Risk assessment and decision making child protection, safeguarding

Business, Management

Introduction

Whether a nurse, doctor, alliedhealthprofessional, manager or clerical worker, the contribution of health service workers to the protection of children is crucial. The well-being of children and in some cases child's life depends not only on professional vigilance and a willingness to consider the possibility of abuse but also on action taken in response to it. It depends on talking to the child, listening to what they say; sometimes believing things people think do not, could not or should not happen to children.

Ensuring the safety and promoting thewelfare of childrenwho are at risk of harm is not an easy undertaking. It is sometimes difficult to assess the significance of the information about a child, to gauge its seriousness and decide what to do next. It is easy to lose a sense of perspective and the focus on the child in an attempt to also take into account the needs of the parent, familyand professional network. It is not necessary to be an expert in pediatrics orchild abuseto have concerns about a child but following child projection guidance once abuse is suspected is a requirements for everyone, managers and clinicians alike. The protection of children is aresponsibilitythat crosses all services and hierarchies. It places equal value on each person's contribution to the process of protecting children, and its guidance is designed to inform everyone working in health service as well as workers in other agencies. (Judy Barker and Deborah hodes 2007).

Child abuse and neglect occur across all socioeconomic, religions and ethnic groups. No one single source can be identified (Finkelhor & Korbin 1988.)

However, because many occurrences of child abuse and neglect go unreported or undetected, official figures do not necessarily state the true incidence. They tend to reflect on what State government agencies are doing. (James, M. 1994).

There is a lack of consistency in how ‘ neglect’ is defined. Several definitions of neglect have been proposed. Most commonly they emphasise that a child’s basic developmental needs have not been met by acts of omission by those responsible for that child. In contrast, abuse is associated with acts of commission resulting in harm to the child. Usually neglect is categorised into physical, emotional, supervisory, medical and educational neglect with several sub-categories for each type. Greater specificity of definition is hampered by debates about what constitutes basic developmental needs and the level of care considered adequate to meet these needs. Definitions are further qualified by debates about actual harm, potential harm, impaired development, social conditions, cultural beliefs, levels of chronicity and severity and the intent of caregivers. Neglect is the most common form, and also the fastest growing category, of maltreatment in Canada, United States and the United Kingdom. In Australia overall rates of neglect appear lower. However, definitional differences make international and interstate comparisons in Australia, difficult. (Dr Johanna Watson 2005).

Recently there has been an increase in public awareness of the intricacy of all of the issues connected with child abuse and neglect, as well as a realisation of the complexity of the responses required. Much of this is due to

increased television, radio and newspaper coverage of the topic as well as specific mass media campaigns.

The professional community, however, continues to recognise that child emotional abuse and child neglect can be just as damaging as child physical abuse and child sexual abuse. There is, therefore, a concern to understand both how best to respond to the issue and what can be done to prevent all types of child abuse and neglect from ever occurring in the first place. The long-term nature of the problem and the difficulties in finding solutions has led to the search for more refined responses which involve a range of activities and support programs (Calvert et al. 1992). This needs to involve an interdisciplinary perspective and extend across the community in order to protect abused children and bring about change in their families (Untalan and Mills 1992).

Decision-making takes place all the time; it toggles between small and large, slight and most important, compound and simple, tense and easy, multi-agency or single practitioner (Mantell, 2009) .

DEFINING THE PROBLEM

In United Kingdom there is many legal and variations in the definition of child abuse, so this is make it difficult to provide consistent national data on incidence. Indeed, variations may occur depending on the context in which they are used. For instance, UK government departments may use different definitions from those used bycommunity serviceprofessionals. However, all of the definitions refer to the physical or psychological damage caused to the

child by the abusive behavior of others, or thefailureof others to protect a child from such damage. Most commonly, the categories of abuse cover physical, emotional and sexual abuse, as well as neglect.

The debate surrounding child abuse has now moved away from disbelief that it occurs, to legal andacademicdiscussion as to what parameters it includes (Boss 1987). Many of these arguments centre on disciplinary and other childrearing practices which can sometimes be abusive. For instance, the physical abuse of children can be seen in the context of the prevailing values in our society, where there is a degree of acceptance ofviolenceas a legitimate means of attaining ends. This element of violence is represented in child-rearing practices where physical force is condoned and in some cases encouraged as a disciplinary measure (Miller 1988, Edgar 1991).

Child abuse is, however, more generally characterized by the deliberate infliction of physical, emotional or sexual harm on the child. Child neglect can also incorporate a situation in which there is a failure to provide conditions which are essential for the health, physical and emotional development of the child.

Corby (2000) argues thatchild protectionwork consists of two important assessment points. Firstly, apprehension of an abuse and to make a short term decision for quick safety of child. Secondly, to take an action when decision is made to make sure for the protection and welfare of the child (Corby, 2000).

Corby (2000) summaries that research on short-term assessment and decision making in child protection work points out to a different way being adopted depending on whether the subject inquiry is a case of physical or sexual abuse. Firstly, assessment focuses on the parents and secondly, on children.

In the case of physical abuse and neglect, there is a little evidence of use of research findings in carrying out assessments, and some evidence to suggest that this is vindicated (Corby, 2000).

I did a literature review done by Lord Laming, The purpose of this review is to identify any evidence of changes and improvements in safeguarding practice since the Laming review. It distils current learning about the challenges and identifies factors which are supporting improvements in safeguarding work. In March 2009, Lord Laming published the findings of a review investigating the progress being made across the UK to implement effective arrangements forsafeguarding children. The review, which was commissioned by the (then) Secretary of State for children, Schools and Families in response to the case of Baby Peter Connelly being made public in November 2008 set out to evaluate progress since Laming's first report, published in 2003 in response to the death of Victoria Climbie. The review stated the need for ' a step change in the arrangements to protect children from harm',(DCSF, 2009).

In June 2010, Professor Munro was commissioned by the newCoalitionGovernment to conduct an independent review of child

protection in England. In the review’s first report, published in October 2010, Munro sets out the review’s intended approach and the features of the child protection system that need exploring in detail (Munro, 2010). Following initial feedback from a wide range of stakeholders, Munro suggested that ‘ good practice thrives’, in many parts of the country despite the numerous system-level challenges that are yet to be resolved.

This literature review builds on learning from initial scoping study carried out by the NFER for the local government Association earlier in 2010, which set out relevant literature on safeguarding practice published since the laming review in 2009 (Atkinson, 2010).

Training and professional development of social workers, Ofsted’s first annual survey of social work practitioners across local authorities in England suggested that the training and professional development of social workers has progressed considerably since the Laming review (Ofsted, 2010a). The survey found that, in general, social work practitioners are positive about their training experiences in relation to safeguarding. The majority of respondents also reported that such training helps them to understand and meet the needs of children and young people.

The first line managers always supporting the social workers to assess and manage any risk in their works by attending the required training and by providing them with a full support. A majority also report that they are able to express concerns to their line manager and in just half of the cases; these concerns are dealt with satisfactory (Ofsted, 2010a).

The challenges associated with training and professional development in relation to safeguarding include the need to encourage critical reflection. Social workers can then increase their capacity to make effective decisions by critiquing their own judgment when considering cases (Burton, 2009). In addition, Barlow and Scott (2010) reported that specific safeguarding training is required to support professionals working in multi-disciplinary teams.

Methods used to develop relationships and understanding, a recent report by the Children Commissioner (2010) highlighted social care professionals' qualities and skills conducive to buildingrelationships with childrenand families.

Interagencycommunicationand information sharing, The findings of Holmes et al. (2010) suggested that agencies are continuing to develop and improve their information sharing. However, the same study also suggested this can be improved further. Ofsted's(2010a) survey of social work practitioners found that fewer than half of respondents agree that communication and information sharing is effective both within their local authority and with other organizations contributing to safeguarding children. Within the health sector, the Care Quality Commission (2009) found that just over a third of applicable acute trusts do not have a policy in place for joint working between maternity services and social services.

There were instances where health practitioners had noted the sign and symptoms of potential abuse, but had not communicated there to other

professionals. The use of Common Assessment Framework (CAF), provides all professionals with a consistent method of performing an assessment of a child’s needs and to decide how those requirements can be performed and very useful in places like primary health care schools and children centers to recognize and deal with problems before these problems become serious(Barker and Hodes, 2007). Developing of safeguarding practice, here its examples to develop safeguarding as identified in the literature:

Training and professional development.

(Munro, 2010) highlighted the importance of social workers training and professional development in supporting system change related to child protection. The report also emphasized the commitment of the Government to continuing the reform of the social work profession.

Capacity and recruitment.

The first report of the Munro review echoed this literature review in suggesting that the challenges posed to the social work profession in relation to the recruitment and retention of staff ongoing particularly in the face of intense media and public security. Munro argued that such challenges make it difficult for social workers to provide the flexible and sensitive responses that match the wide variety of needs and circumstances that are presented, (Munro 2010).

Relationships and understanding.

Munro indicated that the review team will work closely with those involved in the family justice review, commissioned by the Ministry of Justice, to improve the experiences of children and young people involved in care proceedings. (Munro2010).

Interagency working. it is evident that the challenges of working across organizational boundaries continue to pose barriers in practice, and that cooperative efforts are often the first to suffer when services and individuals under pressure. (Laming 2009).

Quality assurance and monitoring.

The Laming review identified local authorities performance management as a central ofleadershipandaccountability. Munro highlighted the importance of ensuring quality assurance and monitoring systems (including performance management and inspection processes) are designed to support children's social care teams' core aim to deliver high-quality services for children. Therefore, the review aims to consider how to create a system characterized by good local management information, with focused and meaningful national data, combined with regular feedback from children, young people, families, staff and partners. (Munro 2010).

Serious case reviews.

(SCRs). The purpose of an SCR is to establish whether there are lessons to be learned from a specific child protection case for professionals and organisations that have worked together to safeguard and promote the

welfare of children. SCRs are, therefore, critically important to the ongoing protection of children. Laming identified SCRs as ‘ an important tool for learning lessons from the death of, or a serious incident involving, a child’ (Laming 2009). Munro suggested that there is considerable progress yet to be made in supporting SCRs to reflect learningculturebased upon an understanding of why circumstances have arisen and a keenness to ensure that this learning is carried forward into other child protection activities. (Munro 2010).

Referral and assessment.

Munro highlighted examples of local innovation in response to this. For example, there are systems enabling experienced social workers to discuss potential referrals with referrers before a referral is made to ascertain whether it is necessary and appropriate; there are also systems enabling social workers to form multi-agency teams with potential referring agencies in order to improve the flow of communication. The review will therefore be working with local authorities to explore the effectiveness of such innovative strategies. (Munro 2010)

After reviewing the literature review I noticed that there is a good amount of evidence of change regarding the improvements in safeguarding practice, since Laming did a review in march 2009, also there evidence to suggest that work to develop the safeguarding of children is being used among many practice.

UK Government is fully committed to ensuring that children and young people should have the opportunity to make their views known in decision-making concerning their future but without placing unduestressand unnecessary burdens on them if the complexity of the case does not warrant it. There is now much greater awareness of the need for and importance of criminal record bureau CRB checking. Checking for new recruits is well-established in children's services and robust arrangements exist for checking contract staff in nearly all local authority areas. However, weaknesses in recruitment practices remain in some services, for example in the timeliness of checks on people who apply for approval as adopters resulting in delays in decision- making by adoption panels.(safeguarding children 2008).

I am interested in comparing and contrasting the Maria Colwell and Victoria Climbie inquiries. There are many cases about children who suffering at the hands of their parents, and often ending the tragedy of their lives lead to change in policy, for example Maria Colwell she was killed by her step father in 1973, she was 8 years old when she died, she returned to the care of her mother after she lived 5 years with a foster family who were relatives of her natural father in fact the Colwell report noted clearly that " there is a failure of the system compounded of several factors of which the greatest and most obvious must be that of the lack of, or ineffectiveness of, communication and liaison. (Jones et al , 1987).

While both wereliving at homewith their primary carers (more of this later) and had been in frequent contact with a range of professionals in different agencies for a period of time, no professional was able to intervene

appropriately. More particularly, both inquiry reports identified numerous opportunities when professionals had failed to intervene; these individual failures, it is argued, need to be understood in their wider context. Both reports argue that these failures were not simply a consequence of individual incompetence but were a reflection of fundamental inadequacies in their respective systems. What has clearly emerged, at least to us, is a failure of the system compounded of several factors of which the greatest and most obvious must be that of the lack of, or ineffectiveness of, communication and liaison. A system should so far as possible be able to absorb individual errors and yet function adequately. (Parton, 2004: P. 84).

Acording to the House of Commons 2003 that In England around 80 children die every year from abuse or neglect, for instance, the recent case was the death of Victoria Climbie on 25 February 2000, her death was caused by multiple injuries arising from months of ill-treatment and abuse by her aunt, who take Victoria from her parents in France to UK after she promised them that Victoria would have greater educational in Europe, but Victoria had suffered months of physical abuse and neglect at the hand of her aunt and the aunt’s boyfriend.(Doyle, 2006)

In fact, the suffering and death of Victoria was a result for the system failure, in 2001 after one year of Victoria death the Lord Laming was appointed to chair an independent statutory inquiry into the circumstances leading to and surrounding the death of Victoria Climbie(House of Commons, 2003) the Liming report identified the need for clear accountability about who is

responsible at every level for the welfare of children(Doyle, 2006) and this is the same point that identified 20 years ago in the Colwell enquiry.

In addition, according to the Lord Laming (cited in The Victoria Climbie Inquiry Report, 2003: P9) that" this tragedy of Victoria Climbie been because one doctor, one social worker, one police officer, had failed to see one telling sign indicating deliberate harm" furthermore the report pointed out that the failure in dealing with Victoria case due to many factors such as the failure of communication between different staff and agencies, and Inexperience and lack of skill of individual social workers. Moreover the failure to follow established procedures, and inadequate resources to meet demands. (Lord Laming 2003).

Both inquiries were established by the relevant Secretary of State. However, this is perhaps the first important area of difference, for whereas the Maria Colwell inquiry was set up by the Secretary of State for Social Services, the Victoria Climbie inquiry was set up by the Secretary of State for Health together with the Secretary of State at the Home Office. In effect, the latter was to conduct three parallel statutory inquiries in relation to local authority social services, health services as well as the police. (Parton, 2004: P. 84).

The Victoria Climbie inquiry provides a coherent, convincing and powerful account of what happened to Victoria, how she was failed and how this can be avoided in the future. While the account in the Maria Colwell inquiry is of a similar nature, it is also much more equivocal. This is in part because the inquiry report has within it the minority report written by one of the inquiry

team, Olive Stevenson. It is not that the report has a major dispute over the facts, but it is in their interpretation, particularly in relation to some of the early decisions leading up to why Maria was returned home, from her foster carers, that there is something of a difference of opinion. In her minority report, included as chapter five in the Maria Colwell report, Olive Stevenson writes as follows:“ As a social worker, myeducationand experience has taught me that in such matters, there is no one truth; in considering the subtleties of human emotions everyone is subjective. One’s feelings, attitudes and experience color one’s perception. This is as true for me as it is for my colleagues. And when one is dealing with events now some time in the past, drawing to a large extent on records for evidence, and inevitably affected by the eventual tragedy, the probability of distortion in interpretation is all the greater. Those who have worked in child care social work have learnt of the impossibility of predicting the future”. (Parton, 2004: P. 84).

In Maria Corwell inquiry a major issues was concerned with trying to judge how significant the issue of ‘ blood tie’ was in relation to the decision making, and how this was appropriately addressed. Such issues now seem remarkably old fashioned. There is now considerable variation and complexity in household and family structure and relationships, such that the model of the traditionalnuclear familyno longer seems to represent the majority of the population.

As a consequence we now usually refer the ‘ family’ as opposed to the family. (Parton, 2004: P. 84).

The other major area for social change over the intervening thirty years is probably concerned with globalisation. Issues related to and arising from this are core to the Victoria Climbie in a way which is hardly evident with Maria Colwell. While both reports discuss the importance of cultural differences between the workers and the adults and children with whom they work, the way this is discussed is very different. For example, in Olive Stevenson's minority report she discusses, the cultural differences that were possible in the way Mr Keppel, Maria's stepfather, made sense of and responded to Maria's behaviour compared to the way the professionals might have analysed this (Parton, 2004: P. 84).

The decisions were shown to be bounded by the ' objective' principles of the Children Act 1989 and Working Together (1991). However themes that emerged from the analysis of the cases suggest that there is a ' subjective' influence on decision processes. Evident within the analysis was a shared fundamental belief in keeping children with their mothers. Both these objective and subjective influences suggest that almost inevitably decision making in child protection practice will be driven in directions that result in courses of action that involve potential and actual risks for children. The findings emphasise how an explicit recognition of the multifaceted nature of decision making can assist in more reflective practice. The ways in which national and local policy impacts upon decision processes, at the level of the individual and groups need to be monitored in order that the needs of children in situations that involve risk remain paramount Kelly (2000).

From the two cases I mentioned violence against children is a complex issue, so it seems the system of protection and decision-making in cases of child abuse is difficult and sometimes ambiguous , but over the case difficult is that the decision to take protection to protect children from people who are supposed to be responsible for the protection and welfare (parents), here are a difficult equation between the rights of children and parental rights, but the decision is based on providing the best for the child. The decision in such situation could not be complete without making a careful assessment for the risk which require to cooperation between all the relevant agencies which responsible about the children in the community, then the decision can be made by the professional team who follow the child protection policy.

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