence used regularly over the years, or which had caused physical injury or frequently led to physical effects): 7%
- Serious absence of physical care (behaviours which carried a high risk of injury or long term harmful effects): 6%
- Serious absence of parental supervision (staying home alone without supervision overnight under 10 years of age or staying out overnight without parents knowing their whereabouts under 14 years of age): 5%
- Serious emotional maltreatment (control and domination (psychological and/or physical), humiliation, withdrawal, antipathy, terrorising and proxy attacks): 6%
- Sexually abused (contact and non contact - against their wishes or under the age of 13 years): 16%
- Sexually abused (contact - against their wishes or under the age of 13 years): 11%.

Physical abuse

Assessing the incidence of physical abuse is difficult because attitudes towards the use of physical punishment vary between countries and even within cultures. Whilst physical chastisement within the family is still legal in the UK, the boundaries of what is and what is not considered acceptable are ill-defined. Thus, what some parents clearly feel is normal and necessary verbal or physical admonishment of their children, others would consider abusive.

In the UK, there are relatively few studies that explore the topic of physical punishment, two important exceptions being the normative studies reported by Nobes and Smith (Nobes and Smith 1997, Nobes *et al* 1999). The researchers found that 16% of children had received a beating usually on the leg or bottom, and one in ten children were hit on the head. The severity of punishment was also assessed, and it was found that most were mild, but 14% were severe. In the later NSPCC survey, it was reported that a quarter of a large sample of young adults reported having experienced serious violence including having been hit with an implement.

In the US, it is recognised that serious physical abuse is often more frequently diagnosed in minority groups, but this may be because the diagnosis is more likely to be considered and explored in these children (Lane *et al* 2002).

Sexual abuse

Assessing the incidence of sexual abuse poses its own problems. One study found that three fifths of women and over a quarter of men surveyed at school or college had experienced minor but unwanted sexual attention when wide ranging definitions were used. Restricting the definition to physical contact, the prevalence fell markedly. With the most restrictive definition, 4% of females and 2% of males had been sexually abused (Kelly *et al* 1991). Thus the calculated incidence depends on what is perceived to be abusive. Additionally, the secretive nature of sexual abuse and the fact that it does not 'bruise' must surely mean that much goes on that is not accounted for in official figures.

Neglect and emotional abuse

Neglect can encompass physical, emotional, health or educational neglect while emotional abuse often occurs along side other forms of abuse. Arguably, any child who has suffered from any form of abuse suffers from emotional harm.

Neglect is now the most commonly reported category of child abuse. However, quantifying the number of children exposed to these forms of abuse is difficult as the signs are subtle and not as overt as physical injury. It can be difficult to decide just when a parent's attitude or level of care falls below the threshold that requires intervention. Inevitably, this is influenced by the doctor's own values and how much s/he feels these should be imposed on his/her patients. However, it is often difficult to decide what is just acceptable in terms of growth, development, cleanliness and other aspects of nurturing.

Children with special needs

Disabled children are particularly vulnerable to child abuse. They have a high level of dependency on their carers and limited mobility to escape an abusive environment. Such children often have communication difficulties and may be unable to disclose any abuse to which they might be subjected. The high level of care these children require often causes stress within a family and they may have low bone density that contributes to an increased risk of fracture. These factors would all be recognised as risk factors for abuse, yet this population has been poorly studied and there are virtually no studies in the world literature (Jaudes and Diamond 1985).

Fabricated or induced illness (FII)

The incidence of factitious or fabricated or induced illness (previously known as Munchausen syndrome by proxy) is estimated at 0.5/100,000 children under 16 years in the UK and at 2/100,000 children in New Zealand. Both studies recognised a higher prevalence in infants and toddlers (Denny *et al* 2001, McClure *et al* 1996).

Key Message

Because of differing perceptions of child abuse (and hence changing definitions), as well as difficulties in ascertainment, it is impossible to build up a full picture of its incidence.

Data from referrals to social care and registrations

Some idea of the amount of concern over children's safety can be gauged from referrals to local authority children's social care. In England, there were 572,200 such referrals in the year preceding 31st March 2004. Around half of these will have involved cases where actual or likely child maltreatment was the main reason for the referral. There were 72,100 inquiries under Section 47 of the *Children Act 1989* (HMSO 1989) (a rate of 65 per 10,000 children under 18) to ascertain whether a child had suffered or was likely to suffer 'significant harm' but some of these will have concluded that no maltreatment had taken place and there was no future risk. 'Core assessments' (many which will have involved cases where there was a strong possibility of a child having suffered or being likely to suffer 'significant harm') were undertaken with respect to 63,600 children (a rate of 57 per 10,000 children aged 0-17) (DfES 2005). In the same year-end (2004), there were 26,000 children on the Child Protection Register (CPR). This represents 24 children per 10,000 of the population and compares with 29 children per 10,000 for five years ago.

However, it is important to note that the CPR does not provide a record of children abused in any one year nor of the numbers of abused children living in a community at any point in time. Rather it is a list of those children with respect to whom, following a multi-disciplinary child protection conference, a formal child protection plan was in place on 31 March of that year. Children who are unlikely to be registered include children who have died from abuse, children who are 'looked after' and are in the care system where they are protected from further abuse, children who have suffered from abuse from a perpetrator who is outside the family or children where the perpetrator has moved out of the household. The CPR also contains many siblings of victims of abuse who are themselves deemed at risk of harm. It is estimated from the mortality statistics produced by the Office of National Statistics that one to two children die from child abuse every week in the UK (Home Office 2004).

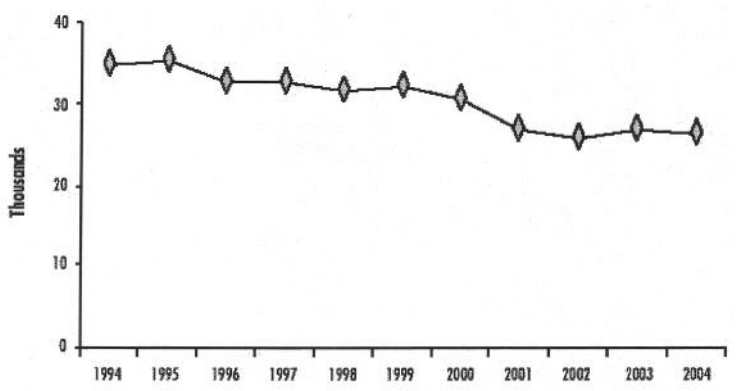
It should also be noted that rates of registration from otherwise similar areas can differ widely. This is because the balance to be struck between working through the family support provisions of the *Children Act 1989* and the formal child protection system is a matter of local policy. For example, in two London boroughs with very similar degrees of deprivation, the rates were, respectively, 14 and 48 children per 10,000 under 18.

Following a recommendation in the Laming report (HMSO 2003), and in line with the conclusions of several research studies and child death inquiry reports about the efficacy of the CPR in protecting children, consultations were held about phasing out the register. As a result, child protection registers were phased out in England in 2006 and instead children were made subjects of a child protection plan under *Working Together* (HM Government 2006).

Numbers of children on the register

Figure 1 illustrates the trend since 1994 of numbers of children on the register. The decrease in numbers in part indicates the trend towards more local authorities working with parents through the (less coercive) family support provisions of the *Children Act 1989* whenever this can be achieved without compromising the child's welfare and safety. It also results from a tightening up of the definitions of abuse in the 1999 revision of *Working Together* (DoH 1999) especially the removal of 'grave concern' as a registration category and a move to take children's names off the register as soon as a formal child protection plan is no longer considered necessary, and, where appropriate, replacing it with a family support plan.

Figure 1: Trends showing number of children on Child Protection Register.



There were 31,000 additions to the register during the year ending 31 March 2004 and 31,200 children removed from the register over the same period. This represents an increase of 3% for registrations and an increase of 7% for removals from the register with the previous year.

Length of time on the register

For the year ending 31 March 2004, about 19% (16% for the previous year) of children removed from the register had spent less than three months on the register and 7% (8% for the previous year) of those deregistered had been on the register for more than two years.

Categories of abuse

The following table shows numbers from registrations of children on the CPR (showing the mixed categories incorporated in the main categories) England at 31 March 2004, by category of abuse:

Category	Number	% of total registrations
Neglect	12,600	41
Physical Injury	5,700	19
Sexual Abuse	2,800	9
Emotional	5,800	18
Mixed/Categories and categories not recommended by Working Together	4,300	14

Age and gender patterns

Children under one year of age have the highest registration rate (71 per 10,000 children in that age group), and babies under one year old are four times more likely to be killed than the average person in England and Wales (Home Office 2004). A population-based study in Wales is one of the only population-based epidemiological studies of the subject. It gives an incidence of abuse in infants under one year of 11.3 per 10,000 per year. Seven per cent died from the abuse and 31% were re-abused when they were returned home to the same carers (Jayawant *et al* 1998, Ranton *et al* 2004).

Non-accidental head injury has an incidence of 3.5 per 10,000 babies under six months of age and 2.1 per 10,000 infants under one year old, according to a population-based study in South Wales and South West England (Sibert *et al* 2002).

Girls and boys have the same registration rates (27 per 10,000). However, at 31 March 2004, there were slightly more boys on the register; this is because there are more boys than girls in the population.

Characteristics of children and their families dealt with under child protection procedures

In a study of registers undertaken by Gibbons *et al* (1995), of the 160,000 children about whom inquiries were made annually, the following characteristics were noted:

- Headed by lone parent 36%
- Both natural parents resident 30%
- Dependent on income support 54%

- Lacked a wage earner 57%
- Domestic violence prominent in family 27%
- Mental illness in family 13%
- Child previously known to social services 65%
- Subject of a previous investigation 45%

One in seven parents under suspicion was known to have been abused as a child.

Key Message
Children under one year of age are most vulnerable to physical abuse, are at greater risk of serious harm, and are more likely to be placed on the Child Protection Register.

Under-reporting of abuse

Many children may be at risk of impairment to their health and development, in some cases as a result of parental incapacity, and in other cases as a result of poor environmental circumstances, or a range of family stressors which could promote maltreatment, but are not included in child protection registration figures.

Summary

Current data reflect the reported cases and depend on the awareness of child abuse and neglect amongst professionals. The difficulties of collecting accurate data on child abuse have been discussed. Neglect continues to be the largest category of abuse recorded on the current child protection register system. Overall figures on the register have been falling, but, for the reasons given, the rate of registrations is a poor indicator of the rate of maltreatment. Young children are the most likely to be reported and registered because of the higher likelihood of very serious consequences of severe neglect and physical assault.

References

Cawson, P, Wattam, C, Brooker, S. *et al*. 2000. *Child maltreatment in the United Kingdom: A study of the prevalence of abuse and neglect.* London: NSPCC.

Denny, SJ, Grant, CC, Pinnock, R. 2001. Epidemiology of Munchausen syndrome by proxy. New Zealand. *Journal of Paediatrics and Child Health* 37(3): 240-3.

Department for Education and Skills. 2005. *Statistics of education: Referrals, assessments and children and young people on Child Protection Registers year ending 31 March 2004.* London: HMSO. www.dfes.gov.uk/rsgateway/DB/S/FR/.

Gibbons, J, Conroy, S, Bell, C. 1995. *Operating the Child Protection System: A study of child protection practices in English local authorities.* London: HMSO.

HM Government. 1999. *Working Together to Safeguard Children.* London: HMSO.

HM Government. 2006. *Working Together to Safeguard Children.* London: The Stationery Office.

HMSO. 1989. *The Children Act 1989.* Department for Education and Skills and the Home Office. London: The Stationery Office

HMSO. 2003. *The Victoria Climbié inquiry. Report of an inquiry by Lord Laming.* London: The Stationery Office.

Home Office. 2004. Crime in England and Wales 2002-3: Suppl. vol. 1. *Homicide and Gun Crime.*

Jaudes, PK, Diamond, LS. 1985. The handicapped child and child abuse. *Child Abuse and Neglect* 9: 341-7.

Jayawant, S, Rawlinson, A, Gibbon F, *et al*. 1998. Subdural haemorrhages in infants: population based study. *British Medical Journal* 317: 1558-61.

Kelly, L, Regan, L, Burton, S. 1991. *An exploratory study of the prevalence of sexual abuse in a sample of 16-21 Year Olds.* London: Child and Woman Abuse Studies Unit, University of North London.

Lane, WG, Rubin, DM, Monteith, R, *et al*. 2002. Racial differences in the evaluation of paediatric fractures for physical abuse. *JAMA* 288(13): 603-95.

McClure, RJ, Davies, PM, Meadow, R, *et al*. 1996. Epidemiology of Munchausen syndrome by proxy, non accidental poisoning and non accidental suffocation. *Arch Dis Child* 75(1): 57-61.

Nobes, G, Smith, M. 1997. Physical punishment of children in two-parent families. *Journal of Clinical Child Psychology and Psychiatry* 2: 271-281.

Nobes, G, Smith, M, Bee, P, *et al*. 1999. Physical punishment by mothers and fathers in British homes. *Journal of Interpersonal Violence* 14(8): 887-902.

Ranton, B, Payne, H, Rolfe, K, *et al*. 2004. Do we protect abused babies from further abuse? A cohort study. *Arch Dis Child* 89(9): 845-6.

Sibert, JR, Payne, EH, Kemp, AM. *et al*. 2002. The incidence of severe physical child abuse in Wales. *Child Abuse and Neglect* 26(3): 267-76.

Further reading

Department of Health. 1995. *Child protection: messages from research.* London: HMSO.

Nottinghamshire Area Child Protection Committee. 1998. *Annual report 1997-98.* Nottingham: Notts ACPC.

The Report of the National Commission of Inquiry into the Prevention of Child Abuse. 1996. *Childhood matters Vol. 2.* London: The Stationery Office.

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3

Child Abuse and Neglect: Risk Factors

Reviews on the theories of possible causes of child abuse and neglect have emphasised that child maltreatment has multi-factorial origins. There is recognition that dysfunctional family relationships and poor parent-child interactions can both contribute to and maintain child abuse and neglect and that family violence is a product of poor relationships (Burrell *et al* 1994, Crittenden 1985, Wolfe 1991, Wolfe 1993). There is also the potential for good family relationships and parent-child interactions to act as protective factors and provide some resilience to social and environmental stress impinging on the family (Browne 1997). These realisations have led to the development of a public health approach to child protection. This may be defined as follows:

- Child abuse and neglect is considered within the broader context of child welfare, families and communities.
- Children's developmental needs are assessed in general rather than specifically in relation to child protection.
- The parent's capacity to respond appropriately to their child(ren)'s needs is evaluated.
- Consideration is paid to the impact of wider family and environmental factors on the capacity to parent.

Key Message
Child abuse and neglect usually occurs in circumstances where there are several risk factors. Dysfunctional family relationships can contribute to child abuse and neglect. Positive parent-child interactions may provide resilience in an otherwise adverse environment.

Risk factors

Most of the time, the child is subjected to abuse by people close to them, ranging from family members to friends and acquaintances in the community, and more rarely strangers that the child meets during day-to-day activities. Abuse and neglect is potentially present in many environments where the child interacts with adults: in the family, on the street, in institutions and in the extended social environment. Each of these environments presents factors that may endanger the child's optimal health, survival and development. Risk factors can be grouped as follows:

- The characteristics of the child
- The parental strengths and weaknesses
- The environment, support and resources available to the family (community factors).

These three groupings form the axes of the *'Framework for the Assessment of Children in Need and their Families'* (DoH 2000).

Key Message
Factors associated with the following have been identified to increase the probability of child abuse and neglect in the family:

- Child
- Parents
- Family
- Community

Child factors (Browne and Herbert 1997)

Unwanted children

- Children who fail to meet their parents' expectations and aspirations
- Born at the wrong time, for example, when the parents are more concerned with their alcohol or drug habit
- Unwanted due to a break down in the relationship of the parents
- The child is the progeny of forced, coercive or commercial sex
- Considered to be the wrong gender.

Other factors affecting the child

- Children who are premature, low birth weight or ill are often separated from their parents at birth and/or have repeated periods of hospitalisation through frequent illness. This may disrupt the formation of the attachment between parent and child and make them vulnerable
- Children who have physical or learning disabilities
- Children with behavioural problems, difficult temperament or personality

- Children who are soiling and wetting past their developmental age
- Children screaming and crying interminably and inconsolably.

Parental factors (Browne and Herbert 1997)

Step-parents
Parents not biologically related to the child are often more reluctant to care and show affection. This increases the chances for abuse and neglect.

Parental indifference, intolerance or overanxiousness
Parents with unrealistic expectations and negative attitudes/perceptions of their child's behaviour are more likely to be abusive.

Antisocial personality
Parents with rigid personalities may be impulsive and aggressive, and incapable of emotional or empathic responses to the child's needs and necessities (Dixon and Browne 2003).

Teenage parents
Immature parents, who are dependent on their partner, are more likely to neglect the child's needs and attend to their own.

Multiple births
Parents who have twins or another child before successfully weaning their older sibling and /or many children one after the other with less than 18 months between the births of children place increased stress on their capacity to parent. This, in turn, increases the chances of child abuse and neglect.

Alcohol and drug abuse
This is often associated with parents having a history of multiple stress or trauma (Pernanen 1991).

Parent abused as a child
Parents who have experienced abuse and neglect in their own childhood are often characterised by attachment disorders which affect their relationships as an adult and their ability to show affection and care towards their own children (Morton and Browne 1998). However, it is important to be aware that the majority of individuals who are abused do not maltreat their own children (Widom 1989). During their growth and development, abused individuals may experience positive factors which help break the cycle of abuse. Examples of this are receiving emotional support, stable relationships and home environment, and receiving psychotherapy (Egeland 1988, 1991).

Mental health problems
Parents with psychiatric disorders such as neurosis, psychosis, or psychopathology may abuse and neglect their children.

Disabled parents
Parents with special needs themselves may unwittingly abuse and neglect their children due to the lack of mobility or mental capacity to care and show affection to their child.

Single parent families
Living in a single parent family increases the probability of child maltreatment, due to the extra parental stress, social isolation and economic problems associated with one parent caring for a child/children rather than two.

Domestic violence
There is a higher risk to children living in a household where there is a violent adult.

Risk to children
The term 'Schedule One offender' and 'Schedule One offence' used to be commonly used for anyone convicted of an offence against a child listed in Schedule One of the Children and Young Person's Act 1933. However, a conviction for an offence in Schedule One did not trigger a statutory requirement in relation to child protection issues. Also, inclusion on the schedule was determined solely by the age of the victim and offence for which the offender was sentenced and not by an assessment of future risk of harm to children. Therefore the term 'Schedule One offender' is no longer used. It has been replaced with 'Risk to Children'. This clearly indicates that the person has been identified as presenting a risk or a potential risk of harm to children (see Chapter 11.)

Community/environmental factors (Gelles 1997)

Dwelling place and housing conditions
Inadequate housing conditions and dwelling places include overcrowding, unhealthy living arrangements and lack of sanitation, water and heating may increase the risk of child abuse.

Neighbourhood
Neighbourhoods that are poor, dirty and unsafe or violent and antisocial areas where the child may be discriminated on the basis of age, sex, disability and ethnic group, may increase the probability of child abuse and neglect.

Family violence and dysfunctional family interaction (Browne and Herbert 1997)

Family violence and dysfunctional relationships are harmful to children even if they only witness the violence towards their mothers or siblings. Children who grow up in a violent family are more likely to show aggression and violence to others. Indeed, there is a high correlation between elder abuse, spouse abuse and child abuse in families, so those parents who hit each other or elderly relatives are much more likely to abuse and neglect their children (Browne and Hamilton 1998, 1999).

Violence towards pets
Interest is increasing in the link between child abuse, domestic violence and cruelty to pets in the family. This is a complex area, but research is indicating that animal abuse is part of a continuum of violence within the family. Violent offenders are more likely than non-violent offenders to have been cruel towards pet animals as children (Becker and French 2004).

Social isolation
This is often associated with family violence due to the lack of social constraint and control of others witnessing the abuse and neglect.

Poverty
This increases the chances of child abuse and neglect due to the parents' stressful circumstances and poor relationships in the family. However, the majority of poor families who have good relationships do not wilfully abuse and neglect their children.

Are there effective programmes to reduce child abuse?

Many researchers have addressed this issue and it is beyond the scope of this chapter to review them. However, the following three studies show some encouraging findings. Dixon *et al* (2005) looked in details at risk factors in families. It was found that having a parent that was abused as a child increased the likelihood of that parent abusing their children by a factor of 4, compared with non-abused parents. Three significant risk factors made those abused parents 17 times more likely than non-abused parents to abuse their children. They were:

- Being a parent under 21 - this was especially significant
- Having a history of mental illness or depression
- Living with a violent adult.

From these findings, it could be speculated that parents who recognise themselves as being maltreated as children, could conceivably reduce their own risk to abuse by having children later, not living with violent partners and by seeking help for depression/mental illness. These parents could certainly be prioritised for preventative work. The study acknowledges that the risk factors found accounted for just over half of the total effect, so that other mechanisms come in to play. However, the study illustrates the effect of multiple risk factors present in vulnerable families, and begins to point the way for the possibility for practical focused intervention to prevent the cycle of abuse being perpetuated.

Randomised controlled trials published by Olds *et al* (1995, 1997) found that when vulnerable families have a programme of nurse home visits over a prolonged period of time (prenatally and early childhood), there is a reduced incidence of child abuse and neglect and subsequent pregnancies. Maternal circumstances were also improved.

Key Message
Knowledge of risk factors can help identify vulnerable families and children. Some children can be safeguarded by appropriate intervention which may be able to mitigate adverse circumstances. Intervention is highly specialised, intensive and long term.

Importance of recognising risk factors

Understanding risk factors is clearly relevant when assessing any child where abuse and/or neglect are concerns. Time must be taken to gather information from others involved, as well as whether a child is the subject of a child protection plan, not only to gain further knowledge and understanding about the child and family, but also to see if any vulnerability factors are present. General practitioners, health visitors, school nurses and community paediatricians can often supply much information. Knowledge of previous accident and emergency attendances and other hospital visits is also important. Social workers involved with the family should be contacted.

Summary

It is well established that certain personal, social and family attributes predispose to child abuse and neglect. Knowledge of these risk factors is important so that children at risk of harm can be identified, especially in the presence of clinical concerns. This may involve further enquiries from other professionals to gather information about a particular family. Furthermore, identified families can be offered extra help to try to prevent further abuse and neglect.

References

Becker, F, French, L. 2004. Making the links: Child abuse, animal cruelty and domestic violence. *Child Abuse Review* 13: 399-414.

Browne, KD, Herbert, M. 1997. *Preventing family violence.* Chichester: Wiley.

Browne, KD, Hamilton, CE. 1998. Physical violence between young adults and their parents: Associations with a history of child maltreatment. *Journal of Family Violence* 13(1): 59-79.

Browne, KD, Hamilton, CE. 1999. Police recognition of links between spouse abuse and child abuse. *Child Maltreatment* 4(2): 136-147.

Burrell, B, Thompson, B, Sexton, D. 1994. Predicting child abuse potential across family types. *Child Abuse and Neglect* 18(12): 1039-1050.

Crittenden, PM. 1985. Maltreated infants: vulnerability and resilience. *Journal of Child Psychology and Psychiatry* 26: 85-96.

Department of Health. 2000. *Framework for the assessment of children in need and their families.* London: The Stationery Office.

Dixon, L, Browne, KD. 2003. Heterogeneity of spouse abusers: a review. *Aggression and Violent Behaviour* 8:107-130.

Dixon, L, Browne, K, Hamilton-Giachristis, C. 2005. Risk factors of parents abused as children: a mediational analysis of the intergenerational continuity of child maltreatment (part 1). *Journal of Child Psychology and Psychiatry* 46(1): 47-57.

Egeland, B. 1988. Breaking the cycle of abuse: Implications for prediction and intervention. In *Early prediction and prevention of child abuse,* ed. K. Browne, C. Davis and P. Stratton, 87-99. Chichester: John Wiley and Sons.

Egeland, B. 1991. A longitudinal study of high-risk families: Issues and findings. In *The effects of child abuse and neglect: Issues and research,* ed. R.H. Starr and D.A. Wolfe. London: Guildford Press.

Gelles, RJ. 1997. *Intimate violence in families.* Third edition. Thousand Oaks, CA: Sage Publications.

Morton, N, Browne, KD. 1998. Theory and observation of attachment and its relation to child maltreatment: A review. *Child Abuse and Neglect* 22(11): 1093-1104.

Olds, D, Eckenrode, J, Henderson, C, *et al*. 1997. Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen year follow up of a randomized trial. *JAMA* 278(8): 637-643.

Olds, DL, Henderson, CR, Kitzman, H, *et al*. 1995. Effects of prenatal and infancy nurse home visitation on surveillance of child maltreatment. *Paediatrics* 95(3): 365-72.

Pernanen, K. 1991. *Alcohol in human violence*. London: Guildford Press.

Widom, CS. 1989. Does violence beget violence: A critical examination of the literature. *Psychological Bulletin* 106: 3-28.

Wolfe, D. 1991. *Preventing physical and emotional abuse of children.* New York: Guildford Press.

Wolfe, D. 1993. Child abuse prevention: Blending research and practice. *Child Abuse Review* 2(2):153-165.

Further reading

Falshaw, L, Browne, KD (1997). Adverse childhood experiences and violent acts of young people in secure accommodation. *Journal of Mental Health* 6: 443-455.

Olds, DL, Henderson, CR, Kitzman, H, *et al*. 1994. Does prenatal and infancy nurse home visitation have enduring effects on the qualities of parental care giving and child health at 25 to 50 months of life. *Pediatrics* 93(1): 89-98.

Olds, DL, Henderson, CR, Phelps, C, *et al*. 1993. Effect of prenatal and infancy nurse home visitation on Government spending. *Medical Care* 31(2): 155-174.

4

Ethnicity and cultural perspectives in child abuse and neglect

*'*Given the cultural diversity of modern British society, describing the many customs that different cultures use to bring up their children is a difficult task. The ongoing challenge to professionals, who are duty bound to safeguard children, is how to interpret these practices impartially and in the child's best interest yet in a way that is sensitive to the family's cultural values. Discussing difficult cases with appropriate colleagues is often helpful to clarify the exact concerns and then plan a further assessment or referral.

Cultural knowledge is not the focus of this chapter, although some relevant examples are used to illustrate points. It is not required to know the essentials of Hindu birth customs in the acquisition of cultural competence. It is the misperception of some cultural knowledge, believing that 'I know about this custom', that often leads to false assumptions and stereotyping (Webb *et al* 2002). Above all, professionals should be aware of potential pitfalls when faced with unfamiliar practice and the approach to assessment, investigation and management must be unaffected by personal beliefs and without discrimination (GMC 2001).

Assumption based on race can be just as corrosive as blatant racism. Fear of being accused of racism can stop people acting when otherwise they would. Assumptions that people of the same colour, but from different backgrounds, behave in similar ways can distort judgements' Neil Garnham QC – The Victoria Climbié Inquiry (HMSO 2003).

This chapter highlights the following areas:

- Core knowledge on ethnicity, culture and child abuse and neglect
- Description of the barriers and confounding influences in assessing unfamiliar practices
- Guidance for frontline professionals in the principles and approach in dealing with potential child abuse in different ethnic groups.

Ethnicity, culture and racial appearance

The terminology used to categorise groups of people often causes confusion. Ethnicity is a social label, referring to people with a certain geographical origin, ancestry, nationality, religion, and specific cultural practices. It is often wrongly used when purely describing minority migrant groups as there is also enormous cultural variability in 'white' populations (including travellers, gypsies, French, Irish, Poles etc). Some groups are wrongly aggregated together, for example, Asians, ignoring the many traditions and values that differ between families that come from countries such as Pakistan and Sri Lanka (Spencer 2000). The term 'race' is not useful in child protection and refers to physical and biological characteristics.

Culture is a lifestyle describing learned behaviours and ideas. It includes gender identity roles and position within a family as well as the way people act and dress (Riddell-Heaney and Allott 2003). It is significant, as parent's beliefs, upbringing and their current environment all contribute to the way they raise and value their children. The UK has many such cultures. As immigrants have settled down in the UK they may embrace some values of their adopted country and reciprocate by introducing new ways of nurturing children and structuring families (Spencer 2000). Modern families may have a single or mixed culture and cultural behaviours may be acquired through life experiences. Given this dynamic and the diverse nature of British society, racial appearance as well as self-defined or ascribed ethnicity, does not suggest any particular style of parenting and therefore, no assumptions can ever be made.

Key Message
Ethnic does not just refer to minority migrant groups and everybody has their own culture. Without evidence, no assumptions about parenting behaviour can be made from physical appearance or ascribed ethnic group.

Ethnicity, social class and socio-economic deprivation

Socio-economic deprivation affects ethnic minorities by adding financial stress to families. They may not be able to access help from health or children's social care. This may be a factor in abuse and neglect and should be considered when assessments are being made (Committee on Pediatric Research 2000, Webb 2000, WHO 2002). Data from the first progress report of the Ethnic Minority Employment Task Force quotes that 8.8% of the working age population are from ethnic minorities and 70% live in the West Midlands, West Yorkshire, Greater Manchester and London. This section of the population is more likely to live in poverty. Overall, of the 2.6 million children living in poverty in the UK, 22% of these households are headed by an ethnic minority person (Ethnic Minority Employment Task Force 2004). Therefore, the importance of social and health care support for disadvantaged or isolated families should be recognised in the assessment of abuse and neglect. The National Society for the Prevention of Cruelty to Children (NSPCC) has conducted a UK-wide survey of young people who were abused as children which has re-emphasised the association with socio-economic status. Despite this survey having a low representation of ethnic minority groups, the social class gradient remains (Cawson *et al* 2000). Child maltreatment appears in all social groups but Meier and Moy (2004) found that respondents who were now in social grades D and E who were in working class and those at the lower level of subsistence were

more likely to rate themselves as abused than other groups. There were particular associations with physical abuse, absence of care and inadequate supervision. The 'inverse care law' as described by Tudor Hart still applies as the more privileged members of society will tend to have better services and facilities than poorer members (Tudor Hart 1971). Children from financially poor, ethnic minority families can be disadvantaged in many ways (multiple jeopardy) and correspondingly are most in need of advocacy for their rights (Webb 2004, UNCRC 1989). Assessment of these families potentially needs greater thought and preparation to avoid, unintentionally, providing different standards of care for children (cultural deficit). It is possible that latent discrimination against children can be brought about by the very services that are put in place to protect them (The Child Protection Handbook 2002).

Families with less money are vulnerable to other prejudices. When assessing injuries and burns it should be remembered that children from poorer families may genuinely have more bruises as accidental injuries (and accidental deaths) are more prevalent in social class V compared with social class I households. This does not necessarily alter by ethnic group (Advanced Paediatric Life Support 2001, Alwash and Macarthy 1988). The balance between poverty and inadequate parenting needs careful analysis. In brief, socio-economic stresses require acknowledgement when professionals seek to protect children from harm, remembering that it is the quality of parenting given the resources available that will help professionals to decide the outcome for the child.

Key Message
Some ethnic minority populations have less resources and the assessment of maltreatment or neglect should take this into account. However, poverty is never an excuse for child maltreatment.

The effects of culture on the categories of child maltreatment

Culture influences child abuse in a number of ways. It directly influences its definition as it is believed that certain practices are more acceptable in different countries. According to the World Health Organization some cultures do have differing definitions of abuse but there is almost unanimity when very harsh discipline and sexual abuse is practised (WHO 2002). The International Society for the Prevention of Child Abuse and Neglect (ISPCAN) has also found common ground in definitions from 58 countries, but the more moderate the degree of physical abuse the more disagreement there may be. While culture tends to influence values and ideals it does not necessarily dictate actual parenting behaviour. Traditional values can be upheld without child maltreatment.

Culture strongly influences the psychological disciplining and punishment of children. Practices ranges from shouting, cursing, refusing to speak to children and threatening them with abandonment. Threatening to 'go without you' is a phrase commonly heard in the high street to encourage dawdling children but clearly the actual intent behind such threats needs to be interpreted with common sense. Interpreting unfamiliar practices should be done equally sensibly. Another example, threatening with evil spirits, is reported to occur more commonly in the Phillipines (WHO 2002). Many professionals may be unfamiliar with this custom,

however, the lack of experience with this type of psychological punishment does not necessarily make it any more abusive than bullying or scapegoating. These are more widely recognisable examples but familiarity does not mean they are less offensive as they continue to result in self harm and suicide in UK society.

Sexual abuse occurs in all ethnic groups but the association with culture is not just in defining behaviour. Deep-rooted attitudes may contribute to the family climate in which children are more likely to be abused. Furthermore, a family's culture can also inhibit disclosure and prevent or delay the seeking of outside assistance or mental health treatment (Fontes 1995).

Analysis of US data suggests that neglect has little relation to minority status and is driven largely (but not entirely) by economic factors rather than ethnicity (Jones and McCurdy 1992).

Consequently, many of the factors that affect vulnerable children are independent of ethnicity but are far more fundamental. It is often the methods and extent to which these stresses are taken out on children which varies by country and culture.

Key Message
Culture influences the definition of abuse and can affect its initiation, maintenance and disclosure. Familiarity with practices can shape a professional's interpretation and management of alleged cases of abuse.

Families and parenting

Family dynamics

The composition of a 'family' varies between and also within ethnic groups. In the western world there are fostered and adopted children, one-parent families and same sex couples. Each member's independence is promoted. In contrast, the social group in many non-western cultures relies upon an extended family system that may act as a self-contained community sharing resources, tasks and responsibilities (Korbin 1991). This extended family is often a great aid to parents. Despite this diversity, no one culture in Britain is autonomous and all social groups need to live within the same legal and social framework.

The more culturally-based risk factors for abuse include the gender of the victim, as males appear to be more physically punished, compared with females who may be maltreated by preventing them from attending school in order to look after siblings or even work. The roles and relationships between family members are culturally dependent. Some non-European cultures have been described as socio-centric, where the welfare of each individual is secondary to that of the family group (Maitra 1996). The responsibility for any child maltreatment that may have occurred, for example, sexual abuse may be shared by all relatives and the 'honour' of the family may compete with the interests of the child. This communal outlook, described in some immigrant families, may provide a strong protection against violations in vulnerable environments but conversely, 'shame' may also become a barrier to any public disclosure.

'When one member of a family is at risk of being shamed, all others are also at risk, since each is defined not by her/his 'shame alone but by the family's honour' (Helman 2001).

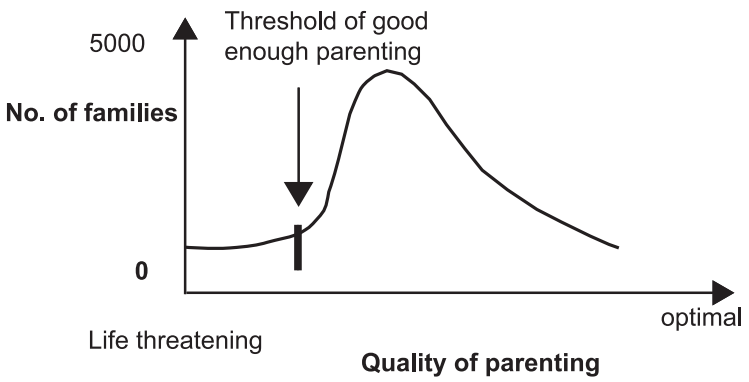
The gender hierarchy that exists in various communities to varying degrees such as travellers and many others, possibly contributes to the delayed disclosure of abuse and also to the silence of partners once abuse has occurred. The remit of professionals does not include judging these communities with the white British standard model. When a hierarchy fails to encourage an environment of competent child care, then defending the child from significant harm must occur. As an example, domestic violence awareness is becoming an increasing priority in primary care with universal screening advocated by some researchers (Richardson *et al* 2002). The evidence clearly shows that this is a serious form of child maltreatment leading to mental health problems, low immunisation uptake and potential delayed development (Webb *et al* 2001).

Key Message
A family's subculture can promote, or protect from, the initiation of child abuse. By competing with the interests of family members or of the unit as a whole, disclosure of this abuse may not occur.

'Good enough parenting' and ethnicity

The concept of 'good enough' parenting has been widely described in the literature, with particular debate surrounding the extent that economic hardship plays in maintaining poor parenting (Hoghughi and Speight 1998, Taylor *et al* 2000). This concept is reliant on the fact that the vast majority of parents are good enough to meet their children's needs and it is unrealistic to expect perfection from parents. The components of good enough parenting have been described as love, care and commitment, control/consistent limit setting and facilitation of development. As a further guide, the indicators of good and poor parenting have been outlined (Taylor *et al* 2000). However it is defined, for practical and moral reasons there can only be one meaning that applies to every ethnic group. Any cultural practices that do not reach this baseline are by definition not 'good-enough'. To illustrate this, a hypothetical model has been suggested where there is a range of 'quality of parenting' (Fig.1). The threshold for abusive behaviour will shift over time as societal expectations change. What was previously tolerated, for example, 'smacking' and corporal punishment, is now increasingly becoming unacceptable in UK society and is banned in other European countries such as Sweden. Most importantly, whatever the current threshold, it should be the same for every cultural group.

Figure 1: Theoretical distribution of parenting in the general population (Stuart-Brown 2004)



Key Message
The basic threshold for 'good enough' parenting should be consistently applied across all ethnic groups and traditional practices that do not reach this standard are unacceptable.

Parenting style, discipline and punishment

The art of discipline refers to the act of turning a child into a disciple, one who will follow your lead. It involves teaching children by actions that are used to promote behavioural change and is a matter of communication (Larson and Tentis 2003). Corporal punishment, which also occurs in the home environment, involves inflicting pain partly for retribution and teaches children that those in power can force others to obey (Whipple and Richey 1997). Children's advocates continue to campaign for the legal abolition of this physical approach (www.childrenare-unbeatable.org.uk). Parents of different cultures will have strong views on this subject and examples of acceptance can still be found in the literature. Islamic teachings are said to permit the physical punishment of children providing certain conditions are met such as never striking the face or head or leaving a bruise (Gatrad *et al* 2001). The same teaching abhors the emotional abuse of children, however they are not mutually exclusive as emotional abuse is fundamental to all forms of abuse (Kairys and Johnson 2002). In addition, whether the injury itself is temporarily red, yellow or blue is arguably immaterial.

'Physical abuse does not necessarily cause trouble… Damage comes when the injuries are inflicted by those to whom one looks for love and protection and there is no relief from the trauma' (Steele 1986).

Key Message
Many cultures traditionally accept the physical punishment of children. The teachings of these cultures may differ from western practices but ultimately should not conflict with what is acceptable under British child protection law.

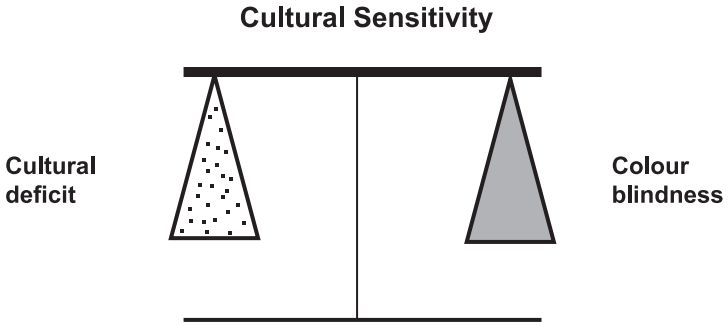
Belonging to an ethnic group does not necessarily mean that all aspects of that group are embraced, but research suggests that levels of verbal and physical punishment do vary with ethnic groups. In a similar way, levels of nurturing are also linked with ethnicity and the negative effects of abuse on the child may be countered by a strong, positive, nurturing element (Ferrari 2002). Thus, the pairing of nurture with physical punishment may promote resilience in abused children. Breaking down the individual components of cultural beliefs may help us understand the relationship with child abuse. The sense of obligation to care for and support family members or 'familism' is found in some Hispanic cultures. Regardless of ethnicity, parents who subscribe to this are reported to use less physical punishment but may be less nurturing, possibly as other members are also primary caregivers. Regardless of ethnicity, fathers who score highly on the 'machismo scale' tend to believe in strict gender roles and their authoritarian approach is predictive of physical punishment. Lastly, parents who value their children more for either economic, cultural or emotional reasons tend to judge child physical and sexual abuse as more serious than those who do not. In one US study, the nurturing behaviour of mothers was evident in spite of their beliefs. Thus, the influence of culture on parenting may well have a gender bias.

Key Message
It is the parental values and beliefs rather than parental ethnicity that may influence the use of punishment and nuture. However, it is the experience of the child in his/her environment, and not the intent of the carers that should be the focus of child protection professionals.

Responding to cultural practices

Cultural sensitivity
All child protection assessments occur within a cultural context. The difficulty lies when people from one culture have to judge another's behaviour. In one sense there is already a mutual 'disagreement' in choice of lifestyle but the power and responsibility in the relationship is firmly on the side of the professional. Those professionals providing the service need to strike a balance between treating everyone the same (colour blindness) and accepting a different standard (cultural deficit) (Webb *et al* 2002). Colour blindness risks inappropriate interventions such as referring cases when the cultural practice is not harmful and cultural deficit may involve overreacting or even agreeing with carers (collusion), at the expense of protecting the child (Fig. 2).

Figure 2: Theoretical approach to cultural assessment (Webb et al 2002)



Key Message
Cultural practices should not be an excuse for causing children significant harm. There should not be an acceptance of different standards of parenting for different ethnic groups (cultural deficit).

Overcoming barriers
There are many additional factors that prevent the ineffective partnership with families that individuals working in child protection should be aware of (Harran 2002, Koramoa *et al* 2002, Webb *et al* 2002). They include:

- Stereotypings
- Professional fear of appearing racist
- Inadequate training of professionals
- Denial of abuse in ethnic minorities

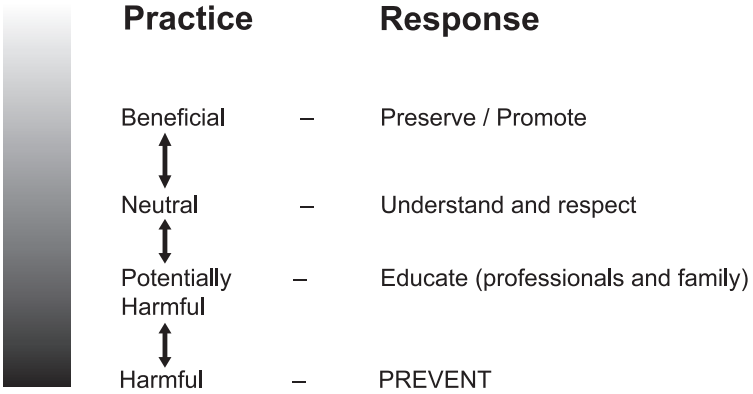
- Communication difficulties
- Professionals over-identifying with carers
- Lack of child centred approach
- Cultural attitudes to disability and mental illness.

These factors are interlinked and should be actively looked for in the analysis of individual cases. Further discussions about their influence is found in the literature and media (Harran 2002, HMSO 2003, Webb *et al* 2002). Complete elimination of them is the ultimate aim for child protection teams but for each individual member, having the insight into personal prejudices is the most important skill to be acquired.

The childcare continuum (Koramoa *et al* 2002)

Professionals will be confronted with behaviour that may be practised widely but remains unfamiliar to them. It has been suggested that childcare practices are on a continuum, but some scenarios are undoubtedly unacceptable, for example cases of physical discipline, female circumcision and extreme neglect. On the opposite side are traditions that enrich the child's cultural development and individuality. They may improve health and improve the child's attachment to its mother. However, many cases will be less clear cut and if there is reasonable doubt as to their acceptability then consultation must occur with members of the local authority child protection team. Before responding to such practices there needs to be clear understanding of the child's experience and the possible immediate or future consequences for the child as a result of this behaviour. Language should never be a barrier and interpreters should be used where necessary. A degree of cultural competence is required on the part of the assessor and advice sought where there is uncertainty (Fig. 3).

Figure 3: Continuum model of child rearing practices (Koramoa et al 2002)



Examples:

Harmful	-	Anogenital insertions as a punishment, female genital mutilation.
Potentially Harmful	-	Enemas to ensure inner cleanliness, body and ear piercing.
Neutral	-	Gentle squeezing of nasal bridge for hiccups.
Beneficial	-	Newborn washing, breast feeding.

Inner cleansing of the newborn with a suppository may be believed to be beneficial but may cause dehydration (Koramoa *et al* 2002). Ear and body piercing in children is apparent in many families in the UK. Skin infections and embedding of earrings are recorded consequences (Dunlop *et al* 1994). In such cases, educating the carers is required and the family's response to such an intervention will decide whether further action needs to be taken.

Key Message
The response to unfamiliar practices should be appropriate to the level of concern.

The difficult concept of 'intent to harm' may need to be considered in certain scenarios where the family genuinely believe that a practice could do no harm. It may not be the practice per se is harmful but the way in which it is conducted. Male circumcision is a typical example of this, where a traditional religious practice has been altered in order to optimise child health. Individual discretion by professionals is allowed for, but standards of good practice are mandatory (GMC 1997). Scenarios where harmful practices are attributed to the family's culture can be envisaged. It may be claimed that the pathological behaviour is a normal expression of the way people of a certain background act. Some authors have coined the phrase of 'cultural camouflage' in order to describe this method of excusing abusive behaviour (DiNicola 1986).

Engaging the family in order to produce behavioural change is a skill that is best provided by culturally aware professionals who are experienced in communicating with such families. The risks of being unsuccessful will inevitably be detrimental to the child.

Key Message
Some traditional practices may be adapted in order to protect the child yet still retain cultural sensitivity. Ultimately, culture is not an excuse for child maltreatment.

Nomadic ethnic groups

Certain ethnic groups may move frequently within and between the boundaries that are covered by child protection teams. Travellers and gypsies have unique lifestyles and some have large extended families. Their community is not excluded from child abuse but their historical mistrust of some professionals may be reciprocated and could lead to false assumptions. They have been described as strict disciplinarians with a high level of physical affection for children (Van Cleemput 2000). Some may deny the existence of abuse or refuse support when offered. The presence of many siblings may make emotional neglect more prevalent in the older children and issues of domestic violence have been raised. Child abuse allegations should be investigated sensitively with an emphasis on communication between organisations particularly if the families cross geographical boundaries, but with the needs of the children central to the process.

Key Message
A nomadic lifestyle poses challenges in child protection particularly with regard to prejudice, communication and supporting families. Families may be deprived and disadvantaged by lack of access to services and education.

Skin colour and bruising

'If Victoria had been a white child, would she have been treated differently?' The Victoria Climbé Inquiry (HMSO 2003).

The adult with dark skin has been described as the 'invisible man' of the medical world and similarly, dark skinned children with bruises, may only be partially 'visible' in the world of child protection (Rubin 1979). Concentrating purely on accidental bruising, some studies have shown a racial divergence. Sugar *et al* reveals statistically significantly less bruising in African American children when compared to white counterparts where as Tush's smaller study reveals a similar but insignificant reduction of bruises in three year old black children (Sugar *et al* 1999, Tush 1983). Following on from this, when data from 616 cases of abuse were analysed, black children had statistically fewer number of documented bruises and it is claimed that some bruises are obscured by the dark skin colour such that black children may be escaping early detection (Johnson *et al* 1985).

The evidence however is speculative and the link between skin colour and bruising appears generally as a secondary conclusion in child protection studies complicated by the inconsistent use of terminology and the ethnocentric viewpoint of some studies. Theoretically, the assumption may have some scientific basis. The unique effect of damage to black skin has been outlined by some authors stating that any trauma can produce depigmentation as well as hyperpigmentation, possibly due to destruction of melanocytes (Kenney 1989, Rubin 1979). Whether or not this phenomenon occurs in bruising due to physical abuse has not been reported. In addition, the colours evident in bruises in white skin can appear different, allegedly, as some dermatological lesions on black skin appear brown, black or purple instead of pink or tan when found on white skin (McLaurin 1988). Thus while larger areas of bruising, swelling or epidermal loss may be obvious, the evidence suggests that possibly smaller, non tender injuries may be overlooked by professionals encountering children with dark skin.

Key Message
Professionals should be aware of potential difficulties when assessing and photographing bruising in non-white children.

Professionals and ethnicity

The ethnicity and the socio-economic homogeneity status of health professionals remains a potential influence on the reporting of abuse. A US study examined the characteristics of children and their families who were diagnosed as abused by hospital personnel (Chance *et al* 2002). Important perpetrator variables were quoted as social class and race, with black, urban and low income families having the strongest effect on whether cases were reported or not. Suggested theories include the physician's stereotypical view of abusive families and the need for the professional to refer families with different social characteristics from his own. More recent statistics reveal a similar situation. Different rates of substantiated child maltreatment may be due to over-reporting but once suspicion has arisen, the extent to which medical staff investigate cases may vary. A six-year study in Philadelphia focussing on skull

and long bone fractures describes the effect of 'race' on investigating a potentially abusive fracture (Hampton *et al* 1984). After controlling for the likelihood of abuse and insurance status, children from ethnic minorities were statistically significantly more likely to have a skeletal survey performed than were white children by up to five times. It would appear therefore that there are psychological influences on decisions made by professionals that may sway the perception and investigation of abuse.

Key Message
The belief that one's own culture and upbringing is the gold standard or norm (ethnocentricity), can lead to the unfair treatment of children from a different culture, religion or ethnic group (discrimination).

Training

The importance of cultural competence in a professional's approach to ethnic minorities has been highlighted in research. The Equal Rights Equal Access (EREA) training pack has been evaluated with positive results (Webb and Sergison 2003). Potentially, those electing to attend the course are the most culturally aware. The high percentage of practice change quoted, illustrates the degree of background competence (or incompetence) in the vast majority of professionals. Although professionals are expected to acknowledge cultural differences, undergraduate and postgraduate training is still inadequate.

Audit

Regular auditing of the figures for child abuse by ethnicity may provide useful feedback. However, there are some confounding factors that should be recognised when interpreting the results. Firstly, forms with self descriptions of ethnicity may not be accurate as the term is sometimes misused. Secondly, aggregation of different cultures into ethnic groups such as 'Asians' shows a lack of understanding for the different beliefs that each may hold. It has been suggested that ethnic does not mean 'non-white' and there are a variety of cultures within the 'white' British population. Being part of an ethnic group does not mean that you ascribe to all of its practices or indeed practise them all of the time. Finally, figures that show differing rates of reporting or substantiating abuse in the local population may highlight deficiencies within the system. Assuming that ethnicity *per se* does not significantly influence rates of abuse, research suggests that socio-economic factors play a far more important role as ethnic minorities may be from poorer families. Where rates of abuse are higher in ethnic minority groups, it may well be that the service is under-reporting the majority group rather than over-reporting the minority, potentially failing to protect large numbers of children.

Summary

Published research often quotes ethnicity as a variable in family demographics for child abuse but fails to convince readers of their understanding of its meaning. In fact, cultural values, family structure, income and styles of parenting are vastly more useful variables. Each family from whatever ethnic group has different requirements. These may be in the form of language, social skills or literacy. To assess each case individually will require different levels of resources. It is not enough to provide a 'one size fits all' approach. Providing the same assessment for all groups of people may in effect ignore their different needs and this 'colour blind' approach will deliver a different quality of assessment for each group.

Parents have the right to choose individual parenting styles that may be defined by their cultural beliefs, personality or by their own childhood experiences, but these should not be in conflict with the rights of their children. Clearly, whatever the beliefs, culturally different parenting should never be an excuse for child maltreatment and cultural deficit must be avoided.

References

Advanced Paediatric Life Support. 2001. *The practical approach.* London: BMJ books.

Alwash, R, Macarthy, M. 1988. Accidents in the home among children under 5: ethnic differences or social disadvantage? *BMJ* 296: 1450-3.

Cawson, P, Wattam, C, Brooker, S, *et al*. 2000. *Child maltreatment in the United Kingdom: A study of the prevalence of abuse and neglect.* London: NSPCC. http://www.nspcc.org.uk/.

Chance, T, Scannapieco, M. 2002. Ecological correletes of child maltreatment: Similarities and differences between child fatality and nonfatality cases. *Child and Adolescent Social Work Journal* 19: 139-161.

Committee on Pediatric Research. 2000. Race/ethnicity, gender, socioeconomic status - research exploring their effects on child health: A subject review. *Pediatrics* 105(6): 1349-1351.

DiNicola, VF. 1986. Beyond Babel: family therapy as cultural transition. *International Journal of Family Therapy* 7(1): 79-191.

Dunlop, D, McCabe, M, Evans, R, Richmond, P, 1994. Ear piercing and children rights. *BMJ* 308: 1639-1647.

Ethnic Minority Employment Task Force. 2004. *Year 1 Progress Report Autumn 2004*. http://www.dh.gov.uk.

Ferrari, A. 2002. The impact of culture upon child rearing practices and definitions of maltreatment. *Child Abuse and Neglect* 26: 793-813.

Fontes, L. 1995. *Sexual abuse in nine North American cultures.* Thousand Oakes,CA: Sage.

Full Text of the UN Convention on the Rights of the Child. www.unicef.org/CRC/fulltext.htm.

Gatrad, A, Sheikh, A. 2001. Medical ethics and Islam: principles and practice. *Arch Dis Child* 84: 72-75.

General Medical Council. 2001. *Good practice. The duties of a doctor registered with the General Medical Council.* www.gmc.org.uk/.

General Medical Council. 1997. *Guidance for doctors who are asked to circumcise male children.* www.gmc-uk.org/.

Hampton, R, Newberger, E. 1984. Child abuse incidence and reporting by hospitals: Significance of severity, class and race. *American Journal Of Public Health* 75: 56-60.

Harran, E. 2002. Barriers to effective child protection in a multicultural society. *Child Abuse Review* 11: 411-414.

Helman, C. 2001. *Culture health and illness.* London: Oxford University Press.

HMSO. 2003. *The Victoria Climbié inquiry. Report of an inquiry by Lord Laming.* London: The Stationery Office.

Hoghughi, M, Speight, A. 1998. Good enough parenting for all children – a strategy for a healthier society. *Archives of Disease in Childhood* 78: 293-300.

Johnson, C, Showers, J. 1985. Injury variables in child abuse. *Child Abuse and Neglect* 9: 207-215.

Jones, E, McCurdy, K. 1992. The links between types of maltreatment and demographic characteristics of children. *Child Abuse and Neglect* 16: 201-215.

Kairys, S, Johnson, C. 2002. The psychological maltreatment of children – technical report. *Pediatrics* 109: e68. www.pediatrics.org/. (accessed December 2004).

Kenney, J. 1989. Pigmentary disorders in black skin. *Clinics in Dermatology* 2: 1-10.

Koramoa, J, Lynch, M, Kinnair, DA. 2002. Continuum of child rearing: Responding to traditional practices. *Child Abuse Review* 11: 415-421.

Korbin, J. 1991. Cross cultural perspectives and research: Directions for the 21st century. *Child Abuse and Neglect* 15: 61-67.

Larsen, M, Tentis, E. 2003. The art and science of disciplining children. *Pediatric Clinics of North America* 50: 817-840.

Maitra, B. 1996. Child abuse: A universal 'diagnostic' category? The implication of culture in defintion and assessment. *International Journal of Social Psychiatry* 42: 287-304.

McLaurin, C. 1988. Cutaneous reaction patterns in blacks. *Dermatologic Clinics* 6: 353-361.

Meier, E, Moy, C. 2004. Social grading and the census. *International Journal of Market Research* 46(2): 141-170.

Richardson, J, Coid, J. *et al*. 2002. Identifying domestic violence: cross sectional study in primary care. *BMJ* 324: 1-6.

Riddell-Heaney, J, Allott, M. 2003. Safeguarding children 3: Getting to grips with culture and ethnicity. *Professional Nurse* 18: 473-475.

Rubin, A. 1979. Black skin. Here's how to adjust your assessment and care. *RN.* March: 31-35.

Spencer, N. 2000. *Poverty and child health.* Oxford: Radcliffe Medical Press.

Steele, B. 1986. Notes on the lasting effects of early child abuse throughout the life cycle. *Child Abuse and Neglect* 10: 283-91.

Stuart–Brown, S. 2004. What is good enough parenting in the context of child protection. RCPCH. Highlights of the 8th Spring Meeting. CD-ROM 2004.

Sugar, M, Taylor, J. *et al*. 1999. Bruises in infants and toddlers. *Arch Pediatr Adolesc Med* 153: 399-403.

Taylor, J, Spencer, N, Baldwin, N. 2000. Social, economic and political context of parenting. *Archives of Disease in Childhood* 82: 113-120.

Phillips, M. 2002. Issues of ethnicity and culture. Chapter 7. In *The Child Protection Handbook*, ed. K. Wilson and A. James. London, Balliere Tindall.

Tudor Hart, J. 1971. The inverse care law. *Lancet* 27: 405-412.

Tush, B. 1983. Bruising in healthy 3-year old children. *Maternal –Child Nursing Journal* 165-17.

Van Cleemput, P. 2000. Health care needs of travellers. *Arch Dis Child* 82: 32-37.

Webb, E, Maddocks, A, Bongilli, J. 2002. Effectively protecting black and ethnic children from harm: Overcoming barriers to the child protection process. *Child Abuse Review* 11: 394-410.

Webb, E, Sergison, M. 2003. Evaluation of cultural competence and antiracism training in child health services. *Archives of Disease in Childhood* 88: 291-294.

Webb, E, Shankleman, J, Evans, M, *et al*. 2001. The health of children in refuges for women victims of domestic violence: cross sectional descriptive survey. *BMJ* 323: 210-213.

Webb, E. 2000. Health care for ethnic minorities. *Current Paediatrics* 10: 184-190.

Webb, E. 2004. Discrimination against children. *Archives of Disease in Childhood* 89: 804-808.

Whipple, E, Richey, C. 1997. Crossing the line from physical discipline to child abuse: How much is too much? *Child Abuse and Neglect* 5: 431-444.

World Health Organization. 2002. *World report on violence and health. Chapter 3. Child abuse and neglect by parents and other carers.* www.who.int/en (accessed May 2004).

www.childrenareunbeatable.org.uk (accessed Dec 2004).

5

Growth: Relevance to child abuse and neglect

An understanding of childhood feeding problems and their implications on the child's growth, are vital in the prevention and recognition of child abuse and neglect. Measurement of height and weight is often left to untrained staff, and the importance of accuracy cannot be over emphasised. There is a need for caution in the interpretation of growth charts.

What determines how a child grows?

The growth of the fetus and its size at birth depend on:

- The health and nutritional status of the mother which include her height and weight, whether or not she smokes and whether she has any illness
- The uterine circulation and placenta
- Problems and disorders in the baby such as premature birth, number of fetuses, length of pregnancy, chromosomal disorders and intrauterine infections.

After birth, the growth of the baby depends on different factors. Assuming that he/she does not have any medical disorder or serious illness, the most important factor is nutrition. But babies also need loving care and attention and if they are neglected or abused, this affects their physical growth as well as their personal and social development. As the baby gets older, the rate of growth is increasingly affected by his/her genes. In turn, the genes affect height, and probably body build – whether he/she is skinny, a normal build, or has a tendency to get overweight.

Key Message
A baby's growth in the first two years of life depends more on maternal and intrauterine factors than on his/her ultimate genetic growth potential.

The fastest growth is in the first year of life. After a transient weight loss, birth weight is usually regained by the end of the second week and thereafter the average baby gains 150-200 g per week. A baby who weighs 3 kg at birth will probably double that by five months (6 kg) and treble it by a year (9 kg) but will only add 2 or 3 kg in the whole of the third year – though he/she will certainly get taller. After that the rate of growth slows down and then speeds up again at puberty but is never again as fast as in the first year (see Fig. 1).

Key Message
Babies double their birthweight by five months and treble it by one year; in the whole of the second year they add only 2-3 kg - however, they get taller by on average 12 cms.

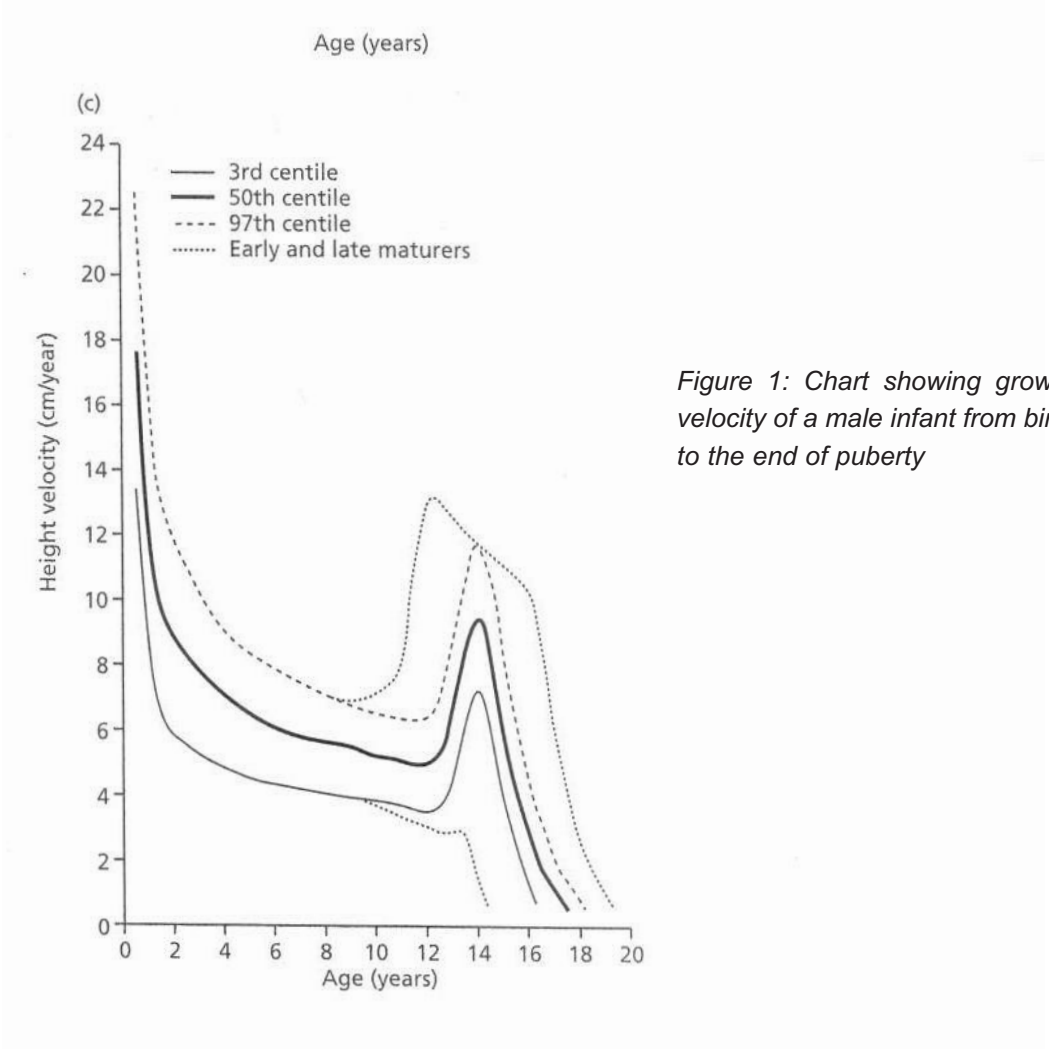


Figure 1: Chart showing growth velocity of a male infant from birth to the end of puberty

Measurement of height and weight

The two most important measurements are height and weight. Babies should be weighed naked whenever possible, in a warm room. Scales need to be checked and calibrated at regular intervals. If nude weight cannot be done, for instance, because the child is wearing a

Key Message
Weight can vary day-to-day by several hundred grams in infancy depending on the contents of stomach, bowels and bladder, so in community settings too frequent weighing can be an unnecessary cause of anxiety.

Weight changes more quickly than height. Weight loss through dehydration can occur in a matter of hours and any acute illness can cause weight loss in a few days or weeks. Thus, the weight can provide information about the recent state of the child's health. The child's height gives an indication of health over a long period of time – months or more usually years. Growth in height may be slowed or stopped by chronic illness or neglect – but this will not become obvious until eventually someone realises either that the child is shorter than his/her younger siblings or his/her peer group, or that he/she is not growing out of his/her clothes. By the time a parent is worried about the child's height, and thinks he/she is not growing, the chances are that the parent is right.

Key Message
Fluctuation in height and weight means different things. Weight changes quickly but it takes a long time for abnormal growth in height to be detectable.

It is important always to measure the child's height and weight, or length and weight, whenever there is any concern about his/her health or well-being. By comparing the individual patterns of plotted height and the weight measurements, it is possible to get an idea of the time over which a child has become unwell. The child who has been undernourished for many years and is short in stature is said to be stunted. The child who has obviously lost a lot of weight is said to be wasted. Of course, stunting and wasting often co-exist in the same child.

Key Message
Stunting means impaired growth in height due to chronic under-nutrition; wasting means substantial loss of weight due to tissue loss rather then dehydration.

Growth charts

Charts are used to compare the height and weight of an individual child and the rate of growth of that child, with what is observed in a reference population – this makes it easier to decide whether or not the pattern is normal. In order to construct a growth chart, measurements are taken from a very large number of babies and children. The UK 1990 charts are constructed from cross-sectional data. Charts can also be constructed from longitudinal data from the same children, but this is a much longer process. It is not necessary to have a separate chart for children of different ethnic groups – the same chart should be used for everyone.

The expectation might be that the perfectly proportioned baby would be on the same centile for both the height and the weight. However, it can be quite normal for a child to be lean or ‘skinny’ or to be chubby or ‘fat’ and in such cases the child would be on a different centile for weight as compared to height. Tall, lean parents are likely to have tall, lean children.

Key Message
Babies do not have to be on the same centile for length and weight. It is perfectly normal to be lean or chubby.

Plotting measurements on a growth chart
When plotting measurements on a chart, a small mark (the point of a pen or pencil) not a large blob should be made, as this reduces accuracy. Plot exactly what the measurement was – the mark should not drift up or down to come into line with previous measurements. Sign and date the measurement on the chart or at the relevant place in the notes. Then check if the chart is telling you the same as your eyes. If the chart shows something unexpected – for instance, if the child has apparently shrunk in height or a child who looks small for his/her age seems to be on the 98th centile – the measuring or plotting may be wrong. Do not accept it – do it again. Growth charts are sometimes presented as evidence in child protection cases. If a growth chart is to be displayed at a child protection conference or in court, every length, height, weight and age must be double checked to make sure that they have been correctly plotted. (If necessary, a new chart should be created, entering the data correctly, and indicating on it that this is what has been done – with a signature and date. Charts in the records must not be altered). Check also whether the baby was weighed in the same state of undress and on suitable scales that are regularly checked or re-calibrated.

Key Message
Check charts before going to a child protection conference or to court, but don't alter them, make a new chart if necessary.

Correct for preterm birth before the results are plotted. This should be done up to the first birthday. After that, the measurement error in relation to the rate of change in height and weight means that the prematurity correction becomes less important.

How to measure length and height

Length and height should be measured using a device designed for the purpose (Fig. 2) - tape measures and biro marks on a sheet or a wall are unacceptable. The current best choice for general use is probably the Leicester Height Measure. (See Fig. 2 for a description of measuring technique). Different observers or different equipment will produce different results. It is important always to be as accurate as possible but there is no such thing as absolute precision. Measurement error and imprecision are two different things. Errors arise through bad technique, poor equipment and wrong plotting. Imprecision is unavoidable because children are not rigid objects and do not have an exact height.

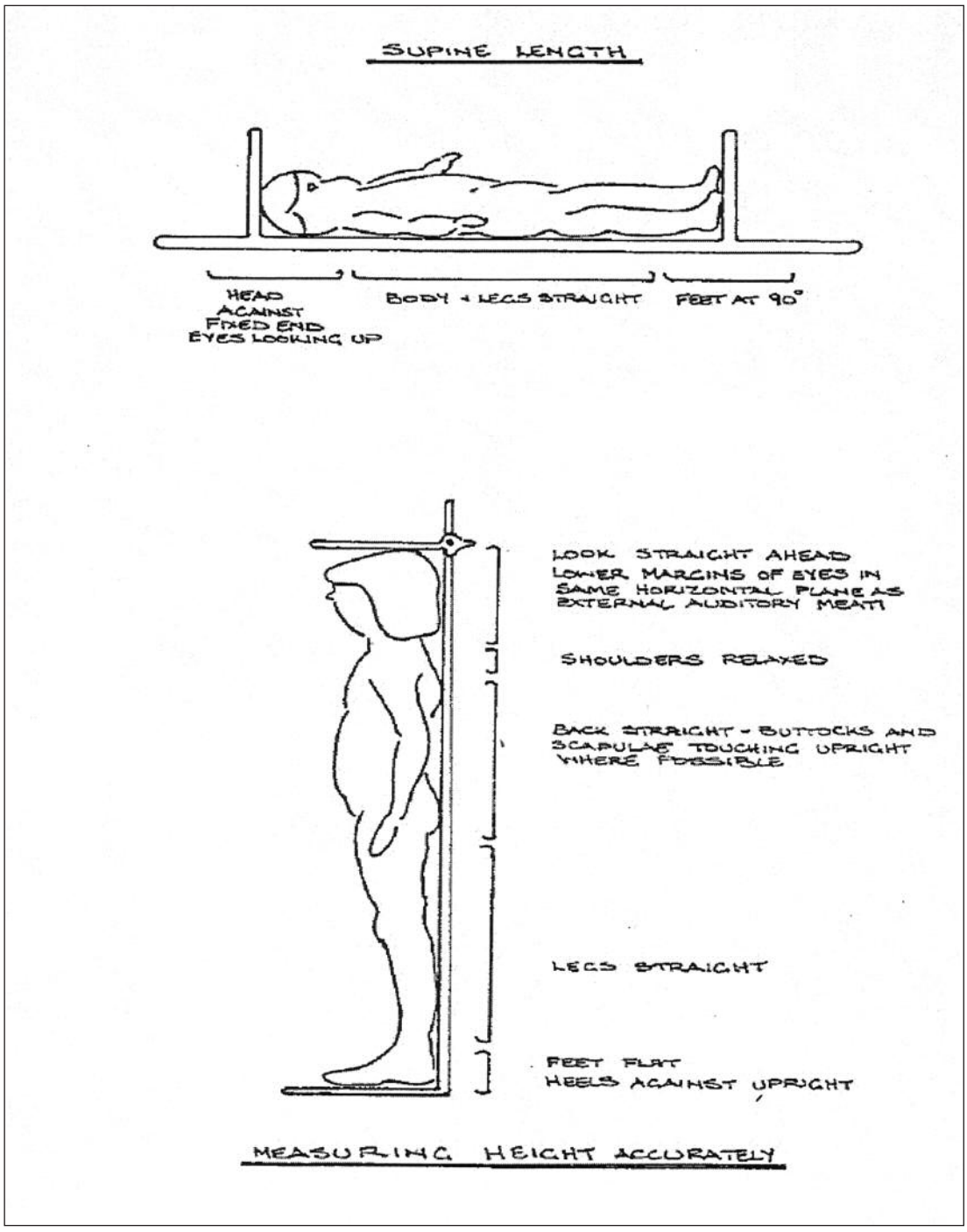


Figure 2: Use of the Leicester height measure

Key Message
Errors are avoidable and are due to poor equipment or technique; however imprecision is unavoidable and is due to the fact that children are not rigid objects. Errors can be minimised by careful attention to consistent technique.

Supine length

This is measured up to the age of two; standing height thereafter. It is often possible to obtain an acceptable measurement of height as early as 18 months but reliable measurement of young children depends on securing their cooperation, which is usually easier in three- and four-year-olds. Standing height varies during the day – it falls on average by 0.3 cm by mid-morning, another 0.2 by lunch time, and very little thereafter.

Parental and child height

A child's unusually small or short stature may be due to having short or tall parents. The formula for seeing if a child's height is in the target range for his/her parents is:

(Mother's height + father's height)/2 +7cm (boy) or – 7cm (girl)
= mid-parental height, (MPH)

Child's predicted adult height = + or – 10cm of MPH or 2 centile spaces

It is important to ascertain that both parents are the biological parents.

Measurement of weight

The first few weeks

Breast-fed babies show a slightly different growth pattern from formula-fed babies. Growth charts are available for breast-fed babies, though these have not so far been widely adopted. Some weight loss is normal in the first two weeks of life (Fig. 3). The average is around 7% for breast-fed babies and somewhat less than this for formula-fed babies; most recover their birth weight by the 9th or 10th day. Some babies lose 10% or more of their birth weight. The most common reason is insufficient intake, though occasionally there may be obvious reasons such as prematurity or illness, or anatomical abnormalities such as cleft palate (tongue tie is virtually never the cause). The underfed baby may be restless and irritable but some are apparently satisfied and go to sleep after a feed which may mislead the mother and the midwife. Weight loss of 12% or more can be associated with serious dehydration and a dangerously high sodium level – hypernatraemia (Laing and Wong 2002, Macdonald *et al* 2003). This may cause brain damage.

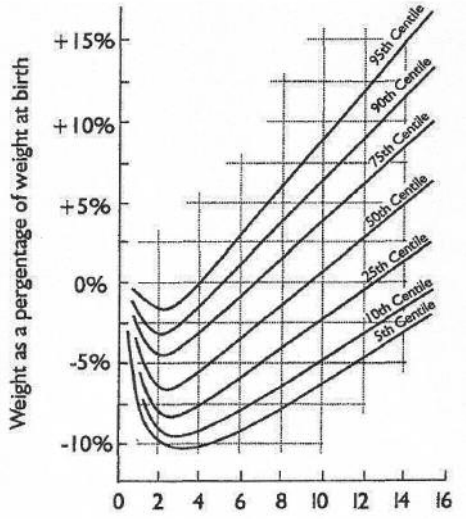


Figure 3: Chart showing weight measurements in first days of life

Opinions differ as to whether, and how often, babies should be weighed in the first two weeks of life in order to identify this problem. Many midwives fear that weighing might worry the mother and may lead her to abandon breast feeding if the baby is not gaining weight.

On the other hand, identifying babies who have lost more than 12% of their birthweight, by weighing them at the same time as the blood spot test, may prevent most cases of serious hypernatraemia. Test weighing – estimating the amount of milk taken, by weighing before and after a single feed – is not recommended because milk production varies so much between feeds and weighing usually underestimates true intake.§.

Key Message
Beware of the baby who feeds poorly, sleeps a lot and loses weight as there is a risk of hypernatraemic dehydration.

Weighing after the first few weeks
The regular weighing of babies may help in the detection of various disorders, although it may also cause needless worry and unnecessary referrals. More importantly, mothers like their babies to be weighed as a reassurance that the baby is well, particularly in the first few months of life and with their first baby.

Patterns of weight gain

Crossing over centile lines
If the weight is plotted regularly during the first two years of life, a growth curve for that particular child is obtained. If that curve is exactly parallel to the centile lines on the chart, everyone is happy – but in the first year or 18 months of life, babies do not necessarily follow the centile lines and may cross over them instead. This phenomenon mainly occurs in the first year or 18 months of life. This is because the size of an older child or an adult is determined mainly by the size of his or her parents whereas the size of the baby when he/she is born is more related to obstetric factors.

For example, consider a baby who has grown well *in utero* and is on the 75th centile at birth. If the parents are small, the child might be on the 10th centile for height and weight by the time he/she is three years old. This means that it is common and normal for a young child's measurements and growth curve to cross the growth chart lines, although of course one must always consider whether that observation could be due to something more serious.

Key Message
Babies do not all grow along centile lines as crossing centiles up or down is common and usually normal.

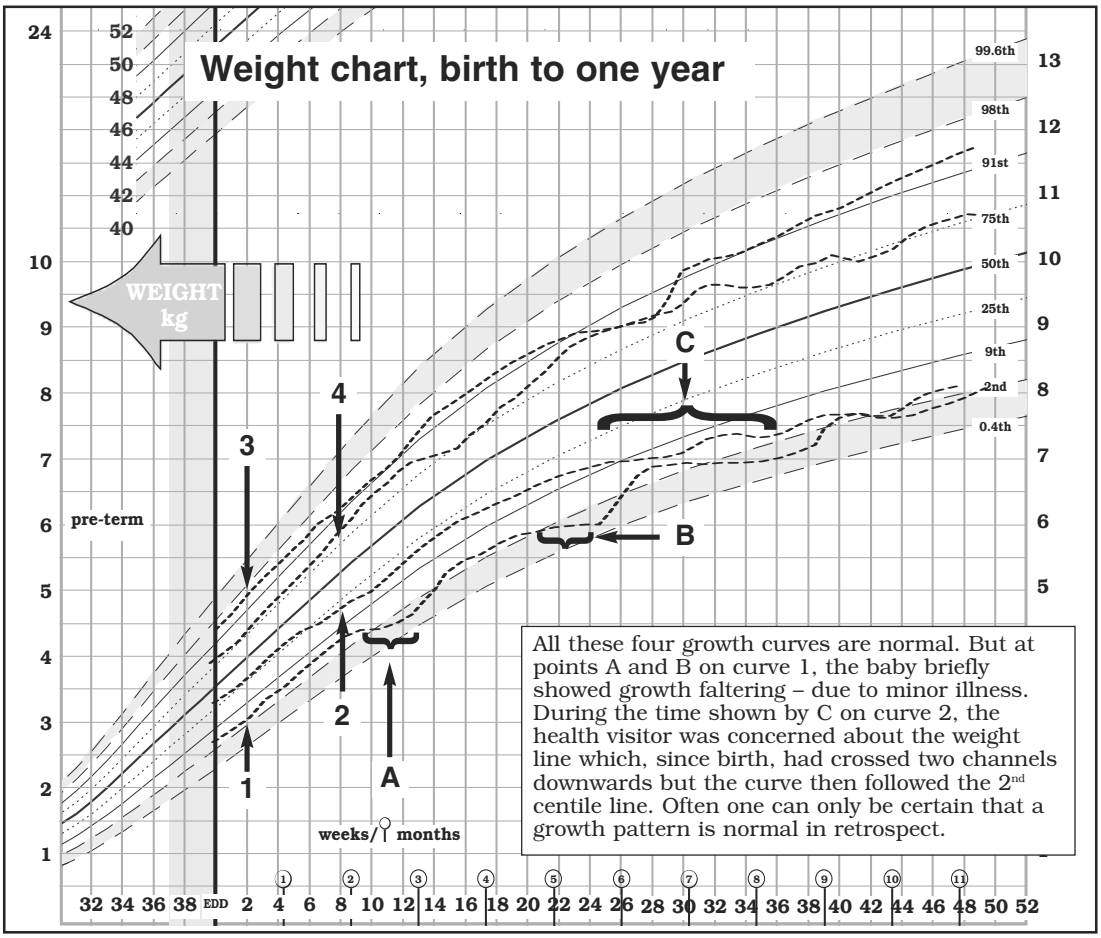


Figure 4: Chart showing normal variation in growth patterns

Weight loss

A short period of weight loss, followed by rapid catch-up, happens quite often if the baby has a viral illness, gastroenteritis or respiratory infection. If the baby is continuing to lose weight, as opposed to simply gaining weight more slowly than the centile lines suggest is normal, further investigation is needed as there are many possible causes.

Growth faltering

A common problem is the baby or child whose chart suggests that he/she is not gaining weight at the 'expected' rate but there is no other evidence of anything wrong. It can be very difficult to decide whether the growth pattern is abnormal for that particular child.

Some people use the term 'failure to thrive' to describe babies whose pattern of weight gain is less rapid than one expected; others refer to 'growth faltering'. Both terms suggest that there is a problem with the baby and can be used where it is suspected that the baby's food intake is insufficient (the most common explanation) or that there may be an underlying illness, disorder or syndrome that merits investigation. The term 'slow weight gain' may be preferable.

Slow weight gain, feeding problems and failure to thrive (Raynor and Rudolph 2000)
Babies who gain weight slowly cause concern to parents and staff. There is often a tendency to blame parents for these problems but that is often a simplistic explanation. Several sets of interacting factors may be involved:

- Parental knowledge, personal resources and mental health; disappointment with the child's appearance or behaviour; preoccupation with other children or other worries
- Insecure infant, disturbed emotional affect in the parent, lack of mutual attachment and enjoyment
- Child characteristics including physical appearance, undemanding or unresponsive behaviour, poor appetite and immature feeding skills
- Family relationships and tensions, social isolation, lack of support and misconceptions about diets, due to lifestyle or culture
- Management problems such as difficulty in establishing predictable mealtimes, allowing unrestricted access to food at all times, no effective cues, prompts or rewards for age-appropriate eating.

The term 'non-organic failure to thrive' has been used to describe the situation where there is thought to be poor parenting and inadequate feeding, although these cases are often more complicated than appears at first sight and the division between organic and non-organic causes is probably unhelpful. Monitoring weight gain is an essential part of managing these cases, but frequent weighing inevitably reveals random fluctuations in weight and must be managed carefully, otherwise parents will dread the next clinic visit and will feel pressured to get more food into the child. They may resort to forced feeding, which invariably makes matters worse.

The baby's overall health and well-being are as important as the growth chart. A baby who has lots of energy, is sleeping and eating well, and is happy and smiling, is unlikely to have anything seriously wrong. Similarly, the mother who is relaxed, competent and caring, and managing her baby well, with good communication between them, is unlikely to be behaving completely differently when she is at home alone with the child. Conversely, when the parent is unhappy or depressed, or is making negative comments about the baby, or has strange ideas about how he/she should be fed, or does not show any anxiety even when the health visitor is obviously concerned, there may be problems that need investigation.

Weaning difficulties
The problem of slow weight gain often begins at the time of weaning. It may be associated with a range of parenting difficulties. It is therefore important to focus on identifying parents who need help with child rearing.

Key Message
Slow weight gain at the time of weaning is often part of a wider picture of family dynamics.

Difficulties with weaning can arise for many reasons:

- Late introduction of solids may result in preference for a more limited range of food. This may occur because of illness, early tube feeding, oro-motor dysfunction or general developmental delay
- Delays in learning to chew food, from lack of early experience, may lead to a gag response when solid or lumpy food is given. However, such difficulties may also be the result of oro-motor dysfunction which may have been the reason for late weaning
- Early unpleasant experiences affecting the mouth and pharynx may also lead to food refusal; for example, tube feeding, gastro-oesophageal reflux, repeated vomiting, unpleasant medicines
- Aversion to food could be due to: abdominal pain and nausea, reflux or constipation
- Iron deficiency may result from weaning problems – there is some evidence that it can also be the cause of behavioural changes and difficulties.

Fussy eaters

Extremely fussy eating seems to run in families. It usually begins around 18 months and growth is generally satisfactory. These children tend to be more difficult in temperament, more cautious and often very shy. Some show a dread of new food, express contamination fears between foods they sense they like and dislike, smell the food before eating it, and are visibly disgusted at foods they do not like. They can distinguish even between different brands of the same food. Some show disgust in other ways, like hatred of getting dirty or standing barefoot on grass.

A few of these children are in the autism spectrum or have semantic pragmatic disorder, but others are normally socially competent.

Key Message

Fussy eating can cause parents and professionals a lot of anxiety. Their eating behaviour is partly related to temperament.

Growth in premature and small for gestational age babies

Infants who were of very low or extremely low birth weight are at risk of poor growth and growth failure, particularly if they also have other problems such as lung disease. Babies who were small for gestational age at birth often show catch-up growth but as adults are more likely to be shorter than expected. Paediatric and nutritional follow-up is often advisable for these groups of babies.

Important causes of impaired growth

Genetic and familial

By definition, 2% of children are below the 2nd centile for height (that is, more than 2 SDs from the mean). Nearly all of them are normal short children and in many cases the parents are also short. When the height is below the 0.4th centile line there is more likely to be a specific cause.

Intrauterine growth retardation

This is a common cause of short stature. Although children who have lost weight acutely in the last few weeks of pregnancy often catch up completely in height and weight, those who have suffered prolonged malnutrition may remain small. A minority of these babies have a dysmorphic syndrome. Some of these babies can be unattractive physically, difficult to feed and care for – in such cases it is easy to understand how some might assume that poor growth is the parents' fault.

Neglect and abuse

In general, the child who is healthy and happy will also be growing normally, but the reverse does not necessarily apply. It is possible for a child to be of normal length and weight, yet still have a chronic illness or be suffering abuse or neglect. Assessment of growth is an important part of any child protection assessment.

All types of abuse may lead to impairment of linear growth as well as failure to gain weight. Often this is associated with other evidence of neglect. In this situation, parents do not usually seek medical advice. Identification of children who are growing poorly because of under-nutrition combined with adverse social circumstances is more likely to be achieved by alert observation (by community staff or teachers) than by routine growth monitoring.

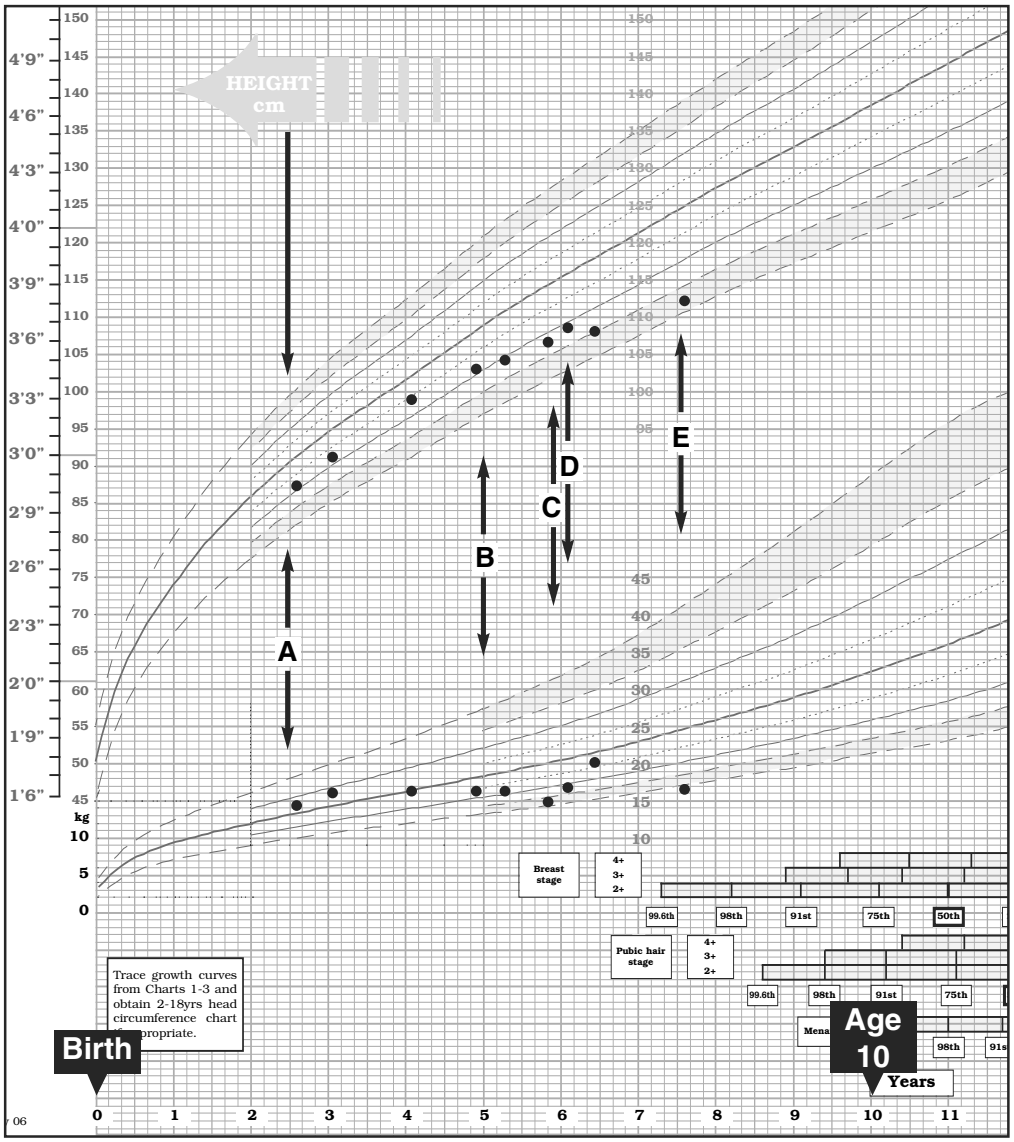
Key Message

Abused or neglected children may show poor growth but this is not invariable. Normal growth does not rule out abuse.

Under-nutrition can also occur when parents develop fixed ideas about food allergies or health food enthusiasts offer their children highly unsuitable diets, with too much fibre and insufficient energy content – for example, using skimmed milk for young children.

Some parents develop distorted ideas about feeding and present their child with repeated complaints about poor growth. This can be one manifestation of fabricated or induced illness or FII (previously Munchausen syndrome by proxy). Such complaints can even mislead paediatricians into embarking upon naso-gastric feeding.

Occasionally, children respond to chronic stress and distress in the home with a characteristic behavioural syndrome, involving hyperphagia and polydipsia, together with growth failure, normal body mass index (BMI) and impaired growth hormone deficiency (Skuse *et al* 1996). Cases of extreme neglect are occasionally seen where the family has managed to conceal their child from all statutory services.



At age $2^1/_2$ (A) the health visitor had no worries about this girl. At school entry (B), the school nurse measured her and noted a slight fall in weight centile but thought she was well. At the start of a new term (C) she was measured again because the teacher thought she looked thin - she had lost weight but the mother said she had been ill during the school holiday. By the end of the term (D) she had gained weight again. During the next year the teacher noted that she often looked hungry and she was found stealing food from other children and looking in bins. At (E), at the start of the new term after the long summer holiday, her weight had fallen again. Social services investigation was then undertaken, revealing a chaotic situation at home and she was removed to a foster home. Note that twice the weight dipped during the summer holiday and rose again on return to school, where she had extra food at the breakfast club and free school meals. However, the height measurements do not show a very clear trend until E. The story told by the chart is obvious in retrospect but was not obvious to staff at the time.

Figure 5: Chart showing a growth pattern in a school aged child

Serious under-nutrition occurs in some chaotic or dysfunctional households. In such cases, there will usually be other evidence that the child is not receiving adequate care and attention, and that the parent is not providing good enough care.

Key Message
Non-organic failure to thrive is rarely simple. Organic dysfunction in the baby, parental mental health, neglect, and social and behavioural issues should be considered. A comprehensive assessment of all factors is essential to get a complete picture.

Other causes
Important treatable causes of short stature include hypothyroidism, growth hormone deficiency (isolated GH deficiency, multiple pituitary hormone deficiency) and Turner's syndrome. Occasionally, serious diseases such as cystic fibrosis, renal failure, inflammatory bowel disease (mainly Crohn's) and coeliac disease can present with poor growth but no other symptoms or signs. Milder forms of dysmorphic and short-limbed short stature syndromes are easily missed if one does not look carefully at the child's appearance and proportions. Some conditions can make the child more difficult to care for and precipitate abuse in a family already struggling to cope.

Management of impaired growth

Management of slow weight gain, feeding problems and failure to thrive needs to address all of the above factors. A psychosocial and medical evaluation is required. If 'medical' causes need to be excluded this is best done early on, so that the anxiety of the parent or health professional can be set aside, but it is vital to explain right at the start that in most such cases no disease or disorder will be found and that the focus will be on approaches to feeding and family issues.

A home visit to observe a mealtime is the best basis for providing support and advice about feeding. An account of the baby's diet and feeding practices given to health professionals in a clinic may not relate very closely to what is happening at home. For example, few parents will admit to feeding their baby by leaving a bottle propped on the pillow. Video recordings made in parents' homes, however have shown how many parents have enormous difficulty in feeding their young child (University of Leeds, media services). The recordings revealed battles over feeding, lack of any routine, too many distractions and no understanding of the social aspects of mealtimes. In most cases, there had been no suspicion in the clinic regarding the extent of the difficulties these mothers were experiencing. These feeding and management difficulties are of course not confined to babies with slow weight gain.

Family and parenting issues

- Consider parents' mental health – depression, social isolation, substance abuse, domestic violence may all affect their ability to cope.
- Start by aiming to reduce parents' anxiety – worries about eating can take over their lives. Identify depression, parental conflict, family violence and lack of interest in child – a community psychiatric nurse or a play therapist may be able to help.

- Nursery or family centre placement can be very beneficial. The parent is relieved of the continuous stress, and children often eat better in this social setting.
- Liaise with other professionals who may have important information that can help in addressing the difficulties.

Assessment of a toddler or older child

In assessing a toddler or older child, a wider look at general behavioural and emotional difficulties needs to be taken. Be aware of unusual behaviours that may give a clue to major feeding and management problems, for example, extreme hunger drive, searching for food, eating or drinking from unlikely places such as animal feeding bowls, begging for food or stealing food, scavenging. It may be necessary to consult a psychologist for guidance on behavioural management and a dietician for advice on increasing calorie density.

Child protection concerns

If there are any concerns that the child may be suffering from abuse or neglect then a children's social care assessment is required. Occasionally, parents' accounts of feeding problems seem incompatible with what is observed in the clinic or during an admission to the ward and one then needs to consider the possibility of fabricated illness.

It is difficult to know in some cases when questions of child protection should be raised. Sometimes there is such obvious neglect and unacceptable parenting that action is imperative; more often, there is a tension between the wish to help and support the family (which community staff fear might be made more difficult by involving children's social care) and the anxiety as to how much the child's safety is threatened (Raynor *et al* 1999). Iwaniec's monograph contains many accounts of children who failed to thrive in association with management problems and the complexity of the family circumstances in most of these cases emphasises the vital importance of consultation with colleagues – for instance, the health visitor, the named or designated doctor or nurse and an experienced social worker as a first step, when in doubt (Iwaniec 2004).

Key Message

Liaison with other professionals who may have important information is essential to provide a complete picture, obtain advice and support and coordinate management.

Measurement of head circumference

The head circumference is a crude but useful proxy for brain size and growth. An infant's head circumference increases from a median of 25 cm at 28 weeks gestation, to 35 cm at term and 45 cm by 8 months. The brain weighs on average 400 g at birth and this has increased to 1 kg (70% of its adult weight) by the first birthday. There is a corresponding rapid increase in brain protein and nucleic acid. During this time there is dramatic growth and remodelling of synaptic connections. These processes need input from the environment and can be adversely affected by deprivation and negative or stressful experiences.

Head circumference should be measured as part of the newborn examination, but preferably not in the first two days as it may be increased by scalp oedema or decreased by moulding. A second measurement should be taken at 6-8 weeks. The head circumference should be measured using a paper tape such as the Lasso. It is important to take the maximum circumference, since this is the only repeatable reading. Some babies are upset by this procedure and it is wise to leave it until near the end of the examination. The measurement is meaningless unless it is plotted on a chart.

What can be learnt from head circumference measurement?
Measurement of the head circumference (HC) is helpful in paediatric practice for several reasons:

- In the newborn, head size may help in the assessment of infants who are small for gestational age. An infant who is small in length, weight and head circumference is likely to have suffered prolonged under nutrition *in utero*, whereas one who has grown well in length and has a normal head circumference, but has a disproportionately low weight is likely to have suffered a shorter period of under-nutrition towards the end of pregnancy. This distinction is not always as simple as it sounds, because genetic disorders, intrauterine infections and hypoxic ischaemic injury to the developing brain may complicate the picture.
- Many disorders (see below) are associated with abnormal size (and sometimes shape) of the head. This may be apparent at birth but sometimes only becomes obvious later in infancy or childhood.
- Measurements at birth and in the first few months of life provide a baseline for future measurements in the event of suspected deviant developmental progress or abnormal growth of the head as may occur, for example, in hydrocephalus. Monitoring head growth can be useful when an infant appears to have suffered severe brain injury at birth or in the early days of life. In these circumstances, a declining rate of growth (that is, the head circumference crosses centiles downwards) is ominous as it suggests that the brain has sustained significant damage. Conversely, if the head circumference was already small at the time of birth, this may suggest that any damage occurred long before the baby was born.
- In individual cases, head circumference measurements are useful if they are abnormally big or small or changing at an abnormal rate. Within the normal range, a single measurement is usually unhelpful for clinical purposes. Generally, the head circumference has a very weak relationship to the child's intelligence quotient (IQ). There are familial variations in head size and in some individuals a very small head may be associated with high IQ and vice versa.

Key Message
it is important to take the maximum head circumference, since this is the only repeatable reading.

Babies with a large head
If the growth line is crossing the centile lines in an upwards direction, or if the measurement is above the 98th centile, but the baby is entirely well and normal, measure the parents'

heads, particularly the father's. A large head is commonly a familial feature; not only the size of the head but also its rate of growth are increased, relative to standard growth charts, in some families. Abnormal growth of the head may present at any age but is most commonly a cause of concern in the first year of life.

There are many causes, of which the two most familiar are hydrocephalus and subdural haemorrhage (haematoma, effusion). In the great majority of cases, there will be other clues that there is something wrong, such as poor weight gain, delayed or abnormal development, irritability, vomiting, seizures or signs of raised intracranial pressure – separated sutures, a bulging anterior fontanelle, downward deviation of the eyes (sunset sign), squint and prominent veins on the forehead. If there is doubt about the tension of the fontanelle, particularly if the baby is crying, the baby should be sat up and the tension felt again. If there is still uncertainty, it is probably abnormal. Other evidence of physical abuse may be present.

Note that hydrocephalus, subdural haematoma and raised intracranial pressure can occur in a head of any size – not just in big ones. In infancy, the sutures are not yet fused and the head can expand easily, so the intracranial pressure, the size of the head and the effect on the baby depend on how quickly the underlying disorder is developing.

Babies with a small head

Microcephaly simply means a small head. Pathological microcephaly cannot be defined purely on the basis of size. Head circumference measurements below the 2nd centile do not necessarily imply abnormality. A head circumference which is far below the 2nd centile line is often associated with pathology and developmental or neurological disorder but this is not invariably the case. The measurement may be less significant if the baby is small or if one or other parent has a small head.

Microcephaly may be obvious at birth as an isolated finding or as part of a syndrome or systemic disorder, or it may occur as a result of severe perinatal or postnatal brain damage - for example, after meningitis or injury. These babies should be under specialist care.

Impact of poverty and neglect on brain growth

Infants who suffer chronic malnutrition, neglect or abuse are at risk of permanent effects on the developing brain. The impact may depend partly on the nature of the adverse experiences, for instance, they may include physical deprivation such as under-nutrition, emotional neglect, failure to teach the infant basic skills and concepts, living in a hazardous and impoverished environment, or actual physical abuse. It seems unlikely that all adverse experiences would have the same impact on the developing brain or lead to the same behavioural and cognitive outcomes in later life. Children vary in their individual resilience to adverse factors and positive influences can partly compensate for negative ones. Differences in the volume of key cortical brain structures can be demonstrated by MRI in children who have suffered various forms of abuse (Glaser 2000).

Key Message

Infants who suffer chronic malnutrition, neglect or abuse are at risk of permanent adverse effects on the developing brain.

Observations in Western Countries

In most cases of child neglect in Western countries, deficits in height and weight are more common than measurable impairments of head circumference and brain volume, and improvement in these parameters after placement in a foster family is more readily demonstrated. Children who have been removed from their home by children's social care and placed with foster carers often show some catch-up growth in height and weight, although it is unusual for these children to be so short or underweight that they could have been identified solely by their growth patterns. Deficits and subsequent catch-up in head circumference are less commonly seen except in the most extreme cases. In premature and low birthweight infants, there is an association between reduced growth in head circumference, neglect and cognitive outcome.

Cause and effect

Deprivation, neglect and abuse are linked with, and may cause, reduced and probably sub-optimal brain growth and development. However, it may also work the other way round – babies who are born with neurological deficits, or are less responsive, or have difficult temperaments, are more likely to be neglected or abused, and perhaps elicit less care-giving from their parent(s).

Summary

Careful evaluation of growth (height, weight, head circumference) is an important part of the medical assessment in child protection work. Doctors should be aware of the wide differential diagnosis of individual variation in these growth measurements. There is a large 'grey area' where it is difficult to disentangle the roles of parent and child factors. Collecting and sharing information from other professionals will aid this analysis. Impaired early growth, especially brain growth can have long-term consequences for future development.

References

Clues from children's mealtimes: a video and teaching manual on eating difficulties in young children (available from Media Services, University of Leeds).

Glaser, D. 2000. Child abuse and neglect and the brain - a review. *J Child Psychol Psychiatry* 41(1): 97-116.

Iwaniec, D. 2004. *Children who fail to thrive – a practical guide*. Chichester: John Wiley.

Laing, IA, Wong, CM. 2002. Hypernatraemia in the first few days: is the incidence rising? *Archives of Disease in Childhood Fetal and Neonatal Edition* 87: F158.

Macdonald, PD, Ross, SM, Grant, L. *et al*. 2003. Neonatal weight loss in breast and formula fed infants. *Arch Dis in Child Fetal and Neonatal Edition* 88: F472.

Raynor, P, Rudolf, MCJ, Cottrell, D, *et al*. 1999. An RCT of focused intervention and its effect on mealtime and eating behaviour in families with children diagnosed as failing to thrive (NOFTT). *Archives of Disease in Childhood* 80 (suppl 1): A62.

Raynor, P, Rudolf, MCJ. 2000. Anthropometric indices of failure to thrive. *Archives of Disease in Childhood* 82: 364-365.

Raynor, P, Rudolf, MCJ, Cooper, K, *et al*. 1999. A randomised controlled trial of specialist health visitor intervention for failure to thrive. *Archives of Disease in Childhood* 80: 500-506.

Skuse, D, Albanese, A, Stanhope, R, *et al*. 1996. A new stress-related syndrome of growth failure and hyperphagia in children, associated with reversibility of growth hormone insufficiency. *Lancet* 10:348 (9024): 353-358.

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6

Recognising child abuse and neglect: child development signs

Neglect is often associated with developmental delay. All forms of abuse may have a lifelong impact on development and emotional well-being.

Detailed knowledge of child development is required for all those undertaking child protection work. This is because interpretation of parental accounts of how injuries may have been caused need to be made in the context of the child's developmental level and reasoning ability (for example, whether the child could have rolled off the bed or accessed a high locked cupboard where medication was stored). Paediatricians are often asked such questions as part of child abuse enquiries.

Child development can be looked at in three different ways:

- Description of milestones – what the child does
- Cognitive development – the level of reasoning and understanding that the child has attained (see chapter 9)
- Emotional development – the development of feelings and relationships and personal attributes such as confidence, trust, anxiety or fears (see chapter 10).

All three are important in child protection.

Milestones

This section is concerned with milestones as they are currently used in child health practice with respect to gross motor and fine motor skills, social and language development. Assessing the development of a child cannot be done from written accounts alone, however. Although

charts, such as the Denver Developmental Screening Chart (Frankenberg *et al* 1992), acknowledge the enormous range of normal that exists, it is impossible within a single scale to record all the individual variations in the quality of response obtained. Obtaining rapport with the child and recognising, for example, the shy, nervous or withdrawn child who is not performing to his/her real level of ability, are important skills that only come with practice and experience. In a way, what is needed is observation of the subtleties and fine detail of behaviour rather than testing for the crude gross milestones of development that are used in screening. If there is a particular concern about a child, more detailed and graphic descriptions are certainly required in order to highlight areas of difficulty where help may be provided. Those using the standardised tests of developmental progress such as the Stanford Binet intelligence scale (Terman and Merril 1961), the Wechsler intelligence scale for children (Wechsler 1974), the Bayley (Bayley 1965) scales of infant development, and the Griffiths scales (Griffiths 1970, 1976) must ask themselves the reason for doing so. Is it to provide a clinical description of the child, his/her abilities and his/her difficulties that would aid diagnosis and management, or is it to provide a comparison of an individual child with his peer group?

Assessment of development depends upon accurate observation and interpretation of those observations in the light of our knowledge about 'normal' development. It must not be forgotten that parents usually are the ultimate authority on the development of their own child, supplemented in the school age child by teachers' observations. Formal developmental screening is no longer part of the UK child health surveillance programme, with the realisation that parental observation and anxiety will lead to earlier diagnoses in more families than by screening tests. However, it should also be noted that in families where there are concerns regarding child abuse and neglect, the parents may not be the best observers of their child's developmental concerns.

Descriptions of normal development, linked to a child's ability to perform particular tasks at a particular age relate only to the performance of the 'average' child. For all milestones there is a very wide range of normal. Allowance must also be made for prematurity in interpretation of developmental information. The initial age is the age at which the first few most advanced children display the skill; the median age is the age at which 50% of children display the skill; the limit age is the age at which nearly all children have acquired the skill. The failure to acquire a range of skills by the limit age signals the need for a more detailed assessment. The development of individual children does not occur at a constant rate so that single observations of development, particularly in very young children, have little predictive value. Serial observations are much more valuable and will highlight children who 'fade' in their developmental progress compared to their peers and those who shine brighter with time. The trajectory taken may be strongly influenced in the same way as growth by adverse or favourable social circumstances.

Assessment of reflexes in the young baby

Reflexes in the newborn are a useful way of studying motor development. Exaggeration of reflexes, diminished reflexes, asymmetry of reflexes, persistence of primitive reflexes or delay in the acquisition of secondary reflexes form a useful body of knowledge in the study of developmental progress. The pattern of reflexes observed may be influenced by injury after birth as well as pre- and parental factors.

Moro reflex
This is elicited in the supine position, with the head supported by one hand a little off the table. The head is then suddenly released, causing first abduction and extension of the arms with opening of the hands, followed by adduction of the arms and crying. This reflex is present very consistently at birth and disappears around five months. Persistence after six months of age must be considered abnormal. Because this reflex can be elicited so easily in its classical form, any variation from this should be considered with suspicion. An asymmetrical Moro reflex may be due to a fractured limb as well as to neurological causes.

Galant's reflex
With the baby held in ventral suspension, sharp stimulation with the fingernails of the skin down each side of the back results in flexion of the spine to the stimulated side. The Galant's response is present in very preterm babies and its persistent absence in the newborn may well indicate a poor prognosis. Asymmetry is also important, as in the Moro reflex.

The stepping reflex
With the baby held vertically, contact of the soles of the feet on to a table causes reflex stepping movements of the legs. Persistence of the stepping reflex beyond the age of six months may indicate cerebral palsy.

The Palmar Grasp reflex
Insertion of an object or the examiner's finger into the palm of the hand or on to the sole of the foot produces reflex flexion of the fingers or toes. This produces a strong grasp with the palm and secondary contraction of the arm muscles sufficient to raise the baby from the supine position when traction is exerted by the examiner's finger. This reflex needs to be lost before voluntary grasping can occur. Abnormal persistence may indicate cerebral damage as may absence or asymmetry in the newborn period.

The asymmetric tonic neck reflex (ATNR)
Turning of the head to one side leads to extension of the arm and leg on that side and flexion on the opposite side. This has been likened to the position required to use a bow and arrow or to the posture required to brush the hair holding a mirror in one hand and a brush in the other. In early life, it may be useful in directing the hand towards objects in the visual field. However, it may prevent rolling over or the hands being brought to the face. Abnormal persistence of the ATNR, particularly in an exaggerated form is very frequently found in infants with cerebral palsy.

Balance reactions
These are necessary in order for the child to develop ability in the sitting position. The response consists of extension of the arm to prevent falling when the child's body is displaced to either side in the sitting position. Similar saving reactions occur in the standing position.

The parachute reaction
The child is held in a ventral position and is rapidly lowered head first towards the table. The arms extend in order to 'save' the child. Failure of the reflex to appear is frequently seen in children with neurological abnormalities.

Posture and gross motor development

The rate of development within an individual child varies depending upon his state of health, the degree of stimulation that he receives and such events as the arrival of a new baby, admission to hospital or a change of house. Allowance also needs to be made for prematurity. For this reason, data related to a child's development cannot be taken in isolation from the environment in which he/she is living. Furthermore, the child's personality and temperament may distort his/her response to the test procedure.

Children follow different patterns of events leading to walking including crawling, creeping and bottom shuffling. Those who bottom shuffle are usually late to walk because it is more difficult to get to the upright posture from the sitting position than from the crawling position. When assessing children who are slow to stand and walk it is obviously important to enquire about other methods of locomotion. Children who bottom shuffle tend to dislike lying in the prone position and thus do not develop crawling. Some children go straight from sitting to walking without an intervening stage.

Six weeks

At the age of six weeks when lying prone, the baby is just able to raise his/her chin momentarily. When he/she is pulled to the sitting position from the supine position, the child still shows head lag but is able to show some ability to raise his/her head, particularly in the half-way position of this manoeuvre. When lying in the supine position, the baby still adopts a pattern of flexion at the elbows, knees and hips. A pattern of extension at this age may be an indication of spasticity. Held in ventral suspension he/she can hold his/her head in line with the rest of the body. A large discrepancy in the performance of the baby in the prone and supine position with superior performance when prone, may indicate a developmental abnormality such as cerebral palsy. However, some babies such as those who are bottom shufflers, greatly prefer one posture to another. Others are not given the opportunity to develop their motor skills in a wide variety of postures.

Three months

By the age of three months there are some most impressive changes in the child's motor abilities. In the prone position, the child is able to lift the head and upper chest clear and is able to sustain this posture supported by the forearms. When pulled to sitting, there is only minimal head lag. In ventral suspension, the head is now above the level of the body. When held sitting, the back is straight and the head only occasionally drops forward. When held standing, the child sags at the knees.

Six months

At six months of age, in the prone position, the baby can lift his/her head and chest clear, supporting his/her weight on extended arms and can roll over. Rolling is a very complex motor activity involving coordination of right and left sides, arms, legs, head and trunk. If the child is able to execute such a complicated manoeuvre it is most unlikely that any motor deficit exists. In the supine position, he/she is able to lift his head from the pillow and in this posture grasp his/her foot. When pulled to sit the head is erect and the back is straight. He/she is able to sit against a wall requiring no lateral support. When held standing, the baby is able to bear weight on his/her feet.

Nine months
By the age of nine months, most children will be able to sit unsupported for 10–15 minutes. This posture will be stable and the baby is able to maintain balance as he/she reaches out to grasp nearby objects. By this age the child can also stand holding on and may attempt to take steps if supported. In the prone position, some may be crawling and most should be making some attempt at this manoeuvre.

One year
At the age of one year the child can sit well and for an indefinite period of time. He/she can rise independently from the lying position to the sitting position and from the sitting position is able to crawl effectively on all fours. Some children g*et al*ong by either hauling using the arms alone, or creeping on the hands and feet, or by bottom shuffling: some miss out these stages altogether. The child is now able to get up and down from the standing position and is able to walk around the furniture, a manoeuvre known as cruising. He/she may be able to stand without support for a few seconds, and may also begin to walk independently.

Fifteen months
At fifteen months the child can get to the standing position without the aid of nearby objects. He/she is able to walk unsteadily on a wide base but frequently falls due to minor obstructions. Additional hazards to safety occur as the child learns to crawl upstairs but is unable to get down. He/she is also able to kneel with or without support.

Eighteen months
By 18 months of age walking skills are well developed and falls are seldom though there is obviously wide individual variation. The child is now sufficiently stable to stoop and pick up an object from the floor without overbalancing. He/she can run for short distances and can push or pull toys around the floor. Carrying a large object does not result in falling over. He/she is able to sit down without help in a small chair. Getting upstairs can now be accomplished in an upright posture with the hand held and downward progression may occur by creeping backwards or by proceeding downwards step by step on the buttocks.

Two years
By two years of age the child can go up and down stairs holding on in the upright position. This is done step by step and does not follow the adult pattern of alternating feet on each step. Running is now more skilled and the child is able to change course to avoid obstacles. He/she may play in a squatting position from which he/she can easily rise to his feet. Climbing on and off furniture is performed with ease but often not with the approval of parents. He/she is beginning to be able to both throw and kick balls without falling over in the attempt. He/she has now developed the ability to jump with both feet together and to stand on tiptoe.

Three years
At the age of three the child can walk upstairs with alternating feet but still has to use two feet on each step for descending. He can walk as well as stand on tiptoe and can also stand momentarily on one foot, a skill that many adults cannot demonstrate. The child can now pedal a tricycle as opposed to the previous manoeuvre of pushing it along with his feet on the ground. Increasing agility enables the child to climb nursery apparatus and to jump down one step. Others may attempt more than this but are not likely to succeed.

Four years
By the age of four years the child can walk both up and down stairs using alternating feet. He can stand on one foot for 3–5 seconds and can also hop on one foot, though there is wide variation depending upon the opportunities and encouragement to develop these skills.

Five years
By the age of five years the child is able to skip on alternate feet and to run lightly on his/her toes. His/her wide repertoire of motor skills will be illustrated by climbing, sliding, swinging, etc. There is increased skill in kicking, throwing and catching balls. He/she is able in 90% of cases to walk heel to toe. By the age of five the child has developed a basic repertoire of gross motor skills. Following this there are improvements related to greater strength, greater precision, greater speed and length of performance.

Fine motor skills

Development of fine motor skills depends on normal vision and appropriate opportunities for learning. Deprivation of either will result in delay of acquisition of such skills.

Six weeks
At six weeks the palmar grasp reflex operates but there are no voluntary fine motor movements.

Three months
At three months of age there is intense hand regard, in which the child stares continually at his/her own hand. This intense observation leads in the next few months to the development of voluntary use of the hand that is visually directed. At three months the child may reach out and hit objects such as pram beads.

Six months
By six months of age the child is able to pick up voluntarily any object such as a cube using a palmar grasp. Both the cube and his/her hand need to be within the same field of vision. At first this is only done with the greatest of difficulty and the cube is soon dropped. Lacking memory, the child does not look for the dropped object but seems to carry on unperturbed. Although voluntary grasp is established at this age, voluntary release is not seen for several months. At six months the child also begins to be able to transfer objects from one hand to another. However, the child is not yet able to use this as part of a problem-solving exercise. So, if the child is offered a second cube, he/she is likely either to ignore this cube or to drop the first one and use the same hand to retrieve the second object. Once the child has learned the ability to grasp objects, he/she soon learns to be able to bring them to his/her mouth, and to add these sensations to his/her other means of exploring and understanding objects.

Nine months
At nine months of age the child has developed a mature grip between thumb and index finger and can also use his/her index finger to approach and poke at small objects. Toys that are dropped are now sought for. The child has a wide range of manipulative skills; objects can be shaken, bashed, pulled, pushed or held.

One year

By one year of age the practice of fine motor skills has enabled the child to pick up small objects such as crumbs. The child is able to use his/her fine motor skills to feed himself/herself with a biscuit or hold his/her own bottle. He/she has developed the phenomenon of casting, in which toys are deliberately dropped and watched as they fall to the ground. Given two objects he/she may bring them together in the midline and match them or imitate a simple action such as banging two bricks together. If offered a third object, most children seem unable to transfer in order to grasp the third object but may become quite upset by this apparent dilemma and drop both of the original objects.

Fifteen months

At 15 months of age the index finger has developed as an organ for pointing to objects that he/she wants. Children are reported to be able to build a tower of two cubes though there is a wide variation between these abilities from various reports. This may well be highly dependent on the child's previous experience of bricks and his opportunity to practise. It cannot be assumed as perhaps some developmental tests do, that most children grow up surrounded by one-inch cubes.

Eighteen months

By 18 months of age the average tower builder has progressed to a somewhat precarious edifice of three bricks. If given a crayon this will be used for spontaneous scribble usually in a preferred hand. The index finger may be used to point at objects in the book and the child can usually turn the pages two or three at a time, inflicting a variable degree of damage.

Two years

At two years of age the average tower builder is up to a tower of six cubes, again bearing in mind the wide variation in accomplishment in this task. Although performance with crayon and paper is still largely scribble, this may begin to assume a circular form and the child might also be able to draw dots and imitate a vertical line. Page turning one at a time is now achieved though it must be remembered that many children do not have books and cannot therefore develop the skill. Between 18 months and two years most children are able to complete simple jigsaws involving fitting a circle, square, and triangle – initially by trial and error and only later by matching. Gains of skills and their level of development depend upon the availability of such toys as posting boxes, etc. Children may more readily demonstrate their fine motor skills in terms of manipulation of toys from activity centres up to small miniature toys, peg boards, jigsaws, dressing dolls, etc than in more standardised tasks which do not hold the same degree of interest.

At two years of age the child is able to build a tower of seven blocks. He/she is also able to construct a 'train' from three blocks placed horizontally in a row and one block placed on top for a chimney. With a pencil, he/she is able to imitate a circle and a horizontal line if this is demonstrated. Only at the next stage is the child able to copy the completed symbol without a previous demonstration.

Three years

By three years of age the child's tower has grown to nine bricks and using three bricks the child can copy a bridge design. He/she can draw a circle from a copy and can now draw a cross if this is first demonstrated. The child is, at this stage, beginning to produce recognisable

pictures and will produce the first crude picture of a person plus a variety of assorted parts. The Goodenough 'draw a man' test is a useful and reliable way of assessing development of children between ages three and ten (Bakwin *et al* 1948, Goodenough 1926). The child is asked to draw a man. He/she is left undisturbed and given as much time as he/she wants. The final drawing is scored using 51 criteria that record the degree of complexity and the anatomical details shown. The child is given a basal age of three years and is accorded an extra three months for each of the features recorded in his/her picture.

Four years

By the age of four years we have now reached the limits of tower building, bearing in mind the number of one-inch cubes the paediatrician can carry in his/her bag at any one time. The tower is now ten or more cubes in height. From about four years of age, the child is able to construct stairs with the one-inch cubes after an initial demonstration. He/she can now copy a cross without a previous demonstration and can also draw a square if the technique is shown first. The drawing of a man will now have a head and legs and the picture may or may not have a separate trunk. Most children will also be able to draw a very simple representation of a house. The child of four years should be able to name the four primary colours in the one-inch bricks and is certainly able to match them. Some children may have been able to do this since the age of three. A four-year old can generally do buttons up, a useful practical skill that enables him/her to dress himself/herself. However, absence of the skill probably indicates that the parent dresses the child because it is quicker.

Five years

The five year old can draw a square and a triangle from a copy. (He/she will need to be seven to be able to copy a diamond and nine to be able to copy a parallelogram.) He/she can also draw a house with door, windows, a roof and a chimney. Using one-inch cubes, he/she can copy the step design without demonstration and also construct a 'gate'. Ideas of shape and copying ability have improved to the extent that the child can now learn to recognise and copy letters from the alphabet.

Key Message

An understanding of motor development enables the paediatrician to judge whether a particular explanation for an injury is compatible with the child's development abilities. There is a wide range of normality.

Social development and play

Although appropriate toys for each age group help child development, it must be recognised that to a large extent, the toys without the parent are useless. Also, the importance of play such as peek-a-boo, round and round the garden, and nursery rhymes that do not require any toys are a very important aspect of stimulation. The TV is not an adequate substitute for one-to-one parent-child interaction. Children who lack these opportunities will be ill prepared for the activities in nursery school and unable to play cooperatively with other youngsters.

Six weeks

At six weeks of age the child smiles in response to a friendly human face. The child is visually

very alert and will fixate and stare at the mother's face for long periods. As well as crying he/she develops a whole range of sounds; coos, glugs, grunts and laughter, which indicate mood. An awake baby in a carrycot only receives the stimulation that is brought to him/her. This may be obtained from mobiles suspended above the cot, by carrying him/her around or by the use of a bouncing cradle in which the baby reclines.

Three months

At three months of age the child begins to react with excitement to familiar and pleasant situations such as feeding and bathing. Similar responses occur when during play. From three months the child may attempt to hit toys suspended on a string across the pram. Although the child can do very little with toys, things to listen to, such as a musical box and things to look at, such as mobiles, are very useful.

Six months

At six months of age the child can successfully grasp suitable toys and transfer them to the mouth. He/she is capable of grasping a rattle and shaking it and may apply this strategy to many other objects. He/she is also able to play with his/her feet and take these to the mouth too. The child is now able to play with a wider range of toys of many different shapes and colours; they appear to enjoy those they can grasp or which make a noise like rattles and bells.

Nine months

At the age of nine months the development of memory means that the child becomes much more wary of strangers and sensitive to separation from his/her mother. It also means that lost toys are looked for and he/she can play games such as peep-bo. He can feed himself/herself with a biscuit, and attempts to hold his/her own cup or bottle. He may also try to grab the spoon. He/she can now handle toys that require a wider range of manipulative skills to make them work.

One year

At one year of age children who have been given the opportunity are able to drink from a cup. However, many parents feed their children, as this is less messy, so children may not develop the skill until somewhat later. The same applies to spoon feeding, which children can manage with help at this age but not all get the opportunity. At 12 months of age, children understand how to cooperate in dressing, recognising that shoes go on feet and arms go in the sleeves. However, although many children do begin to cooperate with dressing at this stage, others who seem to dislike being dressed develop the ability of doing the reverse of what is being required. The same can apply to nappy changing, which can be a nightmare with a mobile, uncooperative child. The child is now able to imitate gestures such as clapping hands and waving bye-bye. Some are able to produce this spontaneously in appropriate situations and others on demand. The child is also able to grasp quickly and imitate other actions such as ringing a bell or banging two bricks together. In play, the child will often concentrate for long periods of time, putting objects in and out of boxes or quietly emptying cupboards. Simple cooperative play is developing and the child will give a toy to the parent on request. Toys such as stacking beakers and pop-up men can be useful, though the child's skills are more directed towards taking apart than putting together. Rag books are also useful.

Fifteen months

At 15 months the curiosity and exploratory behaviour becomes more intense aided by the improved mobility and manipulative skills developed over this time. The child grasps anything within reach and cannot distinguish safe from dangerous objects. He/she will begin to be frequently told 'no' and reacts adversely if removed from unsuitable situations.

Eighteen months

The child of 18 months should be able to manage a cup without too much spillage and to be pretty adept at using a spoon independently. He/she may be able to take off shoes and socks, often in inappropriate circumstances. Negativism and the need for constant supervision are usually more marked than at 15 months. Domestic mimicry such as sweeping or ironing often starts at this age. The beginnings of symbolic play are also seen, for example, putting a doll to bed or giving someone 'a cup of tea' in a toy cup. The child has progressed from toys that one pushes to trucks or cars, or fitting pieces into other types of shape-fitting toys. Sand and water are most appreciated and the child will begin to be able to use drawing and painting materials in a chaotic, uncoordinated and sometimes undesirable manner.

Key Message

Negativism and a wider repertoire of motor skills can lead to multiple accidents, parental anger and abusive behaviour and hence require a high level of vigilant and informed parenting.

Two years

The two-year-old may be slightly less of a danger to himself/herself than the child of 18 months. Greater awareness and knowledge and improved motor abilities may reduce some hazards but increase others. Negativism continues to be prominent and temper tantrums a common feature. The two-year-old should be pretty competent in eating and drinking. The two-year-old is also ready though frequently not willing to be toilet trained, however, with greater or lesser difficulty, most children will become dry during the day around this age. The child's play shows further development in domestic mimicry. He/she begins to want to join in and 'help' with adult activities. Simple make-believe play is also developing. Children of two years are unable to share their belongings and play alongside one another rather than with one another. Useful toys are replicas of adult materials such as tools, cups and saucers, toy cars, simple wooden trains and, of course, picture books and being told stories.

The two-year-old is usually fairly reliable with using the toilet during the day. However, many need help in that they are unable to pull down their pants or replace them. Make-believe play is becoming increasingly elaborate with the child frequently talking to himself/herself in play. Tray jigsaws may be very popular. Stories and picture books provide a good medium for adult interaction and for learning and provide the first section of the path to future reading. Scribbling with crayons and painting may just be beginning to emerge with some recognised form or pattern.

Three years

The three-year-old should at last be fairly independent with toileting and accomplish all the subsidiary functions such as pulling pants up and down and washing hands. He/she is also able to play together with other children and understands concepts such as sharing or taking

turns. Many three-year-olds, and quite a number of younger children too, are confident enough to separate from their parents at nursery school or play group. Recognisable drawings of a human body or a house begin to be made. The three-year old can begin to make real constructions out of bricks or construction toys of various types and can make sensible layouts using things like miniature animals, people, etc. The three-year-old is able to remember nursery rhymes and also stories. He/she is constantly asking questions about things that he/she sees.

Four years

The four-year-old continues to ask questions though they are now of the 'why' or 'how' variety rather than the 'what' or 'who'. He/she can dress and undress except for difficult buttons and laces though the result may often be back to front or inside out. Imagination is shown strongly in play with such items as dressing up. He/she needs other children to play with and the idea of 'friends' becomes a well-established need.

Five years

The five-year-old is able to play games with increasingly complicated sets of rules. A wider time perspective occurs in play. Particular themes either in play or within school can be carried on over a prolonged period in time. A five-year-old can, but not always, be protective and responsible towards his/her younger brothers and sisters. The five-year-old can play and build constructively and copy or produce increasingly complicated designs. He/she has the ability to tell the time, recognise letters and numbers, and begin the process of learning to read.

Key Message

An adverse environment such as physical restriction, for example, confined to a buggy, domestic violence, lack of playthings, poor parent/child, lack of stimulation, postnatal depression can impede normal child development.

Language development

Within a very few years, children develop the most complex cognitive function known to man, that is the acquisition of a spoken language.

The development of language is an individual process with universal trends. It is a gradual process continuing well into primary school years and even then it cannot be said to be complete, for modification and acquisition of higher and more complex language takes place in teenage and adult years.

The acquisition of a spoken language is an interactive process, depending upon active conversational practice with parents, siblings and others and is not based on imitation alone, although it does have a role, with some children imitating more than others. It seems that the active participation of the child, 'trying out' new vocabulary and 'testing out' new conversational rules, is the key to the successful acquisition of language.

A baby develops pre-linguistic skills in the first year of life. He/she is born with a very mobile tongue and sophisticated vocal organs to allow vocalisation and soon after birth he/she

becomes a highly sociable being, initiating two-way interactions with his/her carers by looking, smiling, cooing and crying. A neonate also has sophisticated auditory perceptual skills and is capable of distinguishing individual speech sounds (for example, ‘p’ and ‘b’). This has been shown by analysis of changes in amplitude of sucking pressures on an artificial nipple, in response to tape recorded speech sounds.

In addition, a baby has the ability to develop symbolic systems and seems to be ‘pre-programmed’ to comprehend and develop grammatical patterns.

At three to six months babies start to vocalise developing babble patterns, containing consonant and vowel sounds (for example, ‘ba’ and ‘da’). At around six to twelve months babble then becomes repetitive (for example, ‘ba-ba’ and ‘da-da’) and also becomes more speech like. Babble then drifts towards the child’s own language, for instance, a Chinese baby’s babble by nine months of age may sound quite different to that of an English baby of a similar age. Distinct words then gradually emerge from babble patterns and can initially be quite difficult to distinguish.

At around twelve months of age the child acquires his first word that is individual to him. First words may not have a specific syntactic role; ‘drink’, for example, may be used as a noun for a cup, as a subject for fruit squash or as a verb for the act of drinking.

Throughout his/her first year, the child’s motivation to communicate advances as does his/her attention and listening skills.

At around 12 to 14 months the child develops referencing. The child is able to filter out of a spoken sentence an object name and understands what that object is, for example, ‘that’s a cat over there’. At the same time meaningful pointing begins, when the child looks and points to an object such as a cup, and then turns to look to the parent and back to the object as if to say ‘I know that you know, that I would like a drink!’

When a child has acquired around 30 words in his/her vocabulary there tends to be a rapid spurt in further acquisition and vocabulary tends to become more adult-like. When the child has developed a vocabulary of around 50 words, he/she starts to combine words into phrases. Typically, a child uses two word utterances, for example, for naming: ‘that car’; for possession: ‘baby book’; for description: ‘pretty bird’; or for plurality: ‘two dog’. This trend appears to be universal across languages (and indeed across manual signing systems).

At around two years a child tends to develop early grammar, for example, ‘daddy sleep’ (object and verb). Some language produced at around this age may appear to be grammatical but on further analysis seems to be the addition of little chunks on to some already learned grammar, for example, ‘that’s mine-sweetie’. Grammar continues to develop by children actively participating in conversation to trial their use of grammar.

A child tends to acquire a grammatical system between the age of two years and four years six months. There is great individual variation but there does appear to be some universal ordering. Most children develop the use of ‘ing’, for example, ‘he is running’ before the correct use of past tense. Three-word phrases tend to appear from the age of two years through to

the age of two years six months with four and five word sentences appearing around three years of age to three years six months. A general maturation of language and grammatical skills takes place from the age of around three years six months for a further year when syntactical development is usually complete. Language continues to develop stylistically from around school entry age and can be used creatively to express ideas and thoughts and to direct activity.

Throughout the process of acquiring grammar and sentence structure, a child practises his/her conversational skills constantly, with parents and carers providing interaction, feedback and correction by indirect means. Parents do not normally provide absolute correction of grammatical mistakes but do offer indirect correction in the form of contingent questioning.

For example:
Child: 'He runned in a race.'
Parent: 'When did he run the race?'
Child: 'Yesterday.'
Parent: 'Yes, he ran the race yesterday.'

Nature or nurture?

Undoubtedly, the development of an effective spoken language will depend upon the conversational environment in which a child is reared and those children deprived of conversational input frequently develop deviant language.

Key Message
Delays in expressive language and the development of imaginative play are particularly common in abused or neglected children. Such children may show poor attention skills and high activity levels.

Nature does play a part and it has been known for some time that communication difficulties run in families. Recently strong evidence has been provided by Dale (Dale *et al* 1998) in the Twins Early Development Study, that heritability is stronger amongst those with the poorest language skills. There is also evidence of a genotype for specific language impairment, which may explain the language delay for some children growing up in a rich conversational atmosphere.

Can the way parents speak to a young child enhance development of an effective spoken language system? This aspect is relatively under-researched but certainly parents from many cultures use 'child-directed speech' as a way of interacting with their children before the children are able to keep pace with adult conversation. This type of speech has differing sound features to that of an adult. The pitch is higher, the intonation is more exaggerated and the tempo is slower. This appears to capture and maintain the child's attention and makes it clear that the parent is talking to the child and no one else. The utterances are predominantly short; only two to three words longer than the child's own utterances and well formed. This enables the child with a shorter attention span to follow the whole sentence. In 'child-directed

speech', there are fewer false starts and hesitations, and fewer complex sentences and subordinate clauses. It is highly repetitious and uses recasts and reformulations, providing correct 'models of speech'.

As the child becomes more linguistically competent, parents tend to use more questions rather than imperatives. A younger child would probably be directed (imperative) to 'give Mummy the cup', but an older child, (though still acquiring language and grammatical skills) might be asked the closed question, 'are you going to give me that cup?'. Open questions are more usually employed when the child has developed a competent language and grammatical system. Table 1 provides an easy clinical framework to describe preschool language development.

Key Message

By looking in detail at the process of acquisition of spoken language it can be seen that those children with permanent (or temporary) hearing loss, those with global development delay, those with social and emotional developmental delay and those with social deprivation are likely to have significant difficulty and therefore delay in acquiring an effective spoken language system.

Table 1: The typical pattern of language acquisition over time

AGE LEVEL	LANGUAGE DEVELOPMENT	GRAMMATICAL STRUCTURES	SOUND SYSTEM
9-18 months	First words	Noun-like: cup Verb-like: gone Other: bye bye	p / b / t / d / w /m /n final consonant - missing reduplication: gee-gee
18-24 months	2- word phrases	SV: Daddy kick SO: Mummy shoe VO: kick ball	as above
24-30 months	3-word phrases	SVO: daddy kick ball use of: the / is / a word endings: ing / ed plural s	above and k / g / ng / h final consonant may be missing still
36-42 months	4-word phrases	SVAA: me go in kitchen in a minute have been + could have er / est / s /	above and f / s / l / y clusters may appear f final consonants present
36-42 months	5-word phrases	more complex sentences. use of because me becomes I tenses appear	as above
42-54 months	Maturation of language skills	correct past tense I goed = I went sheeps = sheep plurals	as above and v / z / sh / ch / j / r
54 months onwards	Creative language to express ideas and thoughts	Syntactic development complete	mature sound system b but may still be w for r and th for f

Key

S= subject,

V= verb,

O= Object,

A= Adverb

Key Message
Language acquisition is the best predictor of future developmental progress and intelligence. It is essential for education. Language is the vehicle for thought.
Those unable to argue verbally or express their needs could become frustrated and may be more likely to become violent.
Enlist help with children who do not speak English to access expression and comprehension in their mother tongue.

Developmental assessment

Developmental delay can be seen in children who have been abused or who are at risk of abuse. Therefore, developmental assessment is an important part of any paediatric evaluation and is needed as part of paediatric child protection investigation (see Appendix). It also helps paediatricians to assess the credibility of parents' statements with regard to causation of injuries.

In most cases a brief question to the parents enquiring as to whether they have any concerns about the child's developmental progress, together with informal observation of the child's activities during the appointment will be sufficient. In other circumstances, a more detailed assessment will be necessary. This may be because there is already concern about a developmental problem, or because the child is felt to be at increased risk of there being developmental delay, for example, in the follow-up of preterm infants, assessment of children with other disabilities (physical or sensory impairment) or in socially deprived children. Sometimes it will be necessary as part of an assessment of special educational needs, or as part of an evaluation of the needs of children in the care of social services.

The developmental assessment is just part of the whole evaluation which should also include a developmental history, an account from the parents of the child's current functioning, and a medical examination. It may include reports of the child's functioning in other environments, for example, a family centre, nursery or school. It may be helpful to observe the child directly, not just in the clinic, but also in one of these settings, and/or in the home. There may be large and important differences.

Summary

Assessment of children where there is concern about child abuse of any type must take place within a framework that includes the child's development. Understanding of development will help us to evaluate the credibility of histories and to include developmental status as part of the overall consequences of abuse.

Key Message
Knowledge and understanding of child development is essential when assessing a case of child abuse and neglect.

References

Bakwin, RM, Weider, A, Bakwin, H. 1948. Mental testing in children. *Journal of Paediatrics* 33: 484.

Bayley, N. 1965. Comparisons of mental and motor test scores for ages 1–15 months by sex, birth, order and race, geographical location and education of parents. *Child Development* 36: 379.

Bellman, M, Lingam, S, Aukett, A. 1996. *Schedule of growing skills.* Windsor: NFER – Nelson Publishing Company Ltd.

Dale, PS, Simonoff, E, Bishop, DV, *et al*. 1998. Genetic influence on language delay in two-year-old children. *Nature Neuroscience* 1(4): 324-328.

Frankenberg, WK, Dodds, J, Archer, P, *et al*. 1992. The Denver II: a major revision and restandardisation of the Denver Developmental Screening Test. *Pediatrics* 90(3): 477-479.

Goodenough, FL. 1926. *Measurement of Intelligence through Drawings.* New York: World Book Company.

Griffiths, R. 1970. *The abilities of young children.* Amersham, Bucks, Association for Research in Infant and Child Development.

Griffiths, R. 1976. *The abilities of babies.* Amersham, Bucks, Association for Research in Infant and Child Development.

Henderson, S, Sugden, D.A. 1992. *Movement assessment battery for children.* London: The Psychological Corporation, Harcourt Brace.

Pollak, M. 1993. *Textbook of developmental paediatrics.* Edinburgh, Churchill Livingstone.

Reynell, J. 1969. *Reynell Developmental Language Scales.* Windsor: NFER – Nelson Publishing Company Ltd.

Reynell, J, Zinkin, P, 1979. *Manual for Reynell-Zinkin Developmental Scales for young visually handicapped children.* Windsor, NFER – Nelson Publishing Company Ltd.

Roid, GH, Miller, LJ, Leiter, R. 1970. *International Performance Scale-Revised (Leiter-R.).* Windsor: NFER – Nelson Publishing Company Ltd.

Terman, LM, Merril, MA. 1961. *Stanford Binet Intelligence Scale.* London: L M Harrap.

Wechsler, D. 1974. *Manual for the Wechsler intelligence scale for children.* New York: Psychological Corporation.

Further reading

Bea, H, Boyd, D. 2004. *The developing child. Tenth edition*. Boston: Pearson Education.

Buckler, JMH. 1979. *A reference manual of growth and development.* Oxford, Blackwell Scientific.

Egan, D, Illingworth, RS, McKeith, R. 1971. *Developmental screening 0–5. Clinics in Developmental Medicine No. 30.* London: Spastics International Medical Publications and Heinemann.

Holt, KS. 1977. *Developmental paediatrics*. London: Butterworths.

Holt, KS. 1991. *Child development, diagnosis and assessment.* London: Butterworth-Heinemann.

Illingworth, RS. 1979. *The normal child. Tenth editon*. Edinburgh: Churchill Livingstone.

Robson, P. 1970. Shuffling, scooting and sliding; some observations on 30 otherwise normal children. *Developmental Medicine and Child Neurology* 12: 608-617.

Sheridan, M. 1973. *Children's developmental progress.* National Foundation for Educational Research.

Smith, P, Cowie, H, Blades, M. 2003. *Understanding Children's Development. Fourth edition.* Oxford: Blackwell Publishing.

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APPENDIX 1
Child development signs

Informal

In many cases, it is sufficient for the paediatrician to carry out an informal assessment in the clinic. An experienced paediatrician will be able to use a range of toys, books and simple tests, for example, drawing shapes and building with bricks, that he/she is familiar with to build up a picture of the child's developmental level. With experience, he/she will become familiar with the range of responses to a particular task at any given age, and can therefore compare the child being assessed with this. It is useful to consider a few skills in each area of development, including gross motor, fine motor, social development and play, and communication. The paediatrician can then give an approximate developmental age at which the child is functioning for each parameter. When expressed in this way it is easily understandable to parents, who will be able to discuss their own view of the child's development and whether the paediatrician has got what they consider to be an accurate picture. In other cases it may serve to illustrate to parents the degree of difficulty the child has in a specific area or alternatively may reassure them about their child's progress.

Formal

Sometimes it is necessary to use a more formal, standardised assessment. This will give a quantitative assessment, resulting in a test score. Providing it is carried out with appropriate skill, the results should be reproducible. Such tests are used to compare the performance of groups of children, as may be necessary in research. For clinical purposes, they can be useful to gain a deeper insight into an individual child's pattern of strengths and weaknesses, helping with diagnosis, planning interventions, and monitoring progress over time. There are many different tests available; some used for screening and others detailed assessment. Most require specific training and a set of equipment. The use of some tests is restricted to particular professional groups, usually psychologists. The tests described here are those commonly used by paediatricians in the UK.

Denver II (Frankenberg 1992)
Age range 0–6 years
Previously known as the Denver Developmental Screening Test, this is widely used in clinical practice. In some areas, it has been introduced as a universal screening tool used by health visitors. The assessor completes a form, which represents graphically the developmental profile with boxes showing the 25th, 50th, 75th and 90th centile for children attaining each ability.
This test is best used as a screening test. It can be performed quickly, in 10–20 minutes in a clinic. Its use is not restricted to any professional group and no specific training is required.

Schedule of growing skills (Bellman 1996)
Age range 0–5 years
This test is also primarily designed as a screening test, but is more detailed and can therefore be used as a more in-depth assessment. A record form is completed, looking at nine skill areas – passive postural, active postural, locomotor, manipulative, visual, hearing and language, speech and language, interactive social and self-care social. A skills score is calculated for each area, which is then converted to a

developmental age. An additional cognitive skills score is derived from selected items in the other nine areas. The schedule takes about 20 minutes to complete. No specific training is required, and its use is not restricted.

Griffiths Scales of Mental Development (Griffiths 1976, 1970)
Age range 0–8 years
This is a British test, widely used by UK paediatricians. Its use is restricted to those who have been on an accredited training course. The scales are divided into six areas:

- A locomotor
- B personal social
- C hearing and speech
- D eye and hand co-ordination,
- E performance
- F practical reasoning (for those over two years).

Results are scored as a mental age in months for each area which is divided by chronological age to give a developmental quotient (DQ). General quotient (GQ) can also be obtained by the average of the sub-quotients, but the meaning of this is limited, the real value of the test being not just levels attained, but the profile of the child's skills across the six areas. The Griffiths scales take about an hour to complete.

Other tests to consider
The paediatrician should also be aware of some of the many other tests that may be appropriate in particular circumstances, or to look at specific areas of development. Details of these are beyond the scope of this text but are discussed in detail elsewhere (Pollak 1993).

Examples of other tests include Reynell-Zinkin scales (Reynell and Zinkin 1979), for assessment of children with visual impairment, and the Leiter International Performance Scale Battery (Roid *et al* 1970), which assesses non-verbal ability, and can be useful for those with no language, including deaf and autistic children. There are many specific language assessments (for example, Reynell Developmental Language Scale (Reynell 1969)) and developmental co-ordination problems can be usefully assessed using the Movement Assessment Battery For Children (Movement ABC) (Henderson and Sugden 1992).

The Wechsler Intelligence Scale for Children (WISC) and Wechsler Preschool and Primary Scale of Development (WPPSI) (Wechsler 1974) are primarily used by psychologists. They cover the age ranges 4–17, and have separate verbal and non-verbal sections. They are likely to be used for educational purposes in older children, where assessment is beyond the skills, or the remit of most paediatricians.

7

Emotional and psychological development: Relevance to child abuse and neglect

Whilst the previous chapter on development provides a description of 'what children do' at different ages, this section gets 'into the works' so to speak; to describe the development of thought processes (thinking, reasoning) and the development of emotions that will shape the personal characteristics of the adult.

Both are important in child protection. Would the child have been able to work out how to open the drawer, select the key and open the lock to get the pills? How has the experience of abuse affected the development of confidence and self-esteem? How does exposure to violence, family breakdown, or professional interventions into family life influence emotional development? Do children interpret what is happening differently to an adult? What is the impact of investigation, giving evidence or experiencing losing contact with a parent? Could a 'behaviour problem' (enuresis, encopresis, sleeping problem, eating problem, self-harming, conduct disorder) be the result of abuse? All these are very common questions and problems and all can be related to abuse. This chapter gives a very basic introduction to address these questions. Further reading is recommended.

There are many profiles of childhood which describe behaviour at different ages. Theories based on these observations give us a means of understanding the process of learning, the development of reasoning and of emotional responses. Such theories have contributed towards educational progress and in our understanding of abnormal or difficult behaviour. They provide a view of the child's world as the child perceives it, as opposed to our description of what the child does. The theories are not only clinically useful but also provide a fascinating insight into the world of a developing child. They are not mutually exclusive, for each examines different aspects of child development and each makes its separate contribution towards our understanding. They help us to understand how positive and negative experiences shape development in childhood and influence their future functioning as adults.

Gesell (Gesell 1948, 1966)

Arnold Gesell at Yale University was the first to make detailed observations of normal child development which he classified into gross and fine motor, adaptive, language and personal/social.

On the basis of these observations, he drew three conclusions:

- That there is a defined sequence of development
- That development proceeds in a cephalo-caudal progression
- That development proceeds from gross undifferentiated skills to precise and refined ones.

The important implication of these findings for management in cases of developmental delay is that the child should be helped to acquire skills according to the sequence. Thus, it is inappropriate to teach a child to walk when he/she is yet unable to sit. Gesell thought that development reflected maturation of the central nervous system, rather than the results of learning. This theory was supported by observations that motor skills developed in a normal way in infants who were swaddled, however, the quality of their performance was not studied.

Gesell also observed that it was not possible to induce the earlier development of particular skills by specific training and practice. He concluded from this again that central nervous system maturation was the dominant factor rather than training. It would be wrong to draw the conclusion from these relatively limited observations that nothing need be done or can be done for the young handicapped child on the argument that progress awaits brain maturation. This approach is too simplistic and although it must be accepted that damaged or delayed maturation will cause delay in development, it cannot be accepted that appropriate therapy and stimulation are not required.

Some aspects of development are certainly dependent upon external stimulation, for example, the development of visual function depends on appropriate stimulation of the retina. Deprivation of this stimulation by opacities or gross uncorrected refractive errors results in the failure of development of visual function if these ophthalmic problems are corrected late. Similarly, cutting off the whiskers of mice results in defective development of the parts of the brain that control these sensitive organs. Others have developed the idea of critical periods for the acquisition of particular skills that suggests that optimum learning occurs only if the required stimulation is obtained at a particular time in development.

In spite of these criticisms, Gesell has contributed an enormous amount towards our understanding of normal development, particularly motor development, and its clinical application to developmental diagnosis.

Learning theory and behaviour modification practice have wide applications in many areas including the management of children with learning difficulties. Learning theory is based upon the assumption that, with the exception of reflex responses, all behaviour is learned. It therefore stresses the role of experience in the environment rather than that of cerebral maturation. Certain responses are learned following specific stimuli and appropriate responses are reinforced. This has led to the therapeutic tool of behaviour modification whereby new responses may be learned and reinforcement withdrawn from inappropriate responses. The

theory on which behaviourism is based rests largely on animal experiments starting with Pavlov's classical experiments conditioning dogs to salivate when a bell was rung, through to the later experiments of Skinner and of Watson.

The extreme point of view that all behaviour results from external learning cannot be accepted, but taken in conjunction with the other theories explaining child development, behaviour theory has an important application to our understanding of certain aspects of normal development and certain abnormalities in behaviour.

Animal experiments have shown that there are critical times for acquiring certain types of behaviour, for instance, monkeys reared entirely away from their own mothers do not exhibit normal maternal behaviour and are aggressive and not protective towards their offspring. This animal model parallels that of early childhood deprivation and the failure of those individuals to bond or take care of their children.

Behaviour theory has been very useful in that it has identified how certain types of normal social behaviour are developed. Some understanding of the genesis of disturbed behaviour is gained and why within some families they recur. However, all external influences act upon some substrate. It is clear that babies have particular personalities right from birth, and that these personalities are to some extent independent of external factors.

Erikson (Erikson 1967)

Eric Erikson's psychoanalytical theory covers the whole of human life from birth to old age. There are eight stages. He describes each stage in terms of conflicts between two opposing forces. These conflicts arouse anxiety. Failure to resolve the particular conflicts of each stage in development results in maladaptive behaviours that continue into adult life. These are important in helping us to understand the long-term impacts of abuse in childhood. Temperament and positive influences may moderate these effects for individual children.

Phase I: Infancy (The first year of life)

- Acquiring a sense of basic trust
- Overcoming a sense of basic mistrust
- Realisation of hope.

In this phase, the child is entirely dependent. His/her satisfactions are in being fed and in the important process of bonding to his/her parents. Absence of these results in anxiety. It is easy to see how important it is for the child to acquire, early on, a sense of confidence in the world around him. If he/she fails to do this and the world is seen as a hostile, unpredictable place, then he is likely to be a 'difficult baby' and to have feeding and sleeping problems. As adults, those severely deprived in this early stage and who do not develop secure attachments to their carers are likely to be emotionally detached and aggressive, being unable to form deep and lasting relationships with others. This underlines the great importance of early intervention when abuse or neglect is suspected in young children.

Key Message
If parents do not meet a child's needs in a caring and consistent way and are hostile to his/her demands, the child:

- Will not form secure attachments
- Will have problems in eating, crying, sleeping
- Will have difficulties in relationships as an adult.

Phase II: Early childhood (1–3 years)

- Acquiring a sense of autonomy (own will)
- Combating a sense of doubt and shame
- A realisation of will.

In this stage the child acquires confidence in his/her own ability as opposed to self doubt. He/she realises his/her own will and has the ability for independent action. He/she is, however, required to conform to certain behaviours and may feel guilty if he/she does not. Children of this age develop negativism, temper tantrums and toilet training difficulties. He/she needs to learn to balance his/her own wishes against those of others. If he/she is unable to realise the strength of his/her will then as an adult he/she may be lacking in confidence and initiative. On the other hand if he/she does not develop any form of censorship mechanism then he/she might have difficulty accepting the demands made by society. The child learns that there are boundaries and begins to self-regulate his/her behaviour within them. Where there is poor parenting the child does not acquire the necessary competencies and may be either quiet and withdrawn in a social setting or 'out of control' at the other extreme of the spectrum. Both of these are common clinical scenarios in the follow-up of children who have been abused.

Phase III: Nursery school age (3–5 years)

- Acquiring a sense of initiation
- Overcoming a sense of guilt
- Realisation of purpose.

From the self-confidence acquired in Phase II, a child goes on to initiate social behaviour which goes beyond himself/herself into group situations. He/she must learn to share attention, affection and materials. In this phase, conscience formation occurs and the child internalises previously external standards of behaviour. He/she may feel anxious that his/her separate autonomous behaviour is not always in accord with that of the group and guilt may result from this or from the fear of being found out. With the greater sense of initiative the child begins to assume responsibility for himself/herself as well. The child obtains his/her primary identification as male or female. Sexual curiosity and erotic feelings may arise and the Oedipus complex of attachment to the parent of the opposite sex is often seen. The child develops ideas of the future and can postpone satisfactions or pleasures till a later time.

Key Message
Success in overcoming the conflicts of this stage results in a confident, outgoing person who is able to generalise his/her confidence into the group situation. Failure to do so at this stage may result in nightmares, fears of the dark, animals, or physical injury. These characteristics are seen in children who have suffered abuse and neglect at this age.

Phase IV: Primary school age (latency) (5–11 years)

- Acquiring a sense of industry
- Fending off a sense of inferiority
- Realisation of competence.

In this age group, children acquire the drive to achieve whilst attempting to overcome a feeling of failure. This drive and competitive spirit applies in intellectual activities, physical activities and in social relationships. Success at these results in increasing self-esteem (and esteem from others) whereas failure or a sense of failure can result in difficulties in learning and impaired relationships. Those involved with school health will be very familiar with the child who finds himself/herself isolated outside the competitive and energetic world of this age group. They will also recognise the picture of the child covered with badges won for various achievements. Children will drift along through their primary school years, (don't care, not bothered), without the enthusiastic spark that motivates most of their peers. Parental interest and active involvement and support are vital to the child.

Key Message
Parents may reinforce or negate this important sense of achievement through praise and encouragement or denigration as in emotional abuse.

Phase V: Adolescence

- Acquiring a sense of identity
- Overcoming a sense of identity diffusion
- A realisation of fidelity.

This description is perhaps best illustrated by Gauguin's picture '*Ou venons nous ou sommes nous ou allons nous*' – 'where have we come from, where are we, where are we going to?'. Children need to acquire a firm sense of who they are, what they want from life and where they are going. Failure to do this is described by Erickson as 'role diffusion'.

In this stage the child acquires a time perspective and is able to work towards distant goals such as examinations. There is anticipation of particular achievements in the future. The role of leadership is further developed in this age group and for the first time idealogical identification is seen in terms of political attitudes. Sexual identity develops further.

At this age the child should have acquired sufficient self certainty in preparation for an independent life and decision making. The drive towards decision making is combated by a sense of doubt and uncertainty. Role experimentation in terms of jobs, ideology, and

allegiances may cause added conflicts with parents as the adolescent seeks to acquire his/her own individual identity. Understanding adolescent problems is understanding the balance between acquiring the self certainty and anxiety about the ability to do so. Parents who have a good relationship and close engagement with their children have a key role in helping them to steer along the middle part of this channel. The converse is also true.

Phase VI: Young adulthood

- Acquiring a sense of intimacy
- Avoiding a sense of isolation
- A realisation of love.

This is the phase of courtship and marriage. Children who have grown up in an environment of abuse and neglect will have great difficulties in establishing lasting and close personal relationships.

Phase VII: Middle adulthood

- Acquiring a sense of generativity
- Avoiding a sense of self absorption
- A realisation of care.

This is Erikson's description of parenthood and the ability of parents to put the demands of their own child before those of their own. This is an essential characteristic of successful parenting, but those who have been the victims of abuse in the earlier stages of their emotional development will have unresolved conflicts leading to their being poorly prepared for the role of parent. For example, this is sometimes seen in parents attending family centres who want to deal with their own hunger first rather than attending to their crying baby as a priority.

Phase VIII: Maturity

- Acquiring a sense of integrity
- Avoiding a sense of despair
- A realisation of wisdom.

This is maturity.

Piaget (Piaget 1929,1969)

Jean Piaget, a Swiss zoologist, based his explanations of child development upon precise observations, particularly of his own children. His observations on cognitive development have been widely incorporated into teaching schemes in primary education.

The sensori-motor stage (0–2 years)

In this stage, children acquire a permanent image of themselves and of the practical world about them. They learn to understand their separateness (dualism) from their mother.

1. Reflex action (0–1 months)
At this time Piaget describes all reactions as being simply reflex. For example, the child sucks in response to any object put into his/her mouth and he/she cannot distinguish between his/her own finger and the nipple.

2. Primary circular reactions (1–4 months)
By this time the child has formed motor habits which Piaget calls schema. Having developed these motor habits they can be wilfully repeated for their own sake, for example, wilfully sucking the thumb.

3. Secondary circular reactions (4–9 months)
Now actions are produced not for the pleasure of their doing, but for the results they produce in the external world. Intentional acts are carried out. The child tries out all his/her various schemata on a new object until he/she finds one that produces the most satisfying results. Coordination of vision and movement develop although the child only grasps an object if the hand and the object are seen simultaneously.

4. Coordination of schemata (9–11 months)
In this stage the child pursues a particular end rather than trying out all his/her various motor habits to look for a satisfying result. Therefore, if the result is obtaining a particular object that he/she desires, he/she might use his previous experience such as tugging at the blanket on which the object is placed, to bring the object sufficiently near for it to be grasped.

Piaget describes memory developing at this time – the child realises that objects that have disappeared have not gone and that he/she should look to see where they have dropped or where they might reappear. A child will discover a block that has been hidden under a cup. He/she is able to imitate gesture and understand situational clues, for example, preparations for a meal. With memory comes distress at separation from the parents. The child becomes much more discriminating in terms of adults and will not go willingly to a stranger. Children remember the child health clinic and immunising injections. Anticipatory crying occurs in the expectation of receiving a further injection.

5. Tertiary circular reactions (11–18 months)
At this age, the infant seeks new results by active experimentation. Thus, if he/she is dropping objects from a pram, he/she may vary the position of dropping the objects to observe the variation in effect that can be obtained.

6. Invention of new means through mental combinations (18–24 months)
In this stage, the child may be seen to solve problems not by physical experimentation but through mentally working out the solution and then applying this knowledge. Thus, if a chain is in a small box, which does not admit the child's fingers, his/her first action may be to invert the box so that the chain is expelled rather than make unfruitful attempts to get his/her fingers into it to grasp it. These observations of Piaget can be readily repeated. They are a most worthwhile and rewarding part of a developmental assessment.

7. Infantile realism (3–7 years)
By three years of age, the child sees himself/herself as the centre of the universe. He/she cannot conceive that others can have a different viewpoint (egocentrism). Animism describes the child's belief that everything is alive and has thoughts, feelings and wishes, just as he/she

does. Dreams exist and thoughts and wishes are just as powerful as real events. In his/her pre-causal logic, nothing happens by chance. There is always a cause and causes are motivational. For example, balloons go up into the air because they want to. The child's beliefs are based not on what he/she perceives but on an internal model of the world that may bear little relationship to what his/her senses tell him. For instance, the child is insensible to the contradiction that babies come from a baby shop even though he/she has never seen one. In the authoritarian morality of this age, the child believes that the punishment arises out of the crime. Bad events are explained as a punishment for something that he/she has done.

It is during this period of infantile realism that the child may suffer excessive anxiety if he/she feels that his/her bad thoughts and wishes may actually have come true or that having such thoughts may result in some punishment following automatically. The 'pre-causal' child will see teaching about heaven or hell or stories of Father Christmas coming down the chimney as very concrete and real. Rules are rigid and unalterable. Thus, the child in the back seat is happy to point out the red light the parents have just crossed or the double yellow line at the kerbside!

Although there is a rapid expansion of language ability, Piaget observed that children mainly talk to themselves and that their 'conversations' are really a collective monologue.

Key Message
It is easy for the child to feel responsible for events that have taken place, particularly in the view of his/her egocentric standpoint. These events might include domestic violence or the loss of a parent through separation or bereavement.

8. Concrete operations (8–11 years)
At the time of the move to junior school, the child acquires the ability to think logically. He/she realises that words, thoughts and rules are separate from concrete objects and activities. He/she is able to learn to compare and to contrast, and to understand the relationship of parts to the whole, to be able to group objects in time and space, and to understand the principles of conservation of mass, weight and volume.

9. Formal operation (from age 12 years)
From 12 years of age the child acquires the ability for abstract thinking. This involves a systematic approach to problems and the ability to understand hypotheses. There is a progressive ability to acquire an understanding of concepts of space, time, causation, number, definition, order, shape, size, motion, speed, force and energy. It is only within the secondary school that such concepts can be properly understood and taught within the syllabus.

Summary

This chapter has provided an elementary framework for understanding emotional development in childhood and its relevance to child abuse and neglect. The reader is now encouraged to try to apply this knowledge to individual children seen in clinical practice. In time it will be gradually assimilated into clinical practice so that 'history and examination' becomes 'history, examination, development and feelings'. Much of this is already present in the intuitive rapport that paediatricians use in communication with children of different ages.

References

Gesell, A. 1948. *Studies in child development*. London: Harper and Row.
Gesell, A. 1966. *The first five years of life.* London: Metheun.
Erikson, EH. 1967. *Childhood and society.* Harmondsworth, Penguin Books.
Piaget, J. 1929. *The child's conception of the world.* London: Routledge and Kegan Paul.
Piaget, J, Inhelder, D. 1969. *The psychology of the child.* London: Routledge and Kegan Paul.

Further reading

Bea, H, Boyd, D. 2004. *The developing child. Tenth edition.* Boston: Pearson Education.
Holt, KS. 1977. *Developmental paediatrics.* London: Butterworths.
Holt, KS. 1991. *Child development, diagnosis and assessment.* London: Butterworth-Heinemann.
Illingworth, RS. 1979. *The normal child. Tenth edition*. Edinburgh: Churchill Livingstone.
Maier, HL. 1969. *Three theories of child development.* London, Harper and Row.
Smith, P, Cowie, H, Blades, M. 2003. *Understanding children's development. Fourth edition.* Oxford, Blackwell Publishing.

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8

Fabricated or induced illness

Definitions

Fabrication and induction of illness (FII) is a broad term to describe a group of behaviours by parents (or those 'in loco parentis'), behaviours which cause harm to children. The behaviours have a wide range, from those causing immediate, direct physical harm, (inductions) to verbal fabrications of symptoms which are more indirectly and chronically dangerous in both physical and emotional ways. There are many in between variants. The illnesses fabricated include any medical, surgical or psychiatric conditions, and may extend to fabrication of special educational needs and disabilities.

Background: Previous Terminology

Recognition of this type of abuse began in 1970s in the UK and USA. Cases were described where parents had presented their children repeatedly unnecessarily with invented symptoms and this was compared to situations where adults presented themselves similarly , a pattern then known as Munchausen's Syndrome (Asher, 1951). Thus, the term 'Munchausen Syndrome by Proxy' was introduced to link the ideas of repeated false presentations with the 'by proxy' element: a parent presenting a child instead of themselves (Meadow, 1977). The catchy eponymous title quickly took hold as a way to summarise a complex situation and Meadow made a seminal contribution through a series of papers describing different presentations (Meadow, 1982). However, there were weaknesses in this terminology: the suggestion that the behaviours might be explained by a single parental diagnosis; the idea that the motivation of the parents might be an important element in identifying the problem, and the way the title took the focus away from what was happening to the child. Uncertainty about the concept began to enter the public mind at the end of the 20th century, despite

extensive evidence from numerous sources of this form of abuse. In order to clarify the issues, the term 'Fabricated or Induced Illness' has been introduced: this keeps the focus on the child and describes precisely what has happened to him or her: they have been abused either by a fabricated story of illness, with consequent unnecessary healthcare, or they have been the victim of illness induction. This also helps to make it clear that identifying when a child has been the victim of fabricated and induced illness must depend on careful assessment of the child.

Fabricated and Induced Illness Categories

Verbal fabrication

Parents fabricate (i.e. invent) symptoms and signs in the child, telling a false story to health care personnel, leading the professionals to believe the child is ill and requires investigations and treatment (DoH, 2002). Medical and nursing staff are used as the instrument to harm the child through unnecessary interventions, including medication, hospital stays, intrusive tests and surgery. In community settings the false stories may lead to medication, special diets and a restricted lifestyle or special schools (Sheridan 2003).

Any physical or psychological symptom or sign may be falsely described by parents so lists of possible presentations are unhelpful. Nevertheless, it is easier to invent something that a health care professional cannot see – (such as a 'fit' which has now passed, or colour change), than a normally visible sign such as a rash or temperature. The important criterion for this category is that the parent has not carried out direct harm themselves.

Key Message

Any symptoms may be verbally fabricated.

Verbal fabrication supplemented by fabricated evidence

Verbal fabrications (as described above) may be supplemented by false specimens and sometimes documents. These are used to add credence to the illness stories. Evidence will depend on the setting, but may include manufactured stones (reportedly passed by the child), or specimens of bodily fluids contaminated with someone else's blood, often the perpetrator's. Documents might include falsified seizure records or temperature charts. This category is defined by more active forms of falsification and deception but still not including direct harm to the child.

Induction of illness

Direct induction of illness may take place through several methods (Bools 1996) which are more or less acute in their effects;

- suffocation of the child, which may present as an acute life threatening event (ALTE)
- administration of noxious substances or poisons
- excessive or unnecessary administration of ordinary substances (e.g. excess salt)
- excess or unnecessary use of medication (prescribed for the child or others)
- the use of medically provided portals of entry (such as gastrostomy buttons, central lines) to give opportunity for infected or toxic material to be administered.

The criterion for this category is that direct harm has been caused by the perpetrator to the child.

Obstetric induction or fabrication
Obstetric fabrication or induction is when a pregnant woman either falsely describes problems with her pregnancy, or induces them directly by interfering with the fetus (Jureidini 1993). This may result in premature or abnormal delivery, with damage (sometimes serious and long term) to the child.

FII co-existing with organic illness
Organic illness, arising from intrinsic processes, may co-exist with fabricated or induced illness in a child, making the fabrication more difficult to identify (RCPCH 2002). Sometimes the organic illness is itself the result of FII (for example, cerebral palsy as a result of obstetric FII and premature delivery); sometimes as uncomplicated illness (such as mild asthma) is used as the vehicle for extensive exaggeration and elaboration. It is possible that FII is commoner in children with co-existing problems than in the otherwise healthy population: a recent New Zealand study of FII found that 55% of victims had a chronic illness (Denny *et a*l 2001).

Key Message
Coexisting chronic physical illness is found in many cases of FII.

The importance of identifying carefully the category of abuse is that it is likely that pre-existing behaviour is an important component of future risk.

Key Message
Identify FII category carefully for risk assessment.

How common is FII?

In answering this question it is important to be clear about exactly which category of FII is being described. Cases may go unrecognised for long periods (Eminson 2002). Serious case reviews have suggested that the risks of verbal fabrications about a child's health have not always been readily recognised in a timely way. It is difficult to be certain how extensive verbal fabrications are.

Key Message
Recognition of FII is still inconsistent.

In the 1990s, a British study of suffocation, poisoning and other severe and harmful fabrications (McClure *et al* 1986), found rates between 0.1 – 0.8/100,000 children under 16 years in different parts of the country. When recently replicated in New Zealand, rates of

2.0/100,000 children were found (Denny *et al* 2001)(but 1.2/100,000 where child protection procedures had been invoked), suggesting better recognition is now being achieved. Several children in a family may be mistreated, or just one.

How does FII come about?

It is not surprising that doctors are puzzled about such perverse behaviours by parents towards their children; appearing to be caring about their health, whilst actually causing substantial harm (Brown and Feldman 2001). Society at large has also found it difficult to believe that apparently caring mothers and fathers can behave in deeply uncaring ways, sometimes using well-intentional professionals as the instrument. It is somewhat easier to understand if parents are trying to acquire financial gains through various disability benefits and allowances, or where the parent is frankly mentally ill and deluded (but this is very rare). There is however substantial evidence that FII occurs in all societies, that it is readily identified where there is easily available healthcare, and that all paediatric specialists encounter it.

Perpetrator characteristics

Parents who fabricate and induce illness are usually mothers (>80%) with fathers represented most strongly in the direct induction group (Bools *et al* 1994). Much of the evidence is anecdotal. The parent may appear superficially to be concerned, caring and knowledgeable about the child and possible illnesses, sometimes more persistent and demanding. Closer (mental health) assessment usually reveals substantial interpersonal and relationship problems and a wide range of psychological and psychiatric symptoms and history including self harm, substance misuse, eating and body image problems, depression, anxiety and personality difficulties. Common, but, far from invariable, is somatisation of various levels by the mother for herself. 'Somatisation' is another broad label to describe a range of recurrent medically unexplained physical symptoms presented in a physical health setting, and affecting any or all body systems.

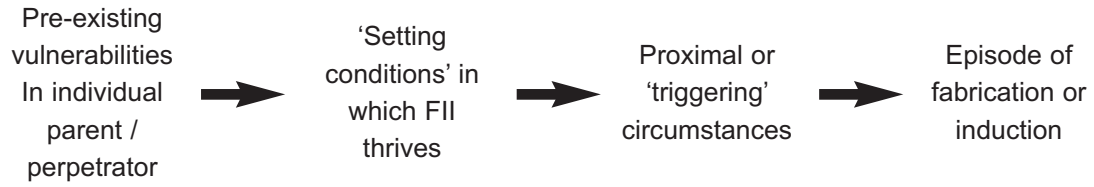
Key Message
The parent(s) may appear knowledgeable and may be persistent and demanding.

Family relationships

Fathers are often distant or absent with the mother 'expert' on the children's health (Berg and Jones 1999). Relationships between parent and child are usually disturbed with intensely ambivalent attachments; aspects of the mother's own early life are relevant to understanding but rarely acknowledged.

Although there are explanations for the behaviours from a number of different theoretical standpoints, each case requires an individual assessment of risk and protective factors. A pathway model may be most helpful in understanding the interrelationships of individual factors over time.

Pathways to FII



A range of individual factors: the abuse itself; within-child; within-perpetrator, family, parent-child and family interaction; professional and social network factors need to be taken into account in understanding and evaluating the risks in each case (Jones et al 2000).

Which children are vulnerable to FII?

There is evidence that FII is a deeply maladaptive pattern of behaviours by parent(s) and that it is often long-standing and dangerous to both the physical and emotional wellbeing of the children (Davies *et al* 1998)

Children are vulnerable to FII by their carers at almost all ages, but younger children (under 2 years) are the most common victims of direct inductions, especially suffocation (Southall *et al* 1997). It seems that verbal fabrications also often start very early in a child's life and may continue for many years, sometimes continuing throughout childhood and adolescence. Children may be able to describe what has happened to them, but may acquiesce and even collude in the falsification, finding it impossible to separate their experience from what their parents tell them is happening.

Recognition of FII

This is dependant on both the acuteness and severity of the presentation. Verbal fabrications by parents for children seen over a long period in outpatient or community settings are easier to recognise because there is time to appraise discrepancies between the account and the presentation in the child. For example, whilst severe asthma is reported, wheeze is trivial and peak flows not reduced; or seizures are said to be frequent at home but never observed at school. Even so, recognition may be especially difficult for developmental or psychological symptoms, such as social withdrawal or attentional problems, which vary in different settings anyway.

Recognising acute presentations (direct inductions) may be more difficult and depends on:

- patterns of presentation in the child which are not consistent with any known disease and incongruent.
- the conjunction of unobserved parental access with crises or deterioration in the child's health, suggesting suffocation, tampering or ingestion.

Thus the differential diagnosis includes an acute medical problem (e.g. arrhythmias or apnoea) i.e. acute organically explained life threatening events. Only close monitoring is likely to tease out the cause in these cases (Southall *et al* 1997).

The most difficult situations may be those where there is co-existing physical illness which by its nature may have fluctuations and exacerbations, or where the presentation has already been confused by surgery. Where the child is very young, has learning difficulties, multiple handicaps and complex needs, there is additional difficulty. The child may not be able to give an account themselves and the parent may already have opportunities to administer powerful medication directly at home.

Key Message
Recognition of FII is more difficult:
- When coexisting organic physical illness
- Where fabrication has already lead to unnecessary treatment / surgery
- Where the child is already multiply handicapped with complex needs.

Overlap with other forms of abuse

FII has overlaps both in categorisation and incidence with other forms of abuse. Suffocation is similar to other forms of physical abuse such as fractures and shaking infants (with more male perpetrators than other FII categories) (Gray & Bentovim 1996).

Reduced and unnecessarily restricted diets, false claims of food allergies, or feeding difficulties due to thinning milk result in a picture similar to failure to thrive, faltering growth or neglectful or inadequate food intake. Unnecessary investigations, treatments and surgery involves both physical abuse (carried out by someone else) and emotional abuse.

Key Message
Reduced and unnecessarily restricted diets (from false allergy claims) may result in failure to thrive/physical neglect.

Enforcing an unnecessary invalid lifestyle and false disability on a child is a severe form of emotional abuse. In many, but not all families, other forms of poor parenting and abuse co-exist with FII (Bools *et al* 1992).

FII has long standing effects on the victims who suffer psychological symptoms and problems with relationships themselves.

Key Message
Physical and emotional abuse are common in the families of children subjected to induced illness.

If you are concerned: steps to take which are specific to FII

As with any child protection issues, it is vital to alert the appropriate authorities and follow local and national guidance, with all agencies working together. The urgency of actions depends on the acuteness and severity of presentations, but if direct inductions are suspected, the child may need protection promptly. Always share concerns with senior colleagues. Consider possible extrinsic and organic causes carefully and in the context of the child's objective state of health. Decisions about medical and surgical interventions should be made on the basis of validated observations and a consistent history, not parental account alone. Increase specificity of notes and records.

Key Message
Always share concerns with senior colleagues.

Note exactly what was said to you, by whom, about the child's symptoms and history. Describe exactly what you found on examination. Describe exactly what the child has communicated about the events (if appropriate).

Review history and records from all settings with an open mind, and consider whether notes and records from other family members may need to be reviewed.

Key Message
It is crucial to keep an accurate record of all consultations including the child's account verbatim (if appropriate).

A multi-agency strategy meeting will be needed to decide how best to investigate the concerns and protect the child. Only in such a meeting can a decision be made to seek permission for Covert Video Surveillance(CVS), the use of which is governed by the Regulation of Investigatory Powers Act. CVS can be life saving in cases of direct induction; it is undertaken by the police (DoH, 2002).

Formal Assessment
If there are serious concerns about fabrication or induction, or it is identified, a multi-agency plan will be made, following child protection procedures. Professionals from different backgrounds will be used to assess the children's health status, the family and personal histories, perpetrator and family functioning, risk and protective factors.

References

Asher,R (1951) Munchausen Syndrome. Lancet i,339-341

Meadow, R, (1977) Munchausen Syndrome by proxy- the hinterland of child abuse. Lancet, 1,343-345

Meadow, R, (1982) Munchausen Syndrome by Proxy. Archives of Disease in Childhood, Vol 57, 92-98,

DoH, Home Office and DfES. 2002. Safeguarding Children in Whom Illness is Fabricated or Induced, London, Stationery Office.

Sheridan M.S., (2003) The deceit continues: an updated literature review of Munchausen Syndrome by Proxy. Child Abuse and Neglect, 27: 431-451.

Bools C. (1996) Factitious illness by proxy: Munchausen syndrome by proxy. British Journal Psychiatry, 169:268-75.

Jureidini J. (1993) Obstetric factitious disorder and Munchausen syndrome by proxy. Journal of Nervous and Mental Disease, 181: 135-137.

Fabricated or Induced Illness by Carers (2002) Royal College of Paediatrics and Child Health ISBN 1 900954 63 X

Denny S.J., Grant C.C. & Pinnock R. (2001) Epidemiology of Munchausen syndrome by proxy in New Zealand. Journal of Paediatrics and Child Health, 37: 240-243.

Eminson D.M. (2000) Chapter 2: Background (pages 17-70). Munchausen Syndrome by Proxy Abuse: A Practical Guide. Eminson D.M. & Postlethwaite R.J. (Eds) Arnold. London.

McClure R.J., Davis P.M., Meadow S.R., et al (1986). Epidemiology of Munchausen syndrome by proxy. Archives of Disease in Childhood, 75: 57-61.

Brown R., Feldman MD (2001) International Perspectives on Munchausen Syndrome by Proxy. In Munchausen's Syndrome by Proxy: Current Issues in Assessment, Treatment and Research, Adshead G and Brooke D, Eds. London,13-38.

Bools C., Neale B. & Meadow R (1994). Munchausen syndrome by proxy: A study of psychopathology. Child Abuse & Neglect, 18: 773-788.

Berg B. and Jones D.P.H. (1999) Outcome of psychiatric intervention in factitious illness by proxy (Munchausen's syndrome by proxy) Archives of Disease in Childhood, 81: 465-472.

Jones D.P.H., Byrne G. and Newbould C (2000) Chapter 13: Management, treatment and outcomes (pages 276-194) In Munchausen Syndrome by Proxy Abuse: A Practical Guide. Eminson D.M. & Postlethwaite R.J. (Eds). Arnold. London.

Davis P., McClure R.J., Rolfe K., Chessman N., Pearson S., Sibert J.R. and Meadow R. (1998) Procedures, placement, and risk of further abuse after Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation. Archives of Disease in Childhood, 78: 217-221.

Southall D.P., Plunkett C.B., Banks M.W., Falkov A.F. and Samuels M.P. (1997) Covert video recordings of life threatening child abuse: lessons for child protection. Pediatrics, 100 (5), 735-60.

Gray J. and Bentovim A. (1996) Illness induction syndrome: paper I - a series of 41 children from 37 families identified at The Great Ormond Street Hospital for Children NHS Trust. Child Abuse & Neglect; 20:655-73.

Bools, CN, Neale, BA, Meadow, SR (1992) Comorbidity associated with fabricated illness (Munchausen Syndrome by Proxy). Archives of Disease in Childhood Vol 67:77-79.

9

Psychological consequences of child abuse and neglect

The physical and developmental consequences of child abuse and neglect have already been covered. This chapter looks at some of the other consequences particularly in terms of psychological and emotional development of the child. The impact of these consequences into adult life including the intergenerational aspects of child abuse should be taken into consideration during the assessment phase after referral.

The approach to assessment of physical injury has been unhelpful for considering longer-term effects and psychological consequences of abuse and neglect. It has encouraged us, although erroneously, to think of child abuse and neglect as a series of incidents needing short-term investigation rather than a process that may require longer intervention.

Overview of consequences of abuse

It is now well established that child abuse and neglect causes serious harm to children and has negative consequences for their health and development, both in the short and long term (Briere 1992, Browne *et al* 2002). The severity of harm is mediated by a number of factors (Watkins and Bentovim 1992). These are:

- The type and form of the abusive and/or neglectful act (contact or non-contact)
- The child's age and developmental stage at the time of the maltreatment
- The duration and frequency of the maltreatment
- The relationship of the child to the perpetrator (abuse of trust in close relationships)
- The response to the child's disclosure of abuse and neglect (acceptance or denial)
- The support the child receives after being maltreated (helpful or unhelpful).

All forms of abuse and neglect may have both physical and psychological consequences for the child, some of which may present as symptoms of the maltreatment. These include attachment

disorder, post traumatic stress disorder, somatic symptoms, sexual dysfunctions, emotional disorders, mental illness, self harm, alcohol and drug abuse, antisocial personality, aggressive behaviour, and sexual assault on others (Falshaw *et al* 1996).

Key Message
All forms of abuse and neglect may have both physical and psychological consequences for the child.

Taking into account the serious consequences abuse has on the child, the necessity of the intervention and psychotherapeutic treatment is obvious. Undetected and untreated abuse and neglect yield devastating results for both the individual and the community (Briere 1992). Research has demonstrated that three quarters of young criminals in prison have a childhood history of abuse and neglect (Falshaw and Browne 1996, 1997; Hamilton *et al* 2002), although only one in six maltreated children go on to commit violent offences (Rivera and Widom 1990; Widom 1989a, 1989b, 1991; Widom and Ames 1994). Therefore, immediate reporting, intervention and treatment of abused and neglected children is an essential priority of public and social policy.

Effect on development, behaviour and relationships

Childhood is the time that the brain is developing at the fastest rate in all areas and the cumulative effects of living with neglect, violence, and physical and sexual abuse can have an effect on one or more aspects of the child's functioning. Recent advances in technology have allowed the study of the growth in neuro-synaptic pathways in infants and young children and it has been shown that being reared in chaos, neglect and violence results in disorganised and underdeveloped brains (Glaser 2000, Perry *et al* 1995). In young children, this tends to lead to either hyperarousal with a fight/flight response or dissociation where the child seems unresponsive, numb or cut-off.

Adults often misunderstand these reactions and the child is seen as disordered or defiant. The responses evoked by the child's behaviour reinforce the fear and consolidate the coping mechanisms, so setting up the vicious spiral which is commonly present in chronic abuse. As time goes on, if the situation does not improve, a range of difficulties can emerge. These symptoms can be seen to arise out of coping strategies the child has employed to live with and accommodate to the abuse.

There are no specific symptoms associated with child abuse and different types of abuse do not produce different syndromes. The fear, loss of trust and distortions of their closest relationships are present in all forms of abuse and are the components that influence long-term development.

Any study of socially marginalised young people, for example, runaways, those who self-harm, substance misusers, persistent offenders and those with mental health problems, have a very high rate of reported abuse. However, it is important to remember that a number of children who are abused do not go on to display major difficulties.

The difficulties shown by children depend on their age and developmental level when the abuse began, their innate temperament and resilience. The presence of other factors in the environment interacts with these difficulties to mitigate or accentuate the problems. Anna Freud (Freud 1976) points out that there is no one-to-one relationship between adverse parenting and the distortions that might arise in the child's development – cruel treatment can produce either an aggressive and violent person or a timid, crushed and passive being. 'The developmental outcome is determined not by the environmental interference per se, but by its interaction with the inborn and acquired resources of the child'.

Recent work has moved away from a dichotomy between either genetic and neuro-physiological reasons or psychosocial ones as the cause of behaviour problems. Pre- and postnatal influences of both types affect the brain and this has an effect on the behaviour of the child, which in turn affects the response from others.

Key Message
There is a very high prevalence of reported childhood abuse and neglect in socially marginalised young people, but many with with a history of abuse do not show adverse consequences in later life.

Cognitive effects

Learning can be impaired as the direct result of an understimulating or abusive environment. The ability to learn can also be impaired by the effort necessary to not think or talk about the abuse that is occurring (Bowlby 1979).

The language of maltreated children tends to develop slower than in their non-abused counterparts and abused children also have less ways of describing feelings. Impaired language development prevents the acquisition of symbolic and abstract thought necessary to learn in school.

Overactivity, poor concentration and troublesome behaviour compound cognitive difficulties by making school placement and academic achievement difficult.

Psychological effects

It is important to remember that most child abuse happens within the family. This is a betrayal of the core relationships a child needs to develop and very basic psychological functions like trust, attachment and a sense of self identity are compromised.

John Bowlby studied the relationships between infants and their primary caregivers, usually their mothers. This first relationship with an attachment figure becomes the blueprint from which the child develops other relationships. As work on attachment behaviours has been expanded, there is a greater understanding of how difficulties in early attachment can lead to problem behaviours later. The minute day-to-day interplay between an infant and carer gives

rise to trust and an ability to control inner feelings if things are going well. Secure attachment allows a young child to develop self-esteem and empathy.

When studied closely, other forms of attachment can be described (Ainsworth 1985).

Inconsistent caring gives rise to 'ambivalent' attachment where the child wants his/her carer but resists the comfort offered.

Unresponsiveness in the carer commonly due to depression or substance misuse leads to 'avoidance' attachment where the child does not look to the parent for reassurance and shows little emotional response to the parent coming and going. This avoidance pattern can later lead to depression, substance misuse, self harming and bulimia.

Abusive parenting, where the main caregiver is also the source of harm, gives rise to 'disorganised' attachment where the child approaches the parent in a distorted, disorganised way. They might freeze or stare into space. Children with this type of attachment pattern are particularly vulnerable to further problems within and outside the family. Their relationship with their peers is difficult and it is hard for them to make close, trusting relationships. This has serious implications if they are placed outside the family, as it may be hard for them to gain positive experiences from an alternative placement.

Other behavioural effects

Many abused children have low self esteem and this can interfere with them taking advantage of good experiences that could help to mitigate the effects of abuse. They do not think they deserve to be well treated or respected. The inability to internally contain strong emotions and the way these early relationships affect brain development can lead to impulsive, poorly controlled behaviour, which is often aggressive. It is not uncommon to meet young people that have an early history of severe abuse in the criminal justice system.

Key Message
For infants who have been abused, insecure attachment leads on to difficulties in establishing relationships in later life.

All of these behavioural problems lead to unrewarding contact with adults and peers and validate the child's view, developed through abuse, that they are unlovable and bad and the world is a dangerous place.

Effects of abuse in childhood on adult development

Untreated trauma arising from abuse contributes heavily to mental health and social problems, not just in childhood but into adult life. Adults can have great difficulty creating and sustaining intimate, personal relationships which can lead to sexual and marital difficulties (McCann and Pearlman 1990). This can then go on to make parenting difficulties for the next

generation. For some, the early effects on their brain and emotional development means they are impulsive, aggressive, have learning difficulties, get excluded from school and go on to become delinquents and substance misusers. This pattern of behaviour has been repeatedly shown to be very persistent if there are no mitigating factors and the children go on to be parents who rear their children in similar ways.

The children who are more withdrawn and internalise the emotional distress are likely to go on to develop mental health problems. Patterns of deliberate self-harm, eating disorders, depression, anxiety and personality disorders consume large amounts of resources and professional time, often to little avail as the link between the patients' symptoms and their childhood experiences of abuse are not made and the interventions offered not helpful. Post traumatic stress disorder is now thought to be a significant consequence in some cases of abuse and may give rise to symptoms that can be mistaken for a developing psychosis.

The ongoing debate about the smacking of children and the meaning of 'reasonable chastisement' has again confirmed our cultural acceptance of the aggression and exploitation embedded in the way our children are reared (This debate was rekindled in the UK following a case in the European Court and comments by the UN Committee on the Convention on the Rights of the Child). It hampers our ability to recognise parent-child difficulties early on and to manage them in a sensitive way. The connection between child maltreatment and later dysfunctional behaviours, therefore, gets overlooked in spite of the body of evidence supporting the connection.

We need to develop a broad framework to address the spectrum of child abuse and its consequences. Professional groups and agencies can overcome their differences and contribute together towards effective intervention in this difficult field.

Intervention

Although the effect of abuse on children's neuro-psychological development can be profound, it is important not to take a position of despair. The brain is a plastic organ and patterns of thinking and behaviour can change. Violence towards children is a culturally embedded phenomenon, not a disease, so the interventions need to be social as well as professional. Society has periods of recognising child maltreatment and then forgetting again. The current interest only began with Kempe's work 44 years ago (Kempe 1962).

The best intervention is prevention. All professionals involved with children should promote child-centred policies including those addressing family poverty, racism, poor housing, and poor schools. Social forces that allow the victimisation of those with less social power result in high rates of child maltreatment (Briere 1992).

Secondary prevention involves targeting vulnerable groups so that the number of positive and neutral experiences the child has is increased. Government policy is therefore increasingly moving away from only dealing with major events of abuse toward a broader-based service for "Children in Need". Ideally this would offer family and child support when families are under pressure and are seen to be vulnerable rather than waiting until problems have occurred.

Government initiatives under social exclusion policies such as Sure Start (DfES 2002) '*Making a difference for children and families*' should go some way towards meeting these ideas. For families living in areas of social exclusion with a child under four years, the government programme Sure Start is providing enhanced opportunities to develop positive parenting.

A similar programme in the US in the 1960s called Headstart was shown to make a significant difference to the children at long-term follow-up especially with educational attainment and employment.

Summary

Child abuse can have long-lasting consequences in terms of cognitive and emotional development and the ability to establish stable relationships with others. As abused children become parents there can be an intergenerational transmission of abusive parenting. Prevention and early intervention are the best approaches, and global pessimism about the effectiveness of intervention is not warranted. It is important to make the link between later dysfunctional behaviours and disclosed or undisclosed abuse earlier in childhood.

References

Ainsworth, MDS. 1985. Patterns of infant – mother attachment and effect on development. *Bulletin of the New York Academy of Sciences* 61:771-791.

Bowlby, J. 1979). On knowing what you're not supposed to know and feeling what you're not supposed to feel. *Canadian Journal of Psychiatry* 24/5: 403-408.

Bowlby, J. 1989. *A secure basis.* London: Tavistock/Routledge.

Briere, JN. 1992. *Child abuse trauma.* Newbury Park: Sage Publications.

Browne, KD, Hanks, H, Stratton, P, *et al*. 2002. *Early prediction and prevention of child abuse: A handbook.* Chichester: Wiley. (Wiley Series on Child Care and Protection – Eds. K. Browne. M. Lynch)

Department for Education and Skills. 2002. Sure Start. London: HMSO. http://www.surestart.gov.uk

Falshaw, L, Browne, KD. 1997. Adverse childhood experiences and violent acts of young people in secure accommodation. *Journal of Mental Health* 6: 443-455.

Falshaw, L, Browne, KD, Hollin, CR. 1996. Victim to offender: A review. *Aggression and Violent Behavior* 1(4): 389-404.

Freud, A. 1976. Psychopathology seen against the background of normal development. *British Journal of Psychiatry* 129: 401-406.

Glaser, D. 2000. Child abuse and neglect and the brain – a review. *J Child Psychol Psychiat* 41(1): 97-116.

Hamilton, CE, Falshaw, L, Browne, KD. 2002. The link between recurrent maltreatment and offending behaviour. *Legal and Criminological Psychology* 46(1): 75-94.

Kempe, CH, Silverman, FN, Steele, BF, *et al*. 1962. The battered child syndrome. *Journal of the American Medical Association* 181: 17-24.

McCann, IL, Pearlman, LA. 1990. *Psychological trauma and the adult survivor: theory, therapy and transformation.* New York: Brunner/Mazel.

Perry, BD, Pollard, RA, Blakley, TL, *et al*. 1995. Childhood trauma, the neurobiology of adaptation, and 'use-dependent' development of the brain: how 'states' become 'traits'. *Infant Mental Health Journal* 16(4): 271-290.

Rivera, B, Widom, CS. 1990. Childhood victimization and violent offending. *Violence and Victims* 5: 19-35.

Watkins, B, Bentovim, A. 1992. The sexual abuse of male children and adolescents: A review of current research. *J Child Psychol Psychiat* 33: 97-248.

Widom, CS. 1989a. Does violence beget violence? A critical examination of the literature. *Psychological Bulletin* 106: 3-28.

Widom, CS. 1989b. The cycle of violence. *Science* 244: 160-166.

Widom, CS. 1991. Avoidance of criminality in abused and neglected children. *Psychiatry* 54: 162-174.

Widom, CS, Ames. MA. 1994. Criminal consequences of childhood sexual victimization. *Child Abuse and Neglect* 18: 303-318.

Acknowledgement

10

Children's rights

Children's rights are at the core of all aspects of paediatric practice. They apply to the way children and young people are talked to, the information that is provided, the setting in which children are seen and the way in which the problems facing children in society are approached. The protection of children from harm must rank as probably the most important in the last category. This chapter provides a guide to understanding the concept of children's rights as well as how they apply to the clinical settings in which children and young people are seen.

Key Message
Children's rights are at the core of paediatric practice.

The meaning of children's rights (RCPCH Children's Rights course)

The meaning of children's rights was spelled out in the United Nations Convention on the Rights of the Child, which was launched by the UN in 1989. The basis for children's rights is children's needs; because children are vulnerable and cannot protect themselves – and their parents are not always in a position to protect them either – the state has an obligation to ensure that their needs are met. The basic needs of children are outlined in Table 1.

Table 1: A framework of children's needs

Physical needs	Social, economic and cultural needs	Psychological and emotional needs
Shelter	Knowledge of and respect for own language, religion and culture	Opportunities for play
Health care	Stable social and economic environment	Access to education
Water and sanitation	Recognition of and respect for emerging competencies Opportunities to be listened to and respected	Access to age appropriate information
Protection from environmental pollution	Access to appropriate guidance and support	Stimulation
Adequate food	Access to age appropriate information	Access to appropriate guidance and support
Adequate clothing	Respect for privacy and confidentiality	Respect for privacy and confidentiality
Protection from violence	Access to education	Recognition of and respect for emerging competencies
Protection from exploitation and abuse	Opportunities for friendship	Opportunities to be listened to and respected
	Opportunities for play	A family environment, whether the biological or a substitute family
	A family environment – whether the biological or a substitute family	

Key Message
The basis of children's rights is children's needs. Since children are vulnerable the state needs to ensure their needs are met.

The UN Convention on the Rights of the Child (UNCRC)

All countries of the world bar the US and Somalia have ratified the UN Convention thereby signifying that they intend to apply these rights to their own country. The Convention groups children's rights as follows:

Social rights: The right to life and optimum survival and development, to the best possible health and access to health care, to education, to play, and to family life unless not in the child's best interests.

Economic rights: The right to an adequate standard of living for proper development, to benefit from social security, and the right to protection from economic exploitation.

Cultural rights: The right to respect for language, culture and religion, and to abolition of any traditional practices likely to be prejudicial to the child's health.

Protective rights: The right to promotion of the child's best interests, to protection from sexual exploitation, from armed conflict, from harmful drugs, from abuse and neglect, and to rehabilitative care following neglect, exploitation or abuse

Civil and political rights: The right to be heard and taken seriously, to freedom from discrimination in the exercise of rights on any grounds, to freedom of expression, to privacy, to information, to respect for physical and personal integrity, and freedom from all forms of violence, or cruel, inhuman or degrading treatment.

These rights apply to all children from birth up to 18 years of age.

Key Message
The UN Convention has been ratified by all but two countries (Somalia and the US) in the world and applies to children up to 18 years in all situations and circumstances.

International context (Waterston and Davies 2005)

Worldwide there is an enormous need for the UN Convention. The chief problems facing children globally in addition to poverty, starvation and disease are child abuse within the family, child labour, child soldiers, children separated from their family, and child prostitution. However, even basic needs are not met in many countries: food, water, shelter, education and health care are all lacking owing to economic privation. For children with disabilities and chronic illness there is a shortage of adequate care and of education, and few mental health services are available.

However, the convention does not have much power to improve the situation. Monitoring is carried out by the UN Committee (in Geneva) on the Rights of the Child which meets regularly in Geneva and there is an obligation on all signatories to report to the Committee every five years on the progress that is being made. The committee comments but has no legal powers to enforce its recommendation. It is up to civil society to ensure that each country responds appropriately. In England, the Children's Rights Alliance (a non-governmental organisation (NGO)) reports at the same time as the government and its comments are well publicised. This leads to pressure on government to fulfil its commitments. However, there may not be any such process in the countries which protect children's rights least.

Key Message
The convention is monitored by the UN Committee in Geneva but has no legal means of enforcement.

Application in the UK (Children's Rights Alliance)

As discussed above, government activity in England is monitored by the Children's Rights Alliance which produces reports on a regular basis (see end of chapter for details). Also each of the UK devolved countries has a children's commissioner whose role is to ensure that children's rights are given due recognition. However, there are many problems with children's rights in the UK. The main problems which relate to the UK's protection of children, as reported in 2003 by the United Nations Convention on the Rights of the Child (UNCRC) are:

- Teenagers placed in prison without access to health care, education or child protection
- Lack of benefits and access to health care for asylum seeker children
- Continued use of the 'reasonable chastisement' defence to corporal punishment in the home
- Nearly one in three children living in poverty
- A lack of recognition of the need for respect for children's rights in government documents.

Relevance in health care (Waterston and Mann 2005, Webb 2002)

Children's rights are of key relevance to health care and it is important to take a wide ranging view. Thus in health care there might be a special emphasis on the need for confidentiality for teenagers, but the wider rights of the same child to education and to freedom from discrimination should also be considered by the paediatrician.

The articles of the United Nations Convention on the Rights of Children which apply to health care are listed in Table 2. Additional comments are made on some articles of particular relevance. The full text of all the articles is available on the UNICEF website (see end of chapter for details).

Table 2: Rights of children which relate to health care

Article 2: Protection from discrimination

Article 2	Protection from discrimination
Article 3	Best interest of the child a primary consideration; the services responsible for the care or protection of children shall conform with the standards established by competent authorities
Article 5	Parents are responsible for ensuring that child's rights are protected
Article 6	Right to survival and development
Article 9	Right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis
Article 12	The rights of the a child to express their view
Article 13	Freedom of expression including seeking, receiving and imparting information
Article 16	Protection of privacy
Article 17	Access to information from mass media, with protection from material injurious to his or her well-being
Article 18	Assistance to parents with child rearing responsibilities
Article 19	Protection from physical or mental violence, abuse or neglect
Article 20	Special protection for children deprived of their family
Article 22	Protection of children seeking refugee status
Article 23	Rights of disabled children to special care
Article 24	Right to health and access to health care
Article 27	Right to an adequate standard of living
Article 28	Right to education
Article 30	Right to own culture and religion
Article 31	Participation in leisure and play
Article 34	Protection from sexual exploitation

This refers to discrimination on the basis of colour, ethnic origin, religion or gender. This could be, for example, an asylum seeker child from Somalia who is suffering bullying at school on

the basis of colour. This should be taken up by the paediatrician and the parent supported, if necessary by writing to the head teacher.

Article 5: Parents are responsible for ensuring that child's rights are protected
Are the parents doing everything to ensure that the child is being educated, is attending health care, and is being protected? In cases of neglect and emotional abuse this would not be the case, and the paediatrician needs to be constantly sensitive to the detection of inadequate parental care.

Article 12: The right of a child to express his view: with weight given according to the maturity of the child
Does the child have a chance to express a view on his health care? Children are seldom asked for their views, or not in a way that makes it easy for them to respond. Yet their views are worth listening to and are of great importance. An example here would be a child with a chronic illness attending school where they need to take medication. The child should be asked about his views on his treatment and who should administer it. Children and young people should also be systematically be asked their views on the health care setting, for example, the out-patient department and the ward and timing of clinics in relation to school. There is a case for holding some clinics in school where children may feel much more at ease and able to give their views than in a hospital environment.

Article 13: Freedom of expression including seeking, receiving and imparting information
How much information is given to children about their illness and disability and how much do they understand? At present there is a shortage of child-friendly material about most conditions apart from asthma, diabetes and cystic fibrosis. It is important to recognise the child's need for information. This should be given fully but at a level which is appropriate for the child's age and development. Information sheets are available on the internet via certain websites (see end of chapter for details).

Article 16: Protection of privacy
From the practical point of view, this also includes providing a suitable place for the examination of a child who is suspected of being abused, where they can feel their privacy is being respected. This also includes confidentiality, which becomes a requirement in the older child and young person. Teenagers will not divulge personal information unless they know that it will not be passed on. However, there are situations where absolute confidentiality cannot be/should not be promised if there are child protection issues. There is an implication here of needing to see young people separately from their parents. It is good practice to offer a young person a confidential consultation from about 12 years up and to expect it from 14. Clearly, specific ages will vary according to the maturity and independence of the child.

Article 18: Assistance to parents with child rearing responsibilities
Many parents are seen who are having difficulty with their parenting tasks. A consultation is an opportunity to put them in touch with help. Information about local support should be available. Sure Start usually will provide this for the 'under fives', but help is targeted only at certain areas (soon to be merged into children's centres). There tends to be a lack of support or education for parents of older children, in particular teenagers and it is important to communicate with their school health advisers and work with them.

Article 19: Protection from physical or mental violence, abuse or neglect
This article guides work in child protection. Fortunately in this country there is a statutory requirement to protect children, whereas this is still not the case in many other places. However, the law still protects parents who use physical means to punish their children and the defence of 'reasonable chastisement' remains in the UK. Parents are expected to use only light force (so that a bruise does not result) but this is very difficult to define in practice. The Royal College of Paediatrics and Child Health is a signatory of the Children are Unbeatable Campaign, a coalition of organisations which is backing a change in the law (see end of chapter for details).

Article 23: Rights of disabled children to special care
Paediatricians see many children and young people with disabilities and not all are receiving the care and attention they deserve. A paediatrician supporting a parent in obtaining the services appropriate for his/her child can reduce a long wait significantly as well as being of considerable emotional value to the parent.

Article 24: Right to health and access to health care
Not everyone is able to access services especially the poor and those whose first language is not English. Interpreter services may be difficult to obtain at short notice leading to pressure to use family members to translate, a recourse that should be avoided except in emergency. Some parents may find it hard to be assertive in obtaining information about procedures and investigations and results of tests, which should be given within a week of being available to the clinician. Whilst many parents will ring to obtain the relevant information, the less assertive may not, but clearly need the result just as much.

Key Message
Paediatricians should be aware of the articles in the Convention which apply to their every day work.

Obligations of paediatricians

The RCPCH in its current strategy document (RCPCH 2004) has stated that paediatricians should promote the implementation of the UNCRC throughout the College, and in all areas of society and institutions. The College has moved a considerable way forward in this respect following a motion at the annual meeting in 2003. There is now an obligation on all committees to consider the UNCRC in making statements or comments, and each must have a member with expertise in children's rights (RCPCH Advocacy guide). A training day is held annually to ensure that this happens. Following a consultation with children and young people, the College has appointed a participation officer whose role will be to find ways of increasing the participation of children and young people in the work of the College (RCPCH 2005).

Summary

The United Nations Convention on the Rights of the Child has made clear what should be available to all children. The UK has signed up to these principles. An understanding of children's rights impinge on all aspects of paediatric practice and have particular relevance with regard to child protection.

References

Royal College of Paediatrics and Child Health. 2005. *Coming out of the shadows.* London: RCPCH. www.rcpch.ac.uk/.

Full Text of the UN Convention on the Rights of the Child. www.unicef.org/CRC/fulltext.htm.

Royal College of Paediatrics and Child Health. In press. Advocacy guide. London: RCPCH. www.rcpch.ac.uk/.

Royal College of Paediatrics and Child Health. 2004. *Working together for children: College strategy 2003-2008.* London: RCPCH. www.rcpch.ac.uk/.

Waterston, T, Davies, R. 2005. Children's rights and international health. Series in *The Lancet.* In press.

Waterston, T, Mann, N. Eds. 2005. Children rights series. *Arch Dis Child* 90: 171-181.

Webb, E. 2002. Health services: who are the best advocates for children? A*rch Dis Child* 87: 175-177.

Useful websites

www.cafamily.co.uk for child-friendly information on disabling conditions

www.medem.com for child-friendly information on medical conditions including mental health.

www.childrenareunbeatable.co.uk.

www.essop.org/ for RCPCH/AAP Children's Rights Course.

www.unicef.org/

www.crae.org for information on Children's Rights Alliance for England.

11

Safeguarding children and the law

The legal responsibility for intervening to protect children from abuse and neglect in this country is held by children's social care, which has a statutory duty to enquire and take action to safeguard and promote the welfare of children. These important functions cannot be carried out in isolation or in the absence of relevant information and expertise. The legislation therefore provides for social care to have the power to request other professionals and agencies to co-operate and assist with carrying out these functions. The obligation to work collaboratively in this way arises both in relation to individual cases and planning services.

It is important for practitioners working with children and families to understand the relevant legislation, the obligations that this imposes on health services and the implications for professional practice.

This chapter addresses the law as it is applied in England and Wales.

Key Message
children's social care has a legal duty to protect children from abuse and neglect.

The most important legislation underpinning the protection of children from harm is the Children Act 1989 (HMSO 1989) (the 'Act'). The Children Act 1989 provides a framework of law, determines the jurisdiction of and the approach to decision making about children's welfare by the courts. It establishes the responsibilities of public agencies to deliver services in order to safeguard and protect children from abuse and neglect and promote their welfare. There are also several other Acts referred to which have relevant provisions for promoting and safeguarding the welfare of children.

Key Message
The most important legislation underpinning the protection of children from harm is the Children Act 1989 (HMSO 1989) (the 'Act').

Philosophy of the Children Act 1989

The Act seeks to balance the need to take effective action to protect children from abuse and neglect with the need to prevent over intrusive involvement of state agencies in family affairs. It reflects the principle that it is better for most children to be brought up within their families if this is consistent with their welfare. Strong social care powers to take action are balanced by obligations to involve and consult with family members, including children and to provide a range of services for family support.

Guidance issued by the Secretary of State (DoH 1991) requires social care to seek to work in partnership with children and families to address their problems. This reflects the principle that if there is agreement on the nature of the problem, agreement on what is to be achieved and agreement on the means to achieve it, the outcome is likely to be more satisfactory. However, the desirability to reach agreement does not override the needs of the child, for example, if parents do not agree.

The welfare of the child is paramount when courts are making decisions on a child's upbringing. In making decisions about a child, particularly in relation to care, supervision and contact, the court and others need to be mindful of the 'welfare checklist'. This is a list of significant issues to be considered which includes the fact that the court in making decisions, should always take into account the wishes and feelings of the child (in light of his/her age and understanding). Also, courts should only make an order if by doing so it will improve the situation for the child.

Key Message
The welfare of the child is paramount when courts are making decisions on a child's upbringing. The courts should always take into account the wishes and feelings of the child.

Relevant terminology

'Significant' The use of this word has a specific meaning and establishes a threshold of concern. In this context it means noteworthy or important. It is not actually defined in the 1989 Act, but left to the professional's judgment.

'Harm' Harm is defined as including ill treatment or the impairment of health or development and the seeing or hearing the ill treatment of others.

'The accommodated child' The local authority may agree to accommodate the child through a voluntary arrangement with the person(s) with parental responsibility and may place the child in accommodation provided by the local authority or by private or voluntary sectors.

A '**looked after child'** refers to a child accommodated by a local authority whether or not a care order has been made. The local authority is responsible for developing and implementing a plan to ensure that the child's health, education and social development needs are met in partnership with other interested parties including those with parental responsibility.

'Contact' is the term for access but is wide enough to include, for example, telephone calls or letters.

Establishing parental responsibility

The 1989 Act introduced the concept of 'parental responsibility' which is defined as 'all the rights, duties, powers, responsibilities and authority which in law a parent of a child has in relation to the child and his/her property'. The change in emphasis from parental rights to parental responsibilities was intended to emphasise that children are no longer to be viewed as the property of the parents. It also signifies that the extent and exercise of parental responsibility diminishes with the increasing age and independence of the child. Parental responsibility arises as follows:

- Where a child's parents are married at the time of the child's birth, each have parental responsibility.
- Where a child's parents are not married at the time of the child's birth, the mother has parental responsibility.
- The father (in cases such as above) may acquire parental responsibility by:
  marrying the mother, or
  obtaining a court order, or
  having a formal agreement with the mother, or
  being present at the registration of the birth and being recorded as the father.
- Others may acquire parental responsibility through the court by a residence order.
- Others may acquire parental responsibility through the court by a Special Guardianship Order.
- After adoption, the adopting parents have parental responsibility.
- A local authority acquires parental responsibility with a care order (and shares it with the parents who retain parental responsibility). The local authority must determine the extent to which parents exercise their parental responsibility.

Thus, parental responsibility may be held by more than one person at a time and can be exercised by one person independently. The courts decide in cases of disagreement. A local authority acquires parental responsibility (and shares this with the parents that already have parental responsibility) on the making of a care order. However, the local authority may determine the extent that the parents may exercise their responsibility. Those who have the care of a child but no parental responsibility may do what is reasonable in the circumstances to safeguard and promote the welfare of the child.

It is noteworthy that foster parents usually are not able to give consent for medical assessment or treatment for the child in their care. Doctors must ensure that they have a valid consent from a person with parental responsibility. In practice, some of the routine health care activities may be delegated by parents to the foster carer where the child is accommodated and may be carried out on behalf of the local authority where there is a care order. Necessary agreements are recorded on the Placement Information Record.

Although parental responsibility continues until the end of childhood at 18 years of age, a child acquires an increasing ability to influence matters that affect his/her welfare since so far as the parent is concerned, it is:

'a dwindling right which the courts will hesitate to enforce against the wishes of the child, the older he is. It starts with the right to control and ends with little more than advice.' (Gillick v West Norfolk and Wisbech Health Authority and Another (1986) 1 FLR 224).

Key Message
It is important to establish who has parental responsibility when seeing a child and record this in the notes.

Private law

The Children Act 1989 provides courts with a range of flexible orders which they may use according to the individual needs of the child and family. Section 8 of the Act created four new orders:

Residence order
This states with whom the child is to live and is the only section 8 order which may be made when the child is in the care of a local authority. It has the effect of ending any care order and gives parental responsibility to the person with the benefit of the order. If the person is not the parent, then that person shares parental responsibility with parents who had parental responsibility prior to the making of the order. Residence may be shared, for example, the child residing with the mother during term time and with the father in the school holidays.

Contact order
This requires the person with whom the child lives, or is to live, to allow the child to have contact (visit, stay with or correspond) with the persons named in the order.

Prohibited steps order
This prevents the parent(s) of a child or any other person, taking any step in meeting his/her parental responsibility of a kind set out in the order without first obtaining the permission of the court. An example may be where a parent is threatening to take a child out of the country without consent to carry out female genital mutilation.

Specific issue order
This gives directions about the handling of a specific question which has arisen, or may arise, in connection with any aspect of parental responsibility for a child. The aim of this order is to enable particular disputes between those with parental responsibility to be resolved by the court, for example, in relation to education or medical treatment of a child. If a child is not subject to a care order but accommodated by the local authority, application may be made for a specific issue order (or a prohibited steps order) to resolve differences with those who have parental responsibility.

Public law

Section 47 of the Children Act 1989

The local authority has a statutory duty to make enquiries when it has reasonable cause to suspect that any child in its area is suffering, or likely to suffer significant harm, to enable a decision to be made about any necessary action to safeguard and promote the child's welfare. It has a statutory duty to:

- Make enquiries to ascertain whether the child is suffering or likely to suffer significant harm
- Assess the needs of the child and the parents' capacity to respond to these needs within the wider family and environmental context
- Decide whether action is necessary to safeguard or promote the child's welfare.

Key Message
If a health professional makes a referral to children's social care because he/she has concerns about a child's welfare or safety, children's social care must consider their statutory responsibilities.

The local authority's statutory duty to make enquiries cannot be carried out without effective and efficient co-operation from others who have relevant opinions and information concerning the child. In particular, but not exclusively, the enquiries must be directed towards establishing whether the authority should make any court application, exercise any other powers under the Act or apply for a child safety order with respect to the child (section 47(3)). Amendments to this section made by the Crime and Disorder Act 1998 reflect the government's determination to bring young children who are involved in anti-social or criminalised behaviour within the scope of welfare provisions.

Thus, section 47 empowers local authorities to call upon other professionals and agencies to assist them with these enquiries by providing information and advice and places a duty on those professionals and agencies to assist unless to do so would be unreasonable in all the circumstances of the case. Those agencies include the National Health Service. Social work staff who request assistance under these provisions should be able to explain the reason for the request and the purpose for which any information will be used. However, it is important to recognise that just as in reaching a 'diagnosis', it is only the receiver of information that can judge its significance.

This places doctors under an obligation to co-operate with children's social care and share information, not only about the child but also significant information about parents/carers and other adults who may pose a risk of harm, where this is necessary to safeguard the welfare of children.

Key Message
Doctors must co-operate with children's social care and share appropriate information where there are concerns about a child's safety and welfare.

When carrying out enquiries, the local authority has a statutory duty to obtain access to the child unless it considers it unnecessary because it has sufficient information. This duty is not subject to permission by those with parental responsibility.

Section 17 of the Children Act 1989

Under section 17(1) of the Act, Local Authority children's social care has a general duty to: (a) safeguard and promote the welfare of children within 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.

Section 17(10) of the Children Act 1989 states that:

For the purposes of this Part a child shall be taken to be in need if –

(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;

(b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or

(c) he is disabled,
and "family", in relation to such a child, includes any person who has parental responsibility for the child and any other person with whom he has been living.

Part III of Schedule 2 of the Act provide further duties and powers regarding the services to be provided in fulfilment of this duty. A local authority in meeting a child's assessed needs, has a discretion to provide assistance in kind, or in exceptional circumstances, cash, and may provide services to members of a child's family, including persons with parental responsibility or any other person with whom the child has been living but may not be compelled to do so (section 17(3)(6) (10)).

Clearly, children's social care is unable to carry out these important statutory responsibilities without access to information and expertise held and services delivered by staff working in other agencies. The 1989 Act empowers children's social care to call upon other agencies to assist them with the delivery of these functions.

The agencies that may be required to assist children's social care services include:

- any Health authority
- any Special health authority
- any NHS trust
- any Primary care trust.

Thus, children's social care has a duty to assess the child's needs and decide if the child is a 'child in need' and ensure appropriate services are provided. *The Framework for the Assessment of Children in Need and their Families* (DoH 2000) provides the systematic approach that social workers, together with colleagues from other agencies, are required to use to assess a child's developmental needs and the parent's capacity to respond to the child's needs within the context of the wider family and environment. This framework can and should be used by doctors involved

with children when that child may be 'in need'. The *Common Assessment Framework* (DoH 2006) is designed to be used to support early intervention and the provision of additional services at an earlier stage. This may lead to a referral to children's social care.

Key Message
Paediatricians should be aware of circumstances that encompass a 'child in need' so that appropiate referrals to children's social care can be made.

Emergency Protection Order
This order lasts for a maximum of eight days (can be extended by up to seven days). The local authority (or any other person) can apply to the court when there is belief that a child is suffering or likely to suffer significant harm unless that child is removed from where he/she is or kept in a particular place (for example, a hospital). Legal advice should normally be obtained before initiating legal action, in particular when an Emergency Protection Order is sought (HM Government, 2006, paragraph 5.50). This order can also be applied for by a local authority if urgent access is unreasonably denied when making enquiries under Section 47 of the Children Act 1989. Whoever is granted the order (usually the local authority) acquires temporary parental responsibility. In an emergency situation, immediate protection for the child can be obtained by police protection (see below). Police powers should only be used in exceptional circumstances where there is insufficient time to seek an Emergency Pprotection Order or for reasons relating to the immediate safety of the child (HM Government 2006, paragraph 5.51)

Police protection
A police constable can remove a child or prevent the removal of a child for 72 hours if the officer believes that the child is suffering or is likely to suffer significant harm if action were not taken. The timescale means that a court order can be sought if thought necessary after further investigation. Police protection can be used, for example, if parents/carers want to remove a child from hospital, and by so doing would put the child's health or safety at significant risk. Such emergency action should be followed quickly by Section 47 enquiries as necessary.

Care and supervision orders
A local authority only has the power to intervene in the care and upbringing of a child against the wishes of a person having parental responsibility, where a court has made a care or supervision order in proceedings under section 31 of the Children Act 1989. Only a local authority or the NSPCC may apply for a care or supervision order. The concept of 'significant harm' is central to any proceedings to protect the child. A court may only consider making a care order or supervision order if satisfied that certain 'threshold criteria' of the Act are met. The grounds that must be satisfied before magistrates sitting in a Family Proceedings Court, or judges sitting in a County or High Court, in considering making a care or supervision order are:

Section 31
(2) A court may only make a care order or supervision order if it is satisfied—
    (a) that the child concerned is suffering, or is likely to suffer, significant harm; and
    (b) that the harm, or likelihood of harm, is attributable to—
        (i) the care given to the child, or likely to be given to him if the order were not

made, not being what it would be reasonable to expect a parent to give to him; or the child's being beyond parental control.

So, not only must the existence or likelihood of significant harm be found, but this must be attributable to the standard of parenting experienced by the child falling below acceptable levels.

Although a care order gives the local authority parental responsibility for the child, it does not remove it from the parents. It becomes a 'shared' responsibility. However, the local authority may have to decide the extent to which the parents exercise it. As a local authority cannot apply for a residence order, it can only acquire parental responsibility in respect of a child by way of a care order or emergency protection order.

A supervision order may be made if a court decides that there is sufficient concern for a child's welfare to be supervised. The order directs a local authority or probation officer to advise, assist and befriend the child, and gives other specific duties in carrying out the order. This order does not give the local authority or the supervisor parental responsibility; this remains with the parents.

Key Message
A care or supervision order can be made only if the evidence establishes that a child is suffering or is likely to suffer significant harm and that the harm is due either to the child not receiving the care that it is reasonable to expect a parent to provide or that the child is beyond the control of the parents.

Both care and supervision orders may be made on an interim or temporary basis while the court prepares for a final hearing of the case. Interim orders may include provision for medical or psychiatric or other examinations or assessments to be carried out. If of sufficient age and understanding, the child may refuse to submit to the examination or assessment but this refusal may be overridden by an order of the High Court.

Domestic violence

The links between domestic violence and child abuse are now well known. Research confirms that in England and Wales, two women a week are killed by their present or former partners (NHS Executive 1997). It is important for paediatricians to be aware that there are legal provisions which may help to secure the safety of women and children. The Children Act 1989 definition of harm now includes a child seeing or hearing ill treatment of another. This amendment specifically relates to children witnessing domestic violence.

Part IV of the Family Law Act l996 sets out provisions for occupation orders, non-molestation orders, powers of arrest, and amends the Children Act l989 to allow the attachment of exclusion orders to interim care orders, and emergency protection orders.

Occupation orders
Briefly, sections 33-41 outline the terms under which decisions can be made about who should remain in the family home and who can be asked to leave. The issues to be considered will vary depending on whether the occupant is entitled to occupy the property and his/her relationship to the other party or parties. Occupation orders are not restricted to spouses or co-habitees but may in certain circumstances extend to relatives and joint tenants. When an application is made, the court will have to decide if the risk of harm to the applicant or child in the home justifies an order being made.

Non-molestation orders
Section 42 empowers the court to grant a non-molestation order where it considers it necessary for the protection of a child.

Powers of arrest
Section 47 (HM Government 1996) contains a Power of Arrest which may be attached to an occupation or non-molestation order, if it appears to the court that this is necessary to protect the applicant or child.

Exclusion orders
Section 52 and Schedule 6 amended the Children Act l989 to enable the court, when making an interim care order or emergency protection order, to attach an order excluding a suspected abuser from the home. Such an exclusion order may also have a Power of Arrest attached to it which will enable the police to arrest any person he/she has reasonable cause to think is in breach of an exclusion order.

Risk to children

The term ‘Schedule One offender’ and ‘Schedule One offence’ has been commonly used for anyone convicted of an offence against a child listed in Schedule One of the Children and Young Person’s Act 1933. However, a conviction for an offence in Schedule One does not trigger a statutory requirement in relation to child protection issues and inclusion on the schedule was determined solely by the age of the victim and offence for which the offender was sentenced and not by an assessment of future risk of harm to children.

Therefore, the term ‘Schedule One offender’ is no longer used. It has been replaced with ‘Risk to Children’. This clearly indicates that the person has been identified as presenting a risk of potential risk of harm to children.

Interim guidance (“Guidance on offences against children” Home Office Circular 16/2005 http://www.knowledgenetwork.gov.uk/ho/circular.nsf/79755433dd36a66980256d4f004d1514/1b6d4af0fe8c4d4780256fcc00414639?OpenDocument) has been issued explaining how those people who present a potential risk or risk of harm to children should be identified. The circular explains that the present method of automatically identifying an offender, who has been convicted of an offence listed in Schedule One of the Children and Young Person’s Act 1933, as a risk to children, fails to focus on those who continue to present a risk. For a copy of the circular please access the Home Office website.

Recent legislation requires those convicted of serious sex offences to register with the police and to notify changes of address.

Key Message
Where a person has been identified as presenting a risk or potential risk of harm to children, agencies should work together to monitor and manage risk.

Human Rights Act l998

Implementation of the Human Rights Act (HM Government 1998) took place on 2 October 2000 and is applicable to all English courts. The Act implements almost all of the European Convention on Human Rights. The government has made clear that the Children Acts 1989 and 2004 respectively, regulations made under them and guidance relating to safeguarding children have been drafted with regard to human rights principles and are therefore compatible.

Article 2 states that everyone's right to life shall be protected by law and article 3, that no-one shall be subjected to torture or inhuman or degrading treatment. Child abuse and neglect may lead to loss of life and is inhuman and degrading. Public authorities are required to carry out their functions in a way that promotes the protection expected to be afforded to children by these articles.

Article 8 provides that everyone has the right to respect for his private and family life. It is important to note that there is no right to privacy or to family life – the right is to respect for these matters. This article requires these issues and the likely impact to be properly considered when carrying out public functions.

Any interference with the respect required under article 8 must be in accordance with the law and necessary in the interests of national security, public safety, the prevention of crime and disorder, the protection of health and morals, the protection of the freedoms of others or economic wellbeing of the country.

The Court of Appeal has considered the impact of article 8 on the exercise of functions concerned with the protection of the vulnerable and has made clear that the purpose of the article is to promote protection and not to inhibit it:

'The family life for which article 8 requires respect is not a proprietary right vested in either parent or child: it is as much an interest of society as of individual family members, and its principle purpose, at least where there are children, must be the safety and welfare of the child.'

Far from being a tool to use as an 'opt out clause' for fear of getting it wrong, human rights legislation may give professionals and agencies even greater leverage to take action to protect children from harm. Having said this, when making assessments of need and risk of harm, professionals should always be mindful of the human rights of everyone involved, including parents, carers and significant family members. The Human Rights Act underpins current good practice in working in partnership with parents and carers, and sharing information and concerns with them (unless this would place a child at risk of harm).

Key Message
Human rights legislation may give professionals and agencies even greater leverage to take action to protect children from harm.

All those involved in making decisions about the welfare and safety of children will need to demonstrate and record that they have considered relevant issues relating to human rights and that decisions made and actions taken are lawful. For example, doctors may share information with relevant authorities, make referrals to children's social care or recommend actions to be taken to protect children in circumstances where children are suffering or likely to suffer significant harm, particularly where the harm is preventable or due to omissions in care.

All health professionals and organisations have a positive obligation to ensure that respect for human rights is at the core of their day-to-day work and that policies, procedures and practice reflect these principles. It is unlawful to act in a way which contravenes the Human Rights Act and if this is breached, individuals and organisations may be liable. Although the Act is dynamic, and legal challenges will lead to changes in the interpretation, the basic rights will remain the same.

The Children Act 2004

This Act (HMSO 2004) requires local authorities and other key partners (the police, strategic health authorities, NHS trusts and primary care trusts) to co-operate with a view to improving the well-being of children in the local authority's area. This effectively means that all those who work in other key agencies must communicate appropriately and effectively. Well-being is defined as:

- Physical and mental health and emotional well-being
- Protection from harm and neglect
- Education, training and recreation
- The contribution made by them to society
- Social and economic well-being.

In order to improve the well-being of children, the local authority must take into account the importance of parents and carers.

It also requires a range of organisations to make arrangements for ensuring that their functions and services provided on their behalf are discharged having regard to the need to safeguard and promote the welfare of children.

A children's commissioner for England has been appointed. His function is to promote awareness of the views and interests of children and in particular to have regard to the United Nations Convention on the Rights of the Child (UNCRC).

Any reference to a child includes, in addition to a person under the age of 18, a person aged 18,19 or 20 who:
- Has been looked after by a local authority at any time after attaining the age of 16; or
- Has a learning disability, and is receiving education or training.

Key Message
The Children Act 2004 clarifies arrangements for all agencies to safeguard children and promote their well-being and it does not replace the 1989 Act.

Taking histories in child protection cases

Care must be taken when taking histories from adults or children about events that have led to the need for medical or nursing intervention. Suggestion and comment should be avoided and recording should carefully set down the source of historical explanations. Later discrepancies can then be identified and the danger of stated facts being interpreted as the practitioner's opinion of what has occurred will be avoided. Local protocols agreed with local authorities and police may give guidance on these issues.

Particular care must be taken when speaking to a child in order to avoid contaminating potential evidence from that child by inappropriate or leading questions, or encouraging explanations by voice or gesture. Courts have been critical of professionals in cases involving possible sexual abuse for failing to read the full Cleveland Report (HMSO 1987) published in 1987 and in particular for failing to heed the guidance set out in Chapter 12 of the Report concerning interviewing children. This is important for paediatricians who assess cases of possible sexual abuse and are required to give evidence in court.

Appearance in court

Medical and nursing personnel may be required to appear to give evidence in public or private law proceedings, when the future welfare of a child is at issue, or in criminal proceedings. The obligation of a professional witness is to assist the court to reach an appropriate decision by ensuring that it has all the relevant information and benefit of relevant expertise.

Appropriately qualified and experienced professionals are regarded as experts and are privileged in that they may, within the scope of their expertise, give evidence of opinion and inferences based on factual material. It is important to consider all material facts, properly research and identify any data not available. Experts must be objective and non-partisan in the presentation of material and opinions. The court must not be misled by omission and if only a provisional view is being expressed, this must be made clear.

Opinions expressed should be within the scope of a competent body of professional opinion, be logical and within the scope of judicial functioning on the issue.

Where appropriate, it is important to be firm when expressing opinions and not to be drawn into making concessions that distort the evidence.

Arrangements may be made for experts with differing opinions to discuss the areas of difference before court appearances in order to reduce or clearly identify the scope of disagreement.

When giving evidence, and during the processes that may precede court proceedings, care must be taken to ensure that medical terms and phrases are correctly understood and interpreted by those to whom they are addressed. In particular members of other professions may need considerable assistance in drawing appropriate inferences from the material.

Reaching sound professional judgements

It is helpful to consider the means by which the soundness of judgements and conclusions are challenged and undermined in proceedings before the courts. To be sound, the approach must be demonstrably reasonable in the sense that it has been properly reasoned.
The following list sets out the issues commonly explored and against which the forming of judgements or making of diagnoses may be measured. If integrated into practice, these principles will raise the quality of judgements and expose them less to successful challenge:

- Demonstrate proper reasoning.
- Take account of all relevant factors
- Give each factor appropriate weight
- Consider all the options or alternatives
- Keep an open mind until it is appropriate to close it
- Know and act in accordance with the law
- Know and apply procedures or know why deviated
- Consider human rights implications
- Consider any relevant guidance
- Consult appropriately
- Acknowledge lack of expertise and its impact
- Acknowledge lack of information and its impact
- If the position is provisional, identify what is required to make final
- Ensure full and accurate recording of these issues.

Summary

The Children Act 1989 provides the fundamental legal framework for safeguarding and promoting the welfare of children. It makes clear the duties of local authorities in exercising their social service functions and the roles of others who have responsibilities with regard to children's welfare. The Children Act 2004 reinforces the necessity for effective communication between relevant organisations, clarifying and elaborating their function in safeguarding and promoting the welfare of children and in improving the well-being of all children. Aspects of other legislation, including the Human Rights Act 1998, and the Family Law Act 1996 are also relevant to the protection of children.

References

Department for Education and Skills. 2006. *The common assessment framework.* London: The Stationery Office

Department for Education and Skills and the Home Office. 1989. *The Children Act 1989.* London: The Stationery Office.

Department for Education and Skills and the Home Office. 2004. *The Children Act 2004.* London: The Stationery Office.

Department of Health. 1991. *The Children Act 1989: Guidance and regulations.* London: HMSO.

Department of Health. 2000. *The framework for the assessment of children in need and their families.* London: The Stationery Office.

FLR 224 Gillick v West Norfolk and Wisbech Health Authority and Another

HM Government. 1996. *The Family Law Act 1996.* London: The Stationery Office.

HM Government. 1998. *The Human Rights Act 1998.* London: The Stationery Office.

HM Government (2002). *The Adoption and Children Act 2002.* London: The Stationery Office.

HMSO. 1987. *Report of the inquiry into child abuse in Cleveland .* London: HMSO.

NHS Executive. 1997. *Criminal statistics 1992 in domestic violence.* London: The Stationery Office

Further reading

Department of Health. 1995. *The challenge of partnership in child protection practice guide*. London: HMSO.

HM Government. 1996. *Reporting to Court under the Children Act.* London: HMSO.

HM Government. 2006. *Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children.* London: The Stationery Office.

Quality Protects Programme: *Transforming Children's Services* LAC 1998/28

White, W, Carr, P, Lowe, N. 1995. *The Children Act in practice.* London, Dublin, Edinburgh: Butterworths.

Full Text of the UN Convention on the Rights of the Child. www.unicef.org/CRC/fulltext.htm

Acknowledgments

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12

Working together to Safeguard Children (2006): Executive Summary of government guidance

This chapter consists of the Executive Summary from Working Together to Safeguard Children (pp9-21); it is reproduced by kind permission of the DfES.

The document *Working Together to Safeguard Children* was published by the Department of Health in 2006 and it set out how organisations and individuals should work together to safeguard and promote the welfare of children.

It is addressed to practitioners, which includes doctors working at all grades, and frontline managers who have particular responsibilities for safeguarding and promoting the welfare of children, as well as senior and operational managers, in:

- Organisations that are responsible for commissioning or providing services to children, young people, and adults who are parents/carers
- Organisations that have a particular responsibility for safeguarding and promoting the welfare of children.

Part one of the document comprises chapters 1 to 8, which are issued as statutory guidance. Practitioners and agencies will have different responsibilities that apply to different areas of the guidance and should look in the preface for a fuller explanation of their statutory duties. Part two of the document incorporates chapters 9 to 12 and is issued as non-statutory practice guidance.

This chapter provides a summary of the document, which is not guidance in itself, but should help readers gain an overview of the area. The statutory framework for the document is included in an appendix at the end of this chapter.

Part one – statutory guidance

Chapter 1 – Introduction: Working together to safeguard and promote the welfare of children and families
Chapter 1 sets the context for the revised guidance by discussing the reasons for the changes in safeguarding policy and practice since 1999. It also outlines the key definitions and concepts used in the guidance.

The statutory inquiry into the death of Victoria Climbié (2003), and the first joint Chief Inspectors' report on safeguarding children (2002) highlighted the lack of priority status given to safeguarding. The Government response to these findings included the Green Paper *Every Child Matters*, and the provisions, in the Children Act 2004. Three of the most important provisions in this context are: the creation of children's trusts under the duty to co-operate, the setting up of Local Safeguarding Children Boards (LSCBs) and the duty on all agencies to make arrangements to safeguard and promote the welfare of children.

A shared responsibility and the need for effective joint working between agencies and professionals that have different roles and expertise are required if children are to be protected from harm and their welfare promoted. In order to achieve this joint working, there have to be constructive relationships between individual practitioners, promoted and supported by the commitment of senior managers to safeguard and promote the welfare of children, and clear lines of accountability.

Chapter 2 – Roles and responsibilities
Chapter 2 explains the roles, responsibilities and duties of the different people and organisations that both work directly with and whose work affects, children and young people. It states that all organisations that provide services or work with children and young people should:

- Have senior managers that are committed to children's and young people's well-being and safety
- Be clear about people's responsibilities to safeguard and promote children's and young people's welfare
- Have effective recruitment and human resources procedures including checking all new staff and volunteers to make sure they are safe to work with children and young people
- Have procedures for dealing with allegations of abuse against members of staff and volunteers
- Make sure staff get training that helps them do their job well
- Have procedures about how to safeguard and promote the welfare of young people
- Have agreements about working with other organisations.

Section 11 of the Children Act 2004 and section 175 of the Education Act 2002 place duties on organisations and individuals to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. An overview of these duties and the structure of children's services under the Children Act 2004 are set out in the preface to this guidance and Appendix 1.

Safeguarding and promoting the welfare of children is the responsibility of the local authority, working in partnership with other public organisations, the voluntary sector and children and young people, parents and carers, and the wider community. A key objective for local authorities is to ensure children are protected from harm. Other functions in local authorities that play an important role in safeguarding are: housing; sport, culture and leisure services; and youth services.

Health professionals and organisations have a key role to play in safeguarding and promoting the welfare of children and the general principles they should apply are:

- Aim to ensure all affected children receive appropriate and timely therapeutic and preventative interventions
- Those professionals who work directly with children should ensure that safeguarding and promoting their welfare forms an integral part of all stages of care they offer
- Those professionals who come into contact with children, parents and carers in the course of their work also need to be aware of their safeguarding responsibilities
- Ensure that all health professionals can recognise risk factors and contribute to reviews, enquiries and child protection plans. As well as planning support for children and providing ongoing promotional and preventative support through proactive work.

Standard 5 of the National Service Framework for Children, Young People and Maternity Services sets the standards for health and social care agencies' work to prevent children suffering harm and to promote their welfare.

The police recognise the fundamental importance of inter-agency working in combating child abuse, as illustrated by well-established arrangements for joint training involving police and social work colleagues. All forces have child abuse investigation units (CAIU) and whilst they will normally take responsibility for investigating such cases, safeguarding children is a fundamental part of the duties of all police officers. The police are committed to sharing information and intelligence with other organisations and should be notified as soon as possible where a criminal offence has been, or is suspected of, being committed.

LSCBs should have in place a protocol agreed between the local authority and the police, to guide both organisations in deciding how child protection enquiries should be conducted, and circumstances in which joint enquiries are appropriate.

Probation services supervise offenders with the aim of reducing re-offending and protecting the public. By working with offenders who are parents/carers, offender managers can safeguard and promote the welfare of children. Probation services will also supervise 16- and 17-year-olds on community punishment, second staff to youth offending teams, and provide a service to child victims of serious sexual or violent offences. Offender managers should also ensure there is clarity and communication between risk management processes, which are described in greater detail in chapter 12.

Governors or directors of all prison establishments must have in place arrangements that protect the public from prisoners in their care. All prisoners who have been identified as presenting a risk to children will not be allowed contact with them unless a favourable risk assessment has been undertaken by the police, probation, prison and social care services.

Governors or directors of women's establishments with mother and baby units need to ensure that staff working on duty are prioritised for child protection training. Governors or directors of juvenile young offenders institutions are required to have regard to the policies, agreed by the Prison Service and the Youth Justice Board, for safeguarding and promoting the welfare of children held in custody.

Secure training centres house vulnerable, sentenced and remanded juveniles aged between 12 and 17. Each STC has a duty to safeguard and promote the welfare of the children in its custody.

Youth offending teams (YOTs) are responsible for the supervision of children and young people subject to pre-court interventions and statutory court disposals. YOTs have a duty to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children.

Schools (including independent and non-maintained schools) and further education institutions should give effect to their duty to safeguard and promote the welfare of pupils under the Education Act 2002. They should create and maintain a safe learning environment for children and young people, and identify where there are child welfare concerns and take action to address them, in partnership with other organisations where appropriate.

Childminders and everyone working in day care services should know how to recognise and respond to the possible abuse and neglect of a child. All organisations providing day care must have a designated person who liaises with local child protection agencies and Ofsted on child protection issues.

In care and related proceedings under the Children Act 1989, the Children and Family Court Advisory and Support Service's (CAFCASS) responsibility is to safeguard and promote the interests of individual children who are the subject of family proceedings by providing independent social work advice to the court.

Looking after under 18s in the Armed Forces comes under the Ministry of Defence MoD's comprehensive welfare arrangements which apply to all members of the Armed Forces. There is already a responsibility placed upon social care services to monitor the well-being of care leavers and those joining the Armed Forces have unrestricted access to local authority social services workers.

The voluntary sector is active in working to safeguard the children and young people with whom they work and provide a key role in providing information and resources to the wider public about the needs of children.

Faith communities provide a wide range of activities for children and as such should have appropriate arrangements in place to safeguard and promote their welfare.

Chapter 3 – Local Safeguarding Children Boards
Chapter 3 explains the role, functions, governance and operation of Local Safeguarding Children Boards.

The LSCB is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children, and for ensuring the effectiveness of what they do.

The scope of the LSCB role falls into three categories: firstly, the boards will engage in activities that safeguard all children and aim to identify and prevent maltreatment, or impairment of health or development, and ensure that children are growing up in circumstances consistent with safe and effective care; secondly, they will lead and co-ordinate proactive work that aims to target particular groups; and thirdly, they will lead and co-ordinate arrangements for responsive work to protect children who are suffering, or at risk of suffering, maltreatment.

The core functions of an LSCB are set out in regulations and are:

- Policies and procedures on:
  - Action to be taken where there are concerns, including thresholds for intervention
  - Training of persons who work with children or in services affecting the safety and welfare of children
  - Recruitment and supervision of people who work with children
  - Investigation of allegations concerning persons working with children
  - Safety and welfare of children who are privately fostered
  - Co-operation with neighbouring children's services authorities that is, local authorities) and their board partners
- Communicating and raising awareness
- Monitoring and evaluation
- Participating in planning and commissioning
- Reviewing the deaths of children
- serious case reviews.

County level and unitary local authorities are responsible for establishing an LSCB in their area and ensuring that it is run effectively. LSCBs should have a clear and distinct identity within local children's trust governance arrangements. It is the responsibility of the local authority to appoint the chair.

Membership of the local safeguarding children board will be made up of senior mangers from different services and agencies in a local area including the independent and voluntary sector. In addition, the board will receive input from experts, for example the designated nurse or doctor.

To function effectively, LSCBs need to be supported by their member organisations with adequate and reliable resources. The budget for each LSCB and the contribution made by each member organisation should be agreed locally.

LSCB work should be effectively planned and will ordinarily be part of the Children and Young People's Plan.

The LSCBs' work to ensure the effectiveness of work by member organisations will be a peer review process based on self-evaluation, performance indicators and joint audit.

Chapter 4 – Inter-agency training and development
Chapter 4 is about training and development. Training for multi and inter-agency working means training which will equip people to work effectively with those from other agencies. Employers are responsible for ensuring their employees are confident and competent in carrying out their responsibilities and for ensuring employees are aware of how to recognise and respond to safeguarding concerns. They should also identify adequate resources and support for inter-agency training.

Local authorities and their partners are responsible for ensuring that workforce strategies are developed in the local area, including making sure that the training opportunities to meet the needs of the workforce are identified and met by LSCBs. The LSCB should work within the workforce strategy to manage the identification of training needs, use the information to inform the planning and commissioning of training, and check and evaluate single- and inter-agency training.

All training in safeguarding and promoting the welfare of children should create an ethos which values working collaboratively, respects diversity, promotes equality, is child centred and promotes the participation of children and families in the processes. It should also work within *The Common Core of Skills and Knowledge* (2005) for the Children's Workforce which sets out the six areas of expertise that everyone working with children, young people and families should be able to demonstrate.

Training and development for inter-agency work at the appropriate level should be targeted at practitioners in voluntary, statutory and independent agencies who:

- Are in regular contact with children and young people
- Work regularly with children and young people, and with adults who are parents or carers, and who may be asked to contribute to assessments of children in need
- Have particular responsibility for safeguarding children.

Training and development is also relevant to operational managers and those with strategic responsibility for services.

Chapter 5 – Managing individual cases
Chapter 5 provides guidance on what should happen if somebody has concerns about the welfare of a child (including those living away from home), and in particular, concerns that a child may be suffering, or may be at risk of suffering, significant harm. It also sets out the principles which underpin work to safeguard and promote the welfare of children.

The chapter is structured according to the four key processes that underpin work with children and families: assessment, planning, intervention and reviewing as set out in the Integrated Children's System (2002). *The Framework for The Assessment of Children in Need and their*

Families (2000) should be followed when undertaking assessments on children in need and their families.

The chapter sets out in detail the processes to be followed when safeguarding and promoting the welfare of children. These include:

- Responding to concerns about the welfare of a child and making a referral to a statutory organisation (children's social care, the police or the NSPCC) that can take action to safeguard and promote the welfare of children
- Undertaking an initial assessment of the child's situation and deciding what to do next
- Taking urgent action to protect the child from harm, if necessary
- Holding a strategy discussion where there are concerns that a child may be suffering significant harm, and where appropriate convening a child protection conference
- Deciding whether a child is at continuing risk of significant harm and therefore should be the subject of a child protection plan, implementing the plan and reviewing it at regular intervals.

Effective supervision is important in promoting good standards of practice and supervisors should be available to practitioners as an important source of advice and expertise.

Chapter 6 – Supplementary guidance on safeguarding and promoting the welfare of children
Chapter 6 summarises the supplementary guidance to *Working Together to Safeguard Children.* The following guidance is available:

- Department of Health, Home Office. *Safeguarding children involved in prostitution* (2000)
- Department of Health, Home Office, Department for Education and Skills, Welsh Assembly Government. *Safeguarding children in whom illness is fabricated or induced* (2002)
- Home Office, Department of Health. *Complex child abuse investigations: Inter-agency issues* (2002)
- Home Office *Female Circumcision Act* (1985). *Female Genital Mutilation Act* (2003). Home Office Circular 10/2004
- Association of Directors of social services, Department of Education and Skills, Department of Heath, Home Office, Foreign And Commonwealth Office. *Young people and vulnerable adults facing forced marriage* (2004). Practice guidance for social workers
- Guidance on allegations of abuse made against a person who works with children, which can be found in Appendix 4 of the document.

Chapter 7 – Child death review processes
Chapter 7 sets out the procedures to be followed when a child dies in the LSCB area(s) covered by a child death overview panel. There are two inter-related processes for reviewing child deaths:

- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child
- An overview of all child deaths in the area, undertaken by a panel.

Either of these processes can identify cases requiring a serious case review (covered in Chapter 8 of the document).

As stated in chapter 3 of the document, the LSCB regulations mean that the functions to which chapter 7 relates will come into force on 1 April 2008, but can be carried out by any LSCB from 1 April 2006. When an LSCB commences this function before that date, it should follow the guidance in this chapter.

Chapter 8 – Serious case reviews
Chapter 8 sets out the procedures LSCBs should follow when undertaking a serious case review.

When a child dies, and abuse or neglect are known or suspected to be a factor in the death, the LSCB should always conduct a serious case review into the involvement of organisations and professionals with the child and family to consider whether there are any lessons to be learned about the ways in which they work together to safeguard and promote the welfare of children. Additionally, LSCBs should always consider whether a serious case review should be conducted in other circumstances where a child has been harmed. These circumstances are set out in the guidance.

Following the serious case review an action plan should be drawn up and implemented. Reviews are of little value unless lessons are learned from them. At least as much effort should be spent on acting upon recommendations as conducting the review.

Part two – Non-statutory practice guidance

Chapter 9 – Lessons from research and inspection
Chapter 9 summarises the impact of maltreatment on children's health and developmental progress, and goes on to set out some of the key messages from research and inspection which have informed this guidance.

The sustained maltreatment of children physically, emotionally, sexually or through neglect can have major long-term effects on all aspects of a child's health, development and well-being.

Professionals must take special care to help safeguard and promote the welfare of children and young people who may be living in particularly stressful circumstances. Some of these are:

- Families living in poverty
- Families where there is domestic violence
- Families where a parent has a mental illness
- Families where a parent is misusing drugs or alcohol
- Families where a parent has a learning disability
- Families that face racism and other forms of social isolation
- Families living in areas where there is with high crime, poor housing and a lot of unemployment.

Chapter 10 – Implementing the principles on working with children and their families
Chapter 10 sets out in more detail specific aspects of working with children, young people and families.

Family group conferences (FGCs) may be appropriate in a number of contexts where there is a plan or decision to be made. The family is the primary planning group in the process. Where there are plans to use FGCs in situations where there are concerns about possible harm to a child, they should be developed and implemented under the LSCB. FGCs should not replace or remove the need for child protection conferences.

Children and families may be supported through their involvement in safeguarding processes by advice and advocacy services, and they should always be informed of services which exist locally and nationally.

Local authorities have a responsibility to help children and adults understand the processes that will be followed when there are concerns about the child. Information should be available in the family's preferred language.

Children from all cultures are subject to abuse and neglect and whilst professionals should be sensitive to differing family patterns and lifestyles they must be clear that child abuse cannot be condoned for religious or cultural reasons.

Chapter 11 – Safeguarding and promoting the welfare of children who may be particularly vulnerable
Chapter 11 outlines the circumstances of children who may be particularly vulnerable. The purpose of this chapter is to help inform rather than substitute the procedures in chapter 5, which sets out the basic framework within which action should be taken when a parent, professional, or any other person has concerns about the welfare of a child. It gives advice to organisations and individuals on safeguarding in the context of:

- Children living away from home
- The abuse of disabled children
- Abuse by children and young people
- Bullying
- Children whose behaviour indicates a lack of parental control
- Race and racism
- Domestic violence
- Children of drug misusing parents
- Child abuse linked to believe in 'possession' or 'witchcraft', or in other ways related to spiritual or religious belief
- Child abuse and information communication technology (ICT)
- Children and families who go missing
- Children of families living in temporary accommodation
- Migrant children
- Child victims of trafficking
- Unaccompanied asylum seeking children (UASC).

Chapter 12 – Managing individuals who pose a risk of harm to children

The chapter provides practice guidance and information about a range of mechanisms that are available when managing people who have been identified as presenting a risk or potential risk of harm to children.

The Children Act 1989 recognised that the identification and investigation of child abuse together with the protection and support of victims and their families requires multi-agency collaboration. As part of that protection, action has been taken, usually by the police and social services, to prosecute known offenders or control their access to vulnerable children. The Sexual Offences Act 2003 introduced a number of new offences to deal with those who abuse and exploit children in this way. Both Acts can be found at: www.opsi.gov.uk.

The term 'schedule one offender' should no longer be used for anyone convicted of a crime against a child. The focus should be on whether the individual poses a 'risk of harm to children'. Interim guidance has been issued explaining how these people who present a potential risk of harm to children should be identified. This can be found at: http://www.knowledgenetwork.gov.uk. Practitioners should use the new list of offences as a 'trigger' to further assessments.

Where the offender is given a community sentence, offender managers will monitor their risk to others and liaise with partner agencies. Prison establishments will undertake a similar responsibility where the offender has been sentenced to a period of custody.

The Multi Agency Public Protection Arrangements (MAPPA) provide a national framework for the assessment and management of risks posed by serious and violent offenders. The responsible authorities need to ensure that strategies to address risk are identified and plans developed, implemented and reviewed on a regular basis. The MAPPA framework identifies three separate, but connected, levels at which risk is managed: ordinary risk management, local inter-agency risk management, and MAPPP – multi agency public protection panels.

There are other processes and mechanisms for working with and monitoring people who may present a risk to children. For example, the Protection of Children Act (1999) gives the secretary of state the power to keep a list of people who are unsuitable to work with children in childcare positions. DfES List 99 is a confidential list of people who the secretary of state has directed may not be employed by local authorities, schools and further education institutions as a teacher or in work involving regular contact with children under 18 years of age.[1]

People placed on the sex offender list are served with a notification that ensures the police are informed of their whereabouts in the community.

1 The Safeguarding Vulnerable Groups Bill, the legislation necessary to implement the Government's response to Recommendation 19 of the Bichard Inquiry, to set up a vetting and barring scheme, was introduced to Parliament on 28 February 2006. www.parliament.gov.uk

References

Department of Health. 2005.*The common core of skills and knowledge.* London: HMSO. www.everychildmatters.gov.uk /deliveringservices/commoncore/)

Department of Health. 2006. *Working together to safeguard children.* London: HMSO. http://www.everychildmatters.gov.uk/resources-and-practice/IG00060/

APPENDIX
Statutory framework

Following is the text of Appendix 1, Statutory Framework, from Working Together to Safeguard Children, pp222-228.

1. All organisations that work with children and families share a commitment to safeguard and promote their welfare, and for many agencies that is underpinned by a statutory duty or duties.

2. This appendix briefly explains the legislation most relevant to work to safeguard and promote the welfare of children.

Children Act 2004

3. Section 10 required each local authority to make arrangements to promote co-operation between the authority, each of the authority's relevant partners and such other persons or bodies, working with children in the local authority's areas, as the authority consider appropriate. The arrangements are to be made with a view to improving the well-being of children in the authority's area – which includes protection from harm or neglect alongside other outcomes. This section of the Children Act 2004 is the legislative basis for children's trusts arrangements.

4.Section 11 requires a range of organisations to make arrangements for ensuring that their functions, and services provided on their behalf, are discharged having regard to the need to safeguard and promote the welfare of children.

5. Section 12 enables the Secretary of State to require local authorities to establish and operate databases relating to the section 10 or 11 duties (above) or the section 175 duty (below), or to establish and operate databases nationally. The section limits the information that may be included in those databases and sets out which organisations can be requited to, and which can be enabled to, disclose information to be included in the databases.

Education Act 2002

7. Section 175 puts a duty on local education authorities, maintained (state) schools, and further education institutions, including sixth form colleges, to exercise their functions with a view to safeguarding and promoting the welfare of children – children who are pupils, and students under 18 years of age, in the case of schools and colleges.

8. And the same duty is put on independent schools, including academies, by regulation made under s157 of that Act.