



CHILDREN, YOUNG PEOPLE AND FAMILIES – BMHP5004

Seminar -Supporting paper

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Under the legal provisions demanded in chapter 4 of the Statutory Guidance (SG) “Working together to safeguard children” (HM Government, 2018), this critical case study looks at recordings of infant Aiden -victim of abuse and neglect. As mandated by article 16 SG (HM Government, 2018), the safeguarding partners are directly accountable for protecting child’s best interest, stipulated in part 1 article 3 of the United Nations Convention on the Rights of the Child (UNCRC) (UNICEF, 1990), via close cooperation, under Section 10 of the Children Act 2004, to corroborate the information and problems detected, as well as initiate immediate intervention if it is required.

Aiden, presenting severe burns, comes to the attention of the medical personnel, who conclude that these injuries are not accidental, and according to their clinical observations the child shows clear traces of familial carelessness and insufficient oversight (Ball, 2022). Scientists (Pawlik et al., 2016) have an obvious point of view stating that an infant diagnosed with serious burns is perceived as more likely to be maltreated, which requires immediate preventive actions to protect the child from suffering additional injuries. Aiden’s vulnerability was the young age and his partially developed language skills that prevented him from exercising his “right to have a voice” - article 12 UNCRC (2009) and impeded him to defend himself against parental adversity and their malicious actions. Even though social workers have the authority to speak for and make decisions on behalf of children, McCafferty (2017) noted that procedural obstructions, inefficient performance, and theoretical ambiguities led to fewer appropriate strategies, severely compromising a greater concern for children's rights to safeguard them from abuse - article 19 UNCRC (UNICEF, 1990). In the same view, Bastian (2020) and Ferguson (2017) agree that a routine practice characterised by inflexible rules, regulations, and procedures isolates experts from the hardship faced by children, sometimes making them hidden and voiceless, aggravating their social marginalisation and misery, and even unintentionally causing to more suffering.

Aiden’s mother with adverse childhood events (ACE)s demonstrates evidence of intergenerational transmission of child maltreatment (Yang et al., 2018; Aktar et al., 2019) with neurological alterations transferable in mental and emotional disturbances that hinder cognitive processes like resilience, cope with stress, literacy and interpersonal interactions (Hughes et al., 2018; Danese and McEwen, 2012), as recorded in the file.

In this case, the Specialist Midwifery Team (SMT) took the initiative to begin the proceedings for safeguarding unborn Aiden at that time, by a referral in accordance with chapter 1 article 17 SG (HM Government, 2018) considering the following risks factors as mother's medical history, the instability of a safe home, the engagement in violent adult interactions, and the maternal history of abandoning her first infant daughter from a different partner - factors meant to trigger real concerns about the mother's parental capacity (Cleaver, Unell and Aldgate, 2011). Given the mother's social and medical antecedents, the SMT strongly militates for the case to be integrated under Section 47 of the Children Act 1989, as their interpretative awareness and pattern recognition abilities (Whittaker, 2018) immediately detected the emergency for the unborn child's early protection.

The attempt to solve the case through a Public Law Outline (PLO) process proved to be unsuccessful due to mother's absence of adequate legal assistance, so she was rejecting the idea of court proceedings, as well as the lack of planning and preparation for assessment work at an early stage of the pregnancy. Considering mother's questionable parental ability and her social and emotional status at that time, the warrant for a rigorous format Pre-birth Assessment was mandatory (Ball, 2022). Broadhurst, Holt and Doherty (2011) noted that the PLO's defective intentions objective gave all participants the time to construct an initiative during the pre-proceedings consultation to delay commencing court actions for child custody.

The main spotted weaknesses in solving this case are high staff turnover and divergent perspectives of the involved agencies (Ball, 2022), with traces of "silo practice" severely affecting both the partnership and effective communication by non-sharing relevant information or a lack of prompt feedback, and the accuracy of assessments, which are critical for precise criteria and explicit channels of action (Sidebotham et al., 2016). Although eligible, the single assessment conducted by Children's Services partially respected the principles of good assessment, according to Chapter 1 of Article 58 of the SG, by marking strengths and difficulties and proposing further investigation, but it did not prove to be child-centred—maybe because the child was not born yet—and as Lushey et al. (2018) and Masson and Dickens (2014) outline, legal protections often don't exist for an innocent foetus until the time of birth, when personhood is established. Moreover, this assessment, a non-reflection of the multi-agency opinions, contains a minimalistic and generalised view of the social worker, who did not consider much important to the unborn child

(Ball, 2022), and as a result, the Children's Services' decision, as Platt and Turney (2014) named it, was the "off-the-shelf" answer selected to fit the type of requirements affecting a child, the "Child in Need" framework—immediately challenged by the SMT. The inclusion of Aiden's case in the Child in Need Plan was not fully justified; the lack of "professional curiosity" to in-depth investigate the mother's parental capacity determined the evaluation to be incomplete, limited, and permissive. As Burton and Revell (2018) clearly pointed out, the relational coldness between the social workers and clients transfers the goals of the case in line with the views of a more institutional, normative approach that is less likely to inspire experimentation in practise.

The case was prematurely closed, resulting in Aiden's hospitalisation with significant harm. The experts' (Sidebotham et al., 2016) recommendations include exercising prudence, acknowledging the long-term, sometimes repetitive or recurring pattern of hazards in some families, as well as ongoing surveillance and oversight. In general, Akister (2011) emphasises that tragic events cannot always be avoided, but a more comprehensive strategy for developing technical expertise and a significant amount of inter-professional knowledge is suggested rather than signing the "blame culture" by accusing the parents of being dishonest.

From a general perspective, the recorded evidence in this case highlights the shallowness of task performance and overconfidence. Sidebotham et al. (2016) advised that dealing with child abuse may raise awareness of the seriousness of cases that cannot be addressed as isolated incidents demanding short-term interventions before they are finally closed. Safeguarding partners working with at-risk families must be cautious in their actions, strongly supportive of the family, and sensitive to the child's requirements.

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