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Children, young people and families

BMHP5004

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Essay

The purpose of this assignment is to critically explore safeguarding of children policies and procedures in the UK, and it will comment and compare on two high profile cases in the last 20 years, while critically examining and offer policy responses regarding the multi-disciplinary nature of health services in relation to children and families.

It will also explore the historical emergence of the concept of childhood including the social construction of the family and how this affects current situations within society.

The first case that it will analyse and comment on will be baby P (Peter Connelly)

Peter Connelly was a 17-month-old, who was found dead in his cot, after months of systematic abuse in 2007. The people who were supposed to love and care for Peter were the ones who inflicted the horrendous abuse he endured, which subsequently lead to his death. His mother, Tracey Connelly her boyfriend, Steven Baker and his brother, Jason Owen.

At the time of his death Peter had over 50 disgusting injuries on his tiny body. A serious case review ensued. The investigation revealed that not only was Peter known to social services, over an 8-month period Peter was visited over 60 times by Haringey council, by police, doctors and social services. All of them failed this poor little boy.

One of the most disturbing finds when reviewing Peters case, is that in the same borough (Haringey) only a few years prior the local authority also failed a little girl called Victoria Climbié, affectionally known by her friends as Anna.

Not only were there significant failings, but it was also clear that lessons had not been learnt by this local authority and it didn't take long for people to recognise Haringey's repetitive failings.

A case review published in 2010 said Peter Connelly death, could and should have been prevented. All services involved in his care, social services, police and health services had been eager to protect him but their practices as an organisation and individually had severely fell below the expected standard. They failed to adequately challenge Tracey Connelly excuses for the mistreatment of her son. As part of the case review the social worker assigned to Peter Connelly was vigorously examined in the court.

This case had a major impact on social services causing the "*baby p effect*" where they became overwhelmed with referrals all agency's panicking and not wanting another baby p on their hands. This making it more difficult to spot the cases that needed more urgent action.

Just a few years prior, 2002, there were massive changes put in place following the death of Victoria Climbié, an Ivorian girl, sometimes known as Anna, who endured abuse and neglect at the hands of her great aunt, Marie Theresa Kouao and her boyfriend, Carl Manning. This had an instrumental bearing on new legislation composure and resulted in the laming report (laming 2003), which lead to a fundamental shift in the practises for children protection services and local authorities in England and Wales.

Then in 2002 more reforms were made to child protection legislation following the deaths of Holly Wells and Jessica Chapman, who were killed by their school caretaker, Ian Huntley who had previously been investigated by police for crimes such as indecent assault, rape and burglary. After his conviction an inquiry, suggested the system needed developing, where applicants were appropriately vetted before working with minors.

This then led to a more robust legislation framework across the UK to protect children from adults who pose a risk to them paramount in that practise was the Safeguarding act 2006.

In 2004 the children's act assigned a commissioner, the last of the UK to appoint one and composed children's boards and allocated the duty on the local authorities in England to assign a director of children's services and an administrative elected leader for children's services, whom will be held accountable to this deliver this service.

Then followed in 2006 the safeguarding vulnerable groups act was brought in Northern Ireland, Wales and England, due to the recommendations of the investigation of the deaths of Holly Well and Jessica Chapman in 2002.

Also, in 2006 The statutory guidance for protecting children in England was published. The importance of this change in legislation was fundamental within the social care system for children. This outlines responsibilities and holds key individuals accountable when there are failings within these processes.

Then in 2010 Tim Loughton, minister for children and families, publicise that local safeguarding boards in England should issue an overview of the report an abstract of all cases reviews that commenced on or after the 10 June 2010.

Michael Gove, the Secretary of State, authorised professor Eileen Munro to produce an independent review of child protection in England.

Moving in to 2011 Professor Eileen Munro's report A child-centred system, sets out suggestions to "help to reform the child protection system from being over-bureaucratised and concerned with compliance to one that keeps a focus on children, checking whether they are being effectively helped, and adapting when problems are identified" (Munro, and DfE, 2011).

This went on to a review of the statutory child protection guidance in England.

In 2012 the Metropolitan police service set up operation Yewtree to lead an inquiry of sexual abuse accusations against Jimmy Savile and others.

Then the [Protection of Freedoms Act 2012](#) in England and Wales was set out for the requirements for vetting and barring checks for people who are wanting to work or volunteer with children.

2013 brought the independent review into child sexual exploitation, this following the reports that 47 girls were recognised as victims, it examined the Rochdale council's reaction to these issues around child sexual exploitation.

A renewed edition of Working together to safeguard children was published in England.

In 2015 an [Independent Inquiry into Child Sexual Abuse in England and Wales \(IICSA\)](#) officially launched to consider the growing evidence of institutional failures to protect children from child sexual abuse (IICSA, 2018).

[Section 74](#) of the Serious Crime Act 2015 put in place a mandatory reporting duty on regulated health and social care teachers and professionals in Wales and England to make a report to the police if:

- they are informed by a child that they have undergone female genital mutilation (FGM)
- they observe physical signs that an act of FGM may have been carried out on a child.

Going into 2017 the children and social work act 2017 reformed and made several changes to the child protection system in England. It was established the child safeguarding practice review panel to analysis and detail on the serious child protection cases. It was also to replace the model of local safeguarding children's boards with local safeguarding partners.

Following on to 2018 a new and updated edition of working together to safeguard children was issued in England, it took away local safeguarding children boards and replacing them with safeguarding partner arrangements.

Then in 2020 and the second case that will be analysed and commented on will be that of Arthur Labinjo-Hughes, a six-year-old boy who died from a fatal head injury caused by his father's girlfriend Emma Tustin, at her home in June 2020.

Arthur was subjected to horrific abuse and neglect while in his stepmother's care, he was being poisoned by salt and had to endure regular beating, one of the most disturbing things is this was all encouraged by Arthur's father, Thomas Hughes.

Little Arthur was malnourished and very weak, from being starved and refused water, this was very clear to see on the footage captured from the CCTV set up in the living room by Tustin and Hughes, this was detrimental in the convictions of Tustin and Hughes. Poor Arthur had to endure all this mistreatment while his stepmother's two children lived a perfectly happy life all while Arthur was being subjected to this abuse.

Arthur would be made to stand alone in the hallway for hours, but the fatal attack that would lose Arthur his life, inflicted by violently shaking him and smashing his head against a hard floor.

There were many missed opportunities that could have saved Arthur's life. Social services visited Arthur's home in April 2020 after a referral had been made by his paternal grandparents and school reporting to seeing bruises on his back but two months before he died Solihull council concluded he lived in happy home.

After a few years in 2021 Ofsted issued a rapid [review of sexual abuse in schools and colleges in England](#) (Ofsted, 2021). This request was made by the government after children and young people shared unnamed accounts of their experiences of sexual assault and sexual harassment at school and university on a website called 'Everyone's Invited'. This looked on all occurrence of peer-on-peer sexual harassment, sexual violence, and online

sexual abuse. It gave outlining and recommendations for school and college leaders, multi-agency partners, and the government.

In the following year 2022, the independent review of children's social care published its final [report on the children's social care system in England](#) (Mac Alister, 2022). The UK Government set out the measures it would take to improve children's social care for the better, following the publication of the report, which included setting up a [National Implementation Board to advise on reforms](#) (DfE, 2022).

The Independent Inquiry into Child Sexual Abuse (IICSA) published its final [report into child sexual abuse and exploitation in institutions in England and Wales](#) (IICSA, 2022). This set out what it found and frequent themes arising from the work of the Investigation and made 20 recommendations to be reformed for the UK and Welsh governments and other institutions.

Statutory guidance for keeping children safe in education published in September 2022 (DFE 2022) clearly outlines the responsibilities of staff within schools. From ensuring a rigorous recruitment process including DBS and barred lists checks to ensuring regulated activity is monitored and planned out as to what appropriate activity is.

Analysing the last 20 years, and looking at the policy responses, it is clear there have been many failings over the years. While there have been many reviews and reports, the practices and protocols are not being implemented consistently which has had a detrimental effect. Comparing these two high profile cases (baby p & Arthur) lessons have not been learnt and failings continue to be repeated at the detriment of these children at risk. Not only those two cases are isolated, but this assignment also refers to three young girls being failed by the system, which resulted in their deaths. This is significant because this triggered instrumental changes with the policies and procedures and yet children are still being left at significant risk of harm, evidenced by Arthur sadly passing away at the hands of his stepmother, Emma Tustin and his biological father, Thomas Hughes.

It is very concerning that in 2020, there were still opportunities being missed to save Arthur from his torment and abuse, in spite of all the reforms put in place it is evident this is not enough as it was not enough to save Arthur's life.

According to Willis Palmer (a multi-disciplinary organisation that provides independent, psychological, therapeutic & family support services) to the highest of standards there is an identified weakness between the sharing of information. It was also identified that there was a need for more specialist services.

As part of the Lammings Inquiry, it was implemented in the 'working together to safeguard children' guidance that:

"Ensuring all referrals to children's services from other professionals lead to an initial assessment, including direct involvement with the child." (Lammings 2009)

It is also apparent that information seeking and sharing between and within different agencies is weak at points. It also lacks in critical robust challenging and thinking within agencies, confirmed by multiple failures to alert statutory multi agency child protection procedures at a multitude of vital moments.

There is a great need for more diverse specialist child protection knowledge and skill set, surrounding complex risk assessments and making decisions. Expertise is needed when engaging with difficult parents and analysing the daily life of children and domestic abuse. Resolving these problems, will be more efficient to enable leaders to have a powerful impact on child protection practise thus also protecting the organisational conditions for commitment to this complex work.

The concept of childhood has changed over time. Analysing data from the 19th century there are several key themes to be considered such as child labour, schooling and medical care. To support this legislation has emerged to ensure children are protected from danger, harm and or neglect.

Legislation was implemented specifically to protect their welfare through safeguarding legislation specifically.

The government also provided financial support such as child benefit that was introduced in 1977 regardless of families social standing or personal income. Further legislation has been introduced to give children rights including their right to be heard.

Reviewing these changes within legislations, they were unsuccessful because the drivers behind them were not strong enough. There was no surge of increased workforce. The staff in place were put under too much pressure to perform without having the support in place. Social workers were also scared of being put under the microscope which resulted in an increase of referrals reaffirming the '*baby p effect*'. The legislation identified that professionals must be much more vigilant and challenging concerns, no matter how small.

After the Lammings inquiry, there were recommendations that were published, including the formation of the National Safeguarding delivery unit who must report directly to the ministers as well as codes of practice and extra support for newly qualified social workers. The government responded to these recommendations by creating a £58 million fund for training and development. this fund was used to recruit new talent, as well as attract previous social workers back to the profession. Following this a review of the '*working together to safeguard children guidance*' was also actioned.

Every case of a child's death must now be investigated following this Inquiry, however this a reactive measure. Further measures have been implemented however it is the review, monitoring and culpability of these processes that need to be more stringently implemented.

It is clear that there have been several serious care reviews following these failings within the system and changes to policies and legislation and frameworks put into place, however these frameworks are not being efficiently and consistently implemented which has then resulted in further failings. The question is begged to be asked, it doesn't matter how many changes are made, and serious case reviews actions if they are not embedded throughout practice, resource increased and a more robust monitoring system in place, these policies are essentially designed to fail.

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