UNIVERSITY OF SOUTHAMPTON

CERTAIN ASPECTS OF THE MANAGEMENT OF CHILD ABUSE IN AN OUTER LONDON BOROUGH BETWEEN 1970 - 1983

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ABSTRACT

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CERTAIN ASPECTS OF THE MANAGEMENT OF CHILD ABUSE IN AN OUTER LONDON BOROUGH BETWEEN 1973 - 1983

by Alison Leake

This study looks at the way one outer London Borough responded, between 1970 and 1983, to an increasing awareness of the problem of child abuse. It focuses particularly on the number and type of cases on the Register during this period and on the production of a multi-disciplinary handbook of procedural guidance. The aim of the study was to describe how these management tools were developed and used and to consider what lessons could be learnt for the improvement of professional practice.

The Register data is analysed in order to describe the situation both in terms of numbers, the different agencies involved, times and reasons for registration and deregistration as well as to produce a profile of the types of families and children concerned.

The multi-disciplinary discussions which preceded the writing of the Guidelines are described as well as the negotiations which were necessary before the final document could be printed and distributed. The Guidelines were intended to be a practical tool for professionals dealing with cases of child abuse and the preparation also included attempting to discover their needs in order to provide a clear framework for the work. A copy of the final version is included with the study.

The analysis of numbers and types of cases confirms the hypothesis that Registers record professional concern rather than the extent of actual abuse. The profile of the families shows some significant variations from other studies, indicating the importance of tailoring procedures to local needs. These needs, like the numbers on the Register, vary: five years later the Guidelines are being revised and expanded.

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CHAPTER I INTRODUCTION

1. Background to the Study

During the 1970s and 1980s, child abuse was a "hot" topic. Its existence, dramatic incidents of it (and particularly those which ended in tragedy), its management or mismanagement by the caring professions (and particularly by social workers) were a frequent subject for media concern, government instruction or inquiries and articles and books in the professional press. Names such as Maria Colwell, Jasmine Beckford and Tyra Henry became almost synonymous with child abuse in the same way that, in 1988, "Cleveland", hitherto thought of as denoting a geographical area (which many people still preferred to call Co. Durham, Teesside and North Yorkshire) came to symbolise for many a phenomenon otherwise known as child sexual abuse.

The attention resulted in the management of the problem being accorded very high priority in Social Service Departments policies and procedures and, indeed, since all the inquiry reports and memoranda of guidance stressed the importance of the different professionals working together and sharing information, other agencies, in particular those concerned with children and their health or welfare, shared Social Services' concerns.

This study is concerned with certain aspects of the professional response to the management of the problem of child abuse in one outer London Borough, Merton, during the mid-Seventies and mid-Eighties. I had worked for the Social Services department of this Borough since 1975 (the year following the publication of the Maria Colwell report (DHSS 1974a) as a part-time social worker, whose caseload was increasingly composed of families whose children's names featured on the Non-Accidental Injury Register (as it was then known). In March 1981, I completed a Diploma in Family and Child Protective Casework at the NSPCC School of Social Work, a post-qualifying course which focused on the theory and practice of working with abusing families. On my return to my Department, I was coopted onto the Borough Review

Committee, an interagency body which had been set up, as will be seen later, in response to government advice to coordinate professional management and local procedures in relation to child abuse. I was, as a fieldwork social worker, of considerably less seniority than any other member of the Review Committee, but together with the NSPCC Inspector on the Committee and one or two of the doctors, I was one of the few committee members with first hand, and continuing, experience of face to face work with abusing families and I also had, thanks to the Post-qualifying Diploma, a theoretical framework into which to fit my experience.

The aim of this study is to look at the procedures developed by management, through the multi-disciplinary Borough Review Committee, in particular at the Register and at the "written instructions", or guidelines, which the Department of Health and Social Security had charged Review Committees with producing (DHSS 1974b). The Register had been set up in the early Seventies, although it was not until 1974 that it became fully operational. It recorded the names and details of children about whom Case Conferences had expressed concern and decided to "register" as having suffered, or being thought likely to suffer, abuse. Quarterly statistics, in the form of a brief summary of the numbers on the Register, grouped by age, with additional numbers of those who had been added to or removed from the Register in that quarter, were produced for the Review Committee, but no attempt had ever been made to look at or analyse the information available on the Register in any more depth. This study attempts to do that and to see whether there are any trends apparent, which have implication for planning or practice and to flesh out the bare statistics into a profile of the kinds of children and families about whom concern was so evident. As Lord Justice Butler-Sloss wrote in the Cleveland Inquiry report, "the child is a person and not an object of concern" (DHSS 1988a,245) and it was hoped that the study could echo this, by focussing not only on the numbers, but on the characteristics of the real children who were behind those numbers.

The Borough Review Committee, as will be seen, had never got around to producing the "written instructions", despite much discussion of the subject. They were, in fact, written during the course of this study, which looks at the way this was finally achieved, the problems which were encountered and describes the finished product, intended to be a practical guide for practitioners.

My hope, throughout the study, was that ultimately it would contribute to the improvement of professional procedures and practice, by providing professional practitioners with better information and tools with which to work. I hoped that children, who had been abused or who were in danger of abuse, would receive a better service and that their families would be treated with more consistent understanding. I wanted to increase awareness, both of the problem and of ways of dealing with it, and to see whether any underlying trends, which might be revealed, had implication for the provision of resources or for possible preventive work to stop future children being abused. Many professionals were operating in a climate of considerable anxiety and, so it seemed, lacked an overall vision or frame of reference and it was possible that the study could help to provide this.

The two parts of the study were thus closely interlinked. Without the analysis of the Register, the Guidelines would have been written as a theoretical set of procedures, bearing no special relevance for the local situation. Without the writing of the Guidelines, the analysis of the Register would have done little to raise standards of practice, although it might have increased theoretical knowledge of the local situation.

In order to implement a study of the Register and the production of the Guidelines, access to the Register itself was needed as well as access to the minutes of the Borough Review Committee, both past and current. In addition, it was important to keep a record of the negotiations over the Guidelines and to study Social Services' own internal procedure orders for the period of the study. Some access

to Social Services' Central Index of clients was also necessary to check ambiguous or missing data on the Register itself. The access to the Register was willingly given by the Social Services Department, who were responsible for maintaining it, in return for a pledge to respect its confidentiality and not to reproduce anything which could identify a particular child or family. The minutes of past Borough Review Committee meetings were also made available and, once I had been coopted as a member of the Committee, I received the current minutes.

All the information on the Register had to be collected and collated. There was a great deal of information available on the handwritten cards, which made up the Register at that stage, but much was of dubious quality and was couched in a narrative form. The basic facts of numbers of children, length of time spent on the Register, dates of Registration etc. were reasonably easy to extract. Trying to elicit the information, which would confirm that trends observed in other studies also applied in Merton, was often harder. For example, the literature (Straus in Kempe and Helfer 1980, Jones 1982) spoke of families moving frequently. It was not possible to collect any data to support the hypothesis that that happened locally as well as nationally, since each card bore only one address, although it was clear at times that a previous address (or addresses ?) had been carefully erased. There were often, as will be seen, gaps in the data recorded: names were missing, occasionally the sex of the child was not clear, data about the parents, especially the fathers, was often absent. Moreover, the information was recorded in a way that sometimes made clear distinctions difficult. In the absence of guidelines, which required clear basic information to be recorded about each child registered together with the reason for registration, the information had been recorded subjectively, rather than objectively, and it was sometimes difficult to tell, for example, exactly why a child was thought to be at risk or of what form of abuse.

As a result of this the focus of the study had to change. It became increasingly clear that the Register was a record

of varying concerns and that the data was revealing inconsistencies and idiosyncrasies. The result was that it proved impossible to produce as full a profile of the children as had been hoped and it also became clear it was not going to be possible to say: "These are the sort of children who are most at risk of child abuse" but only "these are the sort of children professionals think are at risk of child abuse".

The focus of the study had had to change when it became clear that the information on the Register was less reliable than had been hoped. It changed again as pressure to complete the Guidelines built up and they took precedence over completing the analysis of the Register or over writing up the analysis of the Register. While it was accepted, in theory, that the two parts of the study complemented each other, in practice the guidelines were seen as being more important by management. The printer delivered the copies in June 1984 and they were distributed over the summer holiday period. Throughout September and the autumn, I was kept busy, introducing them and "teaching them in" to a wide variety of professional groups. In February 1985, I moved from being a part-time field social worker to a full time post as a Court Officer and Custodian of the Child Abuse Register. The latter was a new post - previously the Deputy Director of Social Services (or an Assistant Director) had been the nominated Custodian, but the Register had in effect been maintained and run by a secretary. My appointment, which was undoubtedly influenced by the evidence I had uncovered of the underuse, if not misuse, of the Register, when maintained by someone with no professional training, was seen as putting the management of child abuse within the borough on a more positive and professional footing. What followed my appointment will be described later, but briefly the pressure to computerise the Register, to sort out its inconsistencies, to monitor that procedures were being correctly followed and to provide a consultancy and advisory service all took up a great deal of time and the writing up of the study suffered. The Borough thus benefitted directly from the production of the Guidelines which had been heavily influenced by the study of the Register but, while some of

the findings of the analysis filtered through, the presentation of the analysis as a whole was delayed. Consequently, in writing up the findings at this stage greater emphasis has been put on the analysis of the Register in order to redress the balance.

The Setting of the Study

The outer London Borough, for which I worked and which was chosen as the setting of the study was Merton, situated south of the Thames bounded by the Royal Borough of Kingston to the west and by the Boroughs of Wandsworth, Lambeth and Sutton to the north, east and south. Merton is the fourth smallest of the outer London boroughs, with a population, at the time of the 1981 census, of 165,102 (Census 1981). It is made up of the three former boroughs of Wimbledon, Mitcham and Morden and contains a varied population, both socially and ethnically, although the 7.3% who originate from the New Commonwealth or Pakistan make up a smaller percentage of its inhabitants than in London as a whole (9.5%). In addition, 36.9% are recorded as belonging to households classified as Social Class I or II, which is considerably higher than for the United Kingdom as a whole (30.2%) and the figure for classes V and VI is correspondingly lower (15% compared with 23.3% for the UK generally). Housing-wise, 61.7% of its houses are owner occupied and only 21.8% council owned as against 48.6% owner occupied and 30.7% council tenancies in the Greater London area as a whole (Census 1981). The implication of all this, of course, is that Merton is more middle class and prosperous than some of its inner London neighbours, and does not have such intense problems as are associated with some of the inner city areas. Neither does it have so many resources nor attract the same priority for Urban Aid or other Government projects but, while it contains areas of affluence, it also encompasses high rise estates. It rapidly became apparent as the study progressed that the abused children were not confined to any social class or particular area (although some geographical clusters of families were to raise questions about housing policies).

The other distinctive feature of Merton's population is its age. Merton has the second highest percentage (20.2%) of people over retirement age of all the London boroughs - the average figure is 17.9%. At the other end of the spectrum, the number of children under 15 years is slightly above the average for London as a whole but there are less than the average numbers of large families and fewer single parent households (Census 1981).

During the period covered by the study, the Borough was part of the Merton, Sutton and Wandsworth Area Health Authority and the two major hospitals - St. George's and St. Helier's - were both situated outside the borough boundaries. The Social Services Department was organised into four Area Offices and, from the mid-70s, had employed only qualified social workers (although one or two unqualified but long-standing members of staff remained in senior positions). So far as child abuse was concerned there had not been an incident of death or serious injury which had led to any public outcry or inquiry, although, mindful of Olive Stevenson's comment in her minority report in the Maria Colwell inquiry ("most social workers ... would say 'there but for the grace of God went I' ") (DHSS 1974a, 8) one cannot be sure whether this should be ascribed to good management or to good luck.

3. Recognising the Problem of Child Abuse

a. The Historical Background

Child abuse is not a modern phenomenon, although the widespread recognition of it is. Dr Henry Kempe, who described the syndrome and the phrase "the battered child" in 1962 (Kempe et al 1962, 17) was not the first paediatrician to draw attention to the possibility of children being injured by their parents or caretakers. Margaret Lynch, in an historical review of the literature, cites an account by Radbill of the "first surviving treatise in paediatrics", Rhazes' Practica Peurorum, in which a Persian doctor writing in c.900 A.D. says, in the course of a discussion about umbilical hernia, that "the child may have been struck intentionally" (Lynch 1985, 7). In the

last century, concern over the ill-treatment of children led, in 1874, to the foundation of the New York City Society for the Prevention of Cruelty to Children, followed in England by the establishment, ten years later, of the National Society for the Prevention of Cruelty to Children (Radbill in Kempe and Helfer 1980, Solomon 1973).

Nevertheless, it was the work of Kempe and his colleagues and, particularly, Kempe's use of an emotive phrase, which caught the public's attention and led to an increasing awareness of the extent and seriousness of the problem. (It is interesting to note that Kempe first used the phrase "the Battered Child Syndrome" but by 1971 was writing of "the Battered Baby Syndrome" (Kempe 1971, 28 - my emphasis). This was the phrase that received so much attention.) Concentrating initially on physical abuse, Kempe demonstrated how many of the injuries suffered by children were not caused accidentally and how further investigations (particularly the use of skeletal x-rays) often revealed a history of previously undetected injuries. Later, Kempe widened his definition of child abuse and pioneered the recognition of the suffering caused to children by physical and emotional neglect and by sexual exploitation within the family (Kempe and Kempe 1978, 18).

In Britain, as in America, it was the medical professions who published the early papers and articles. In December 1963, an article in the British Medical Journal on multiple epiphyseal injuries in babies was subtitled "Battered Baby Syndrome" (Griffiths and Moynihan 1963, 1558). It was not until 1969 that an article written by a social worker appeared and, perhaps significantly, this was published in the Medical Social Work Journal (Court 1969). However, later that same year, the first of the NSPCC reports were published. Entitled "78 battered children: a retrospective study" (Skinner and Castle, 1969), it dealt only with children under the age of two, but it did move the study of child abuse out of the hospital and into the community. A year later the first of many DHSS circulars on the subject was issued. Entitled "Battered Babies", it referred to the NSPCC study and requested Chief Medical Officers and

Children's Officers to consult together about the problems of the battered baby (DHSS 1970a). Local committees were asked to report their findings and an analysis of these was circulated in 1972 in another circular, also entitled "Battered Babies" (DHSS 1972). (At least 10 Government and DHSS papers headed "Battered Babies" were issued between 1970 and 1974 (DHSS 1970 a,b,c,d,e,f,g, DHSS 1972 a,b,c). It was not until the Maria Colwell inquiry had drawn attention to the fact that older children could be injured or killed by their parents that the circulars began to be entitled "Non-accidental Injury to Children".

b. Central Government and Public Concern

i The pressure for multi-disciplinary cooperation

The Maria Colwell report was published in April 1974. The same month, the DHSS issued a circular which, though not mentioning Maria Colwell or the report by name, was concerned "to repeat the professional guidance about the diagnosis, care, prevention, and local organisation necessary for the management of cases involving non-accidental injury to children" (DHSS 1974b, 1). The circular was sent to Area Health Authorities and to Directors of Social Service Departments and particularly urged the "formation of area review committees as policy making bodies for the management of these cases" (Ibid, Para. 12). The circular directed that "urgent joint action" should be taken in those areas where such committees had not already been established and went on to lay down suggested terms of reference, including advice on the formulation of procedures, the approval of written instructions and the establishment of Registers (Ibid, Para. 12). It also advised that multi-disciplinary Case Conferences should be called "for every case involving suspected non-accidental injury" (Ibid, Para. 14). Even before this circular, Health Authorities and Social Service departments in some areas had been meeting with each other, and other professionals, to discuss ways of diagnosing and managing cases of child abuse. Case conferences were often held to discuss individual cases. The medical profession had led

the way in drawing attention to the problem but Social Service departments had the statutory responsibility for protecting children who might be being ill-treated or neglected. However, there was no uniformity of response and, in most areas, meetings tended to be on an ad hoc basis and depended on the commitment of particular individuals.

The media attention given to the deaths of particular children, and the subsequent inquiries, gave an added impetus and urgency. The Maria Colwell inquiry is the best known and - at least until events connected with the death of Jasmine Beckford - received the most publicity. It had, in fact been preceded by two reports into the death of Graham Bagnall in 1973 (Shropshire 1973, Shrewsbury 1973). The Max Piazzani report (Essex 1974) was published 5 months after the Maria Colwell one and 1975 saw reports into the deaths of John Auckland (DHSS 1975), Lisa Godfrey (Lambeth 1975), Steven Meurs (Norfolk 1975) and Richard Clark (Scottish Office, 1975) followed by the Neil Howlett inquiry in 1976 (Birmingham 1976). Three of these inquiries were set up by Secretaries of State (Colwell, Auckland and Clark), the rest were local inquiries. Of these inquiries, no less than six were specifically charged with considering "coordination" between the various agencies involved in the provision of services for abused children. The pressure was on for all health and local authorities to work together. By the time the DHSS issued their next circular (DHSS 1976) a network of 102 Area Review Committees covered England.

This follow-up circular, besides reporting on the newly established Area Review Committees, urged all those who had not already done so to set up register systems and to provide written instructions and, for the first time, strongly recommended the practice of appointing a Keyworker as a focal point for information about, and to coordinate the management of, a case of child abuse (DHSS 1976, Para. 2a).

Between 1974 and 1976 there was, therefore, considerable concern about non-accidental injury and Central Government was advising the establishment of the procedures and methods

it considered necessary to contain the problem. Local areas were to establish Review Committees and Central Register systems, hold Case Conferences, appoint Keyworkers and issue written instructions to staff. A brief description of how each of these were envisaged will help to explain the background to this study.

ii) Area Review Committees were to be "policy making bodies" (DHSS 1974b, Para. 12) composed of senior representatives of health and local authorities, with a heavy bias towards the medical fraternity. Nine different branches of the health service were suggested as needing to be represented as against four from local authorities. The Police, Probation Service and the NSPCC were also to be included. The Committees were to meet at least 3 or 4 times a year, could establish sub-committees for particular purposes if they wished and, in addition to the functions already mentioned, were charged with collecting information, providing education and training, collaborating with other Area Review Committees and reviewing the work of Case Conferences (Ibid, Paras. 12-13).

While many Area Review Committees, in practice, extended their membership to encompass voluntary organisations, or other interested parties such as magistrates or their clerks, the emphasis on medical membership remained. The stress on the importance of senior people being involved meant that, in practice, apart from some of the doctors present, few members of Area Review Committees had direct, as opposed to managerial, responsibility for cases of child abuse and some might never have had face-to-face contact with abusing families at all.

iii) Case Conferences, the circulars suggested, were also to be multi-disciplinary meetings but about individual cases, and they were to be concerned with trying to reach "a collective decision" in cases of non-accidental injury and how such cases were to be dealt with (DHSS 1974b, Paras. 14-16). (By 1976 the problems of reaching agreed decisions was being recognised and it was acknowledged that decisions made by a case conference "cannot be binding on

the representatives of bodies with statutory powers" (DHSS 1976, Para. 30). The membership of Case Conferences was to include all those with information about the child or his family and people responsible for providing relevant services (DHSS 1974b, Para. 16). In addition senior medical and social services personnel were to be included and by 1976 it was noted that it was normal practice for a senior member of the Social Services Department to convene and chair such meetings (DHSS 1976, Para. 26). Also by 1976, the problem of persuading General Practitioners to attend Case Conferences was acknowledged and has been a recurrent theme of much discussion about child abuse ever since (Ibid, Para. 28).

The 1974 circular recommended that one person should be made responsible for "coordinating the agreed treatment" (DHSS 1974b, Para. 15). By 1976, the term Keyworker was being used and it was advised that this person should be the "professional most clearly concerned with the case and responsible for the actual management" (DHSS 1976, Para. 29). The Keyworker was to be the recipient and disseminator of information about any developments in the case, but, it was stressed, this did not relieve "the other professionals of their responsibilities" (Ibid). Over the years there was continued discussion (and some controversy) about who should or should not undertake the Keyworker role. This will be dealt with in detail later but following the issue, in December 1982, of a joint British Association of Social Workers and Health Visitors Association document (BASW-HVA 1982), Health Visitors became more willing to undertake the responsibility, albeit with the title of Prime, rather than Key, Worker and with back-up from a designated member of the local Social Services Department. Other professionals, such as teachers or day nursery staff, were occasionally nominated Keyworker, but nationally the situation was that the person designated was most commonly a social worker, either from a Social Services department or from the NSPCC. (In 1988, this became officially recommended policy: Working Together, the government manual of advice issued following the Cleveland Inquiry, states "It is not appropriate for anyone other than a social worker from

either the social services department or the NSPCC to act as keyworker" (DHSS 1988b Para. 5.19).

iv) Registers were known by various names in the Seventies: Central Registers, At Risk Registers, NAI (an abbreviation for Non-Accidental Injury) Registers. In the early Eighties, following the DHSS memorandum advising that other forms of child abuse such as emotional abuse should be registered in addition to physical abuse (DHSS 1980), they became known as Child Abuse Registers and in the late Eighties, following the advice contained in Working Together they were renamed Child Protection Registers (DHSS 1988b).

The first mention of Registers was in the 1970 circular which thought there was a value in the setting up of a registry (DHSS 1970a). The 1972 circular indicated that some areas had set them up and said "it may well prove to be a useful source of data" (DHSS 1972, 8). By 1974, they were being described as "a central record of information" and as "essential to good communication between the many disciplines involved in the management of these cases" (DHSS 1974b, Para. 17).

No advice was given about what they were supposed to contain in the way of information as whether the Health Authority or the Social Services department should be responsible for their management. The 1976 circular, however, reported that the majority were kept by Social Services (DHSS 1976, Para. 18) and that has continued to be the usual practice. The great variation in the information contained on Registers and the criteria for inclusion led to detailed instructions, in 1976, about confidentiality and the need for greater standardisation, together with advice about distinguishing proven cases of physical abuse from cases of children thought to be at risk because of concern about their failure to thrive or neglect. Directions were also given about the basic data about a child, his family and the professionals involved, which should be kept on all Registers (DHSS 1976, Paras. 22-23). Cases were to be regularly reviewed but no general advice was given about de-registration apart from the comment that "some authorities never remove children

from the register" (Ibid, Para. 21). It was not until 1980 in a circular entitled "Child Abuse: Central Register Systems" that specific advice was given about deregistration. At this stage, Case Conferences, reviewing cases already registered, were told to consider deregistration and if this was agreed, it was suggested the child's name should be placed in an inactive section of the Register (i.e. one not subject to regular review) for a further two years. If during that time there was no further cause for concern, the record was to be removed completely from the Register (although, of course, that did not mean that the professionals necessarily ceased to be involved with the family) (DHSS 1980, Paras. 4.4-5). By 1988, all mention of inactive sections had disappeared but cases were to be deregistered when formal inter-agency working is no longer necessary to protect the child (DHSS 1988b, Para. 5.36).

The 1980 circular was also the first to make a detailed acknowledgement of the different types of abuse such as physical abuse, neglect, failure to thrive and emotional abuse and to attempt definitions of these. Sexual abuse, however, was not included since it was held to "raise complex issues" (DHSS 1980, Para. 2). (The pressure to recognise sexual abuse as a form of abuse in its own right continued to build up and Working Together, the DHSS guide issued in the wake of the Butler-Sloss inquiry into Cleveland, defined sexual abuse specifically as a form of abuse and devoted a whole chapter to it (DHSS 1988b, Chapter 6).)

v) Guidelines

Area Review Committees had been charged in the 1974 circular with approving "written instructions defining the duties of all personnel concerned with any aspects of these cases" (DHSS 1974, Para. 12(b). In 1976, the DHSS was urging that "such instructions should be available to all professionals and regularly updated" and more detailed instructions were given about content, with two examples attached as possible models. The guidelines were clearly meant to be multi-

disciplinary but it was also said they should "embody a uniformity of procedure" and aim at "the highest professional standards" (DHSS 1976, Para. 37).

It will have been noted that all these are methods of management. Very little was said about how to diagnose cases of child abuse, nothing about methods of working with the families or children or the resources needed to do this. There was no mention of possible causes and only a very brief reference, in the 1976 circular, to the numbers of children involved (Ibid, Para. 33). Little or no research underpinned the directions, which were largely founded on reaction to the criticisms contained in the inquiry reports. The Maria Colwell report had highlighted faulty communication between the professionals involved: therefore they should get together at Case Conferences. No one person had taken critical decisions in the Maria Colwell case: therefore there should be a Keyworker. People did not know of other professionals' concern for a child: therefore there should be a Central Register system. People had not known what to do: therefore written instructions should be issued. (There was awareness in some quarters at the time of the danger of "disproportionate emphasis on management and discussion of cases at the cost of closer involvement with families and an analysis of effective methods of treatment" - but even the writers of that warning agreed with the recommendations in the circulars and also said "in our experience, management of cases is greatly facilitated by inter-agency discussion and co-ordination" (Baher et al 1976, 105).

4. The Local Reaction

Nationally, the government was directing local authorities and health authorities to cooperate in setting up Review Committees and Registers, to produce written advice for workers, in the form of guidelines, and to manage individual cases through a system of Case Conferences and Keyworkers. This study looks at how these instructions, and particularly those relating to the keeping of a Central Register and the production of written, multi-disciplinary guidelines, were

implemented locally in Merton. The establishment of a Review Committee was clearly the top priority if the work was to be multi-disciplinary and the setting up of Merton's will be described in more detail shortly. Case Conferences had, as Hallett and Stevenson have pointed out, long been a feature of work with families in Social Service departments and the Children's departments which preceded them (Hallett and Stevenson 1980). Since the establishment of Registers and the specific attention to child abuse, Case Conferences have come to be uniquely identified with that type of work, rather than indicating a multi-disciplinary conference about any case.

The Register started in Merton in 1970 in a somewhat haphazard manner, as will be seen later, but really got under way in 1974, a year in which 37 new family names were added (a total only exceeded in 1975). The study looks at all the families whose names were on the Register from its inception until March 1983, a cut-off date chosen because it was hoped that the new Guidelines would be in print shortly after that, although in the event their publication was delayed until the following year.

It was stated above that the DHSS had charged Review Committees in 1974 with producing "written instructions" (DHSS 1974b, Para. 12b). Within Merton, Social Services had certainly had its own internal procedures before that, since the earliest extant Procedure Order indicates that it was revised in November 1974 (see Appendix B). While the DHSS clearly intended that the instructions should be multi-disciplinary it gave little advice about how they should be written, although the next circular attached copies of the guidance issued in Durham and Rochdale "as examples of good practice" (DHSS 1976a, Para. 37). As will be seen, the Borough Review Committee first discussed the matter of possible Guidelines in December 1974. The published guidelines were, in fact, received from the printer at the end of June 1984. The study looks at the process of writing them and the delays in implementing the DHSS direction to provide guidance for staff involved with child abuse. The Register and the Guidelines form the bulk of the study and

are dealt with in the chapters which follow. Meanwhile it is necessary to look in more detail at the establishment and functioning of the Merton Borough Review Committee under whose auspices they were established.

The Merton Borough Review Committee

The inaugural meeting took place on December 6th 1974, partly in response to the 1974 DHSS circular which has already been referred to, but also prompted by a second circular in the same year which asked Directors of Social Service to complete a questionnaire on their local situation, particularly in regard to the organisation of Area Review Committees, by the end of 1975 (DHSS 1974c).

In the Wandsworth, Merton and Sutton Area Health Authority an Area Steering Committee had already been established and a two tier system was consequently developed. The Steering Committee covered the whole of the Area Health Authority, but three separate Borough Review Committees were established to deal with the three constituent boroughs. Although each had members who also sat on the Steering Committee, they functioned as separate entities and it is with the Merton Borough Review Committee that we are concerned.

The first meeting was taken up with deciding who should serve on the Committee and what its terms of reference should be. The composition was heavily weighted towards the health professionals. Eight doctors and nurses attended the meeting, four more sent their apologies and three more were proposed for future membership. (The group included two General Practitioners). Social Services, by contrast, were represented only by the Director and Deputy Director (BRC minutes 6.12.74). As has already been pointed out, this proportion was by no means unusual or unexpected. In fact, over the years, the situation in Merton became more balanced, largely because the medical staff were often too busy to attend in force. However, it meant that child abuse was largely interpreted in medical terms, even though the

Committee was hosted and serviced by Social Services, who also, after 1978, chaired the meetings.

That first committee bound itself to quarterly meetings, although over the next 7 years they only actually achieved this in one year (1976). (In practice they averaged 2.3 meetings a year and in 1979 and 1980 only met once in each year). A register of children considered at risk had already been started sometime before by the Social Services Department and statistics culled from this were to be a regular feature on the agenda of each meeting. At this first meeting, another topic, which was to recur regularly over the years, was raised and Item 8 of the minutes records:

> "It was agreed that the Merton Director of Social Services should consult with such sub-groups as may be necessary in the framing of revised Notes of Guidance for general application within the Merton Review Committee area" (Ibid, item 8, original emphasis).

In practice, it appears that the individual agencies, notably the nursing staff and Social Services already had some written internal procedures and there was from time to time discussion about trying to amalgamate these or expand them into something generally applicable. For example, the minutes of the meeting on July 5th 1976 recorded that it was said "it would be useful to send to local authorities who have hospitals in their area to whom (sic) Merton children could be admitted, a combined statement of the nursing procedures, medical procedures and Social Services procedures" (BRC minutes 5.7.76, item 8c). It seems unlikely that this was done, since the minutes of the next meeting record "The Area Manager expressed the hope that one day a common definition of procedure could be agreed. The Specialist in Community Medicine replied that the Steering Committee did agree the criteria. The Deputy Director thought an attempt should be made to weld the three documents together" (BRC minutes 4.10.76, item 5). What did happen at the meetings, however, despite the small representation of Social Services personnel (or perhaps even because of this), was that at six out of the sixteen

meetings held between December 1974 and March 1981, the Social Services Department's internal Procedure Order and various proposed revisions or amendments were discussed in detail. Medical procedures were never formally discussed. In September 1975, the Area Health Nursing staff tabled their procedures, amid comments that the Committee thought they were "very good" (BRC minutes 1.9.79, item 6). Comments and discussion were to be asked for in six months time, but this was not done and they were never directly mentioned again.

Over the years, attendance at the Review Committee became erratic, meetings were postponed and items on the agenda not discussed because those who had asked for their inclusion did not attend the subsequent meeting. The statistics were regularly presented but the format in which this was done was changed several times so that comparisons were difficult. Moreover, they contained little but numbers of children's names added to or removed from the register. Questions about underlying trends seem not to have been asked (and when a request was made for a breakdown of social class it was held to be too difficult to answer) (BRC minutes 4.10.76, item 4 and 7.2.77, item 3ii). There did not appear to have been any attempt to analyse the figures or to consider what was concealed by the fluctuating numbers. Apart from the question referred to above, no comment on the statistics is recorded in the minutes of the various meetings.

On September 24th 1979, the Review Committee met. Item 9 of the minutes is headed "A Common form of notes for Guidance in Non-Accidental Injury" and reads as follows:-

> "The Deputy Director of Social Services asked whether the committee considered it was now time to consolidate the three sets of guidance notes on NAI into one booklet for issue to the borough and the Area Health Authority. He said the Committee should by now be fairly clear about the policies and how they are to be carried out and with new staff being appointed they should also be clear about it.

> It was agreed that the Chairperson should raise this matter with the Steering Committee and it was suggested that the Specialist in Community Medicine should be asked to carry out this task" (BRC minutes 24.9.79, item 9).

However, this meeting also decided that there was little point in meeting so frequently and the date for the next meeting was fixed for a year later (Ibid, item 10). Two months later, the Darryn Clarke report was published and recommended, inter alia, that Review Committees should meet frequently enough to be effective and, in particular, said that they regarded "times when annual meetings were appropriate as being extremely rare" (DHSS 1979, Para 230). At the meeting a year later, this advice was noted and more frequent meetings were again scheduled, although the next one was for a date six months ahead (BRC minutes 22.9.80, item 10). On the subject of the guidelines, it was recorded:

> "At the previous meeting it had been agreed that the Deputy Director should raise the question of consolidating the sets of guidance notes ... at the next Steering Committee meeting. Unfortunately he had not been able to attend the meeting." (Ibid, item 3).

The paediatrician who had proposed the annual meetings had not been able to attend this meeting but he was present at the next one in March 1981. The question of the frequency of meetings was again raised and this, coupled with advice from the Steering Committee that it, in the light of Health Service reorganisation, would cease to function in its present form and that all responsibility would therefore fall directly onto the individual boroughs, led to a lengthy and frank discussion on the "Review Committee's function, its influence on practice, on training and on procedures" (BRC minutes 2.3.91, item 4). It is clear, reading between the lines, that considerable dissatisfaction was expressed. (Earlier in the meeting the Deputy Director of Social Services had said "no progress had been made in getting a common form of guidance. Working with all three boroughs will now be on a very formal basis and we shall become the

Steering Committee as well as the Borough Review Committee. This was the way we should work towards common guidance notes and procedures but it would not be quite as easy as when we had a committee managing the whole thing." (Sic!) (Ibid, item 3b). Returning to the subject of the guidelines within the discussion on the purpose of having meetings at all, it was noted "The Committee had expressed a desire to have guidelines which were applicable to all professionals concerned with NAI and which were simple and straightforward. This had not been achieved" (Ibid, item 4).

Various suggestions of possible activities were made but it was clear that there was a general feeling that the Committee had lost its sense of direction and purpose and that its future existence was being questioned. The solution adopted, in time-honoured fashion, was to appoint a "small working group with the following terms of reference:-

1. to consider the remit of the Borough Review Committee as set out in DHSS circular LASSL (74)13 and Memorandum of Guidance
2. to consider the presentation of statistical information in a more informative manner
3. to prepare the basis of a research project into work on NAI to date
4. to consider how the preventative work could be enhanced" (Ibid, item 4).

Six members were proposed and agreed to serve. They consisted of three health service personnel (two doctors and one nurse), one representative of Social Services, an NSPCC inspector and a police inspector. They were asked to meet soon and to report back to the next meeting of the Borough Review committee in September, 1981 (Ibid, item 4).

The Working group met for the first time on April 27th, 1981. They coopted one further member - myself - on my return from the NSPCC post-qualifying course. At the time of the first meeting, the minutes of the Review Committee were not available (in fact they were, owing to the illness and then retirement, of the Chairman, only circulated

shortly before the September meeting). There was consequently a certain confusion about the working party's brief, although those present at the Review Committee meeting clearly remembered the tenor of the discussion. The minutes of the first meeting of the Working Party, therefore, recorded what they saw as their remit as follows:-

"1. Presentation of statistical information
2. Operational guidance to staff in all disciplines involved with non-accidental injury.
3. To consider how preventative work could be enhanced.
4. Consider the criteria for reporting cases to the Review Committee" (BRC Working Party 27.4.81).

It will be observed that, although these are broadly in line with the original suggestions, the instructions to look at the purpose of the Review Committee and to prepare the basis of a research study are not mentioned. Instead, the subject of the guidelines is specifically placed on the agenda. From this meeting stems the present study. Producing the Guidelines became the preoccupation of the Borough Review Committee (and its purpose was not further questioned). The question of the presentation of the statistical information led to the realisation that, contained in the information held on the Register, there was a wealth of untapped material about children at risk, with considerable implications for the way such cases were handled and the resources needed to deal with them. The research project proposed by the Review Committee (and apparently overlooked by the Working Party) came into being anyway and that and the Guidelines form the basis of this study.

The Literature and other Research Studies

It will already be apparent that the DHSS memoranda of guidance issues in 1974, 1976, 1980 and 1988 provided important background reading. So did the reports of various inquiries, notably the ones on Maria Colwell, Malcolm Page and Darryn Clarke (DHSS 1974a, Essex 1981, DHSS 1979). In 1982 the DHSS issued "Child Abuse - A Study of Inquiry

Reports, 1973-1981 (DHSS 1982). This is an extremely useful discussion of 18 different reports, which analyses the features and procedural problems most frequently found. "Child Abuse: Aspects of Inter-professional Cooperation" (Hallet and Stevenson 1980) is a study particularly concerned with Case Conferences, but it also contains comments and valuable insights about Registers, Area Review Committees and procedural guidelines. "The Protection of Children" (subtitled "State Intervention and Family Life") (Dingwall, Eekelaar and Murray 1983) is a "careful ethnographic examination of how agents of the state identify, investigate and intervene in cases of abuse" (Ibid, Foreword, viii) which also discusses the work of Case Conferences and has a whole chapter on Area Review Committees, including a detailed description of the attempt by one county ARC to rewrite its procedural handbook (Ibid, 134-143). As happened in Merton, the topic featured regularly on the agenda over a period of years, and the booklet had still not been compiled when the study finished.

The most important books describing child abuse, its aetiology and its management are still those of Henry Kempe, notably "Child Abuse", written with his wife Ruth Kempe (Kempe and Kempe 1978) and "The Battered Child" which he edited with Ray Helfer. The third edition of this standard work was issued in 1980 and contains 26 chapters by medical specialists, social workers, psychologists, anthropologists, sociologists and lawyers. Although written primarily for the American scene, it nevertheless contains much that is important and relevant for the British practitioner. (Kempe and Helfer 1980). A less wide-ranging, but practical and useful book, written especially for practitioners in this country is "Understanding Child Abuse" edited by David Jones, which first appeared in 1982 and was reissued in expanded form in 1988. During the period while the study was being written up, several books appeared, in addition to various inquiry reports - notably those into the deaths of Jasmine Beckford (Brent 1985) and Kimberley Carlile (Greenwich 1987) as well as the "Report of the Inquiry into Child Abuse in Cleveland 1987" (DHSS 1988a), which was followed by the DHSS manual "Working Together - a guide to

arrangements for inter-agency cooperation" (DHSS 1988b). All these were important, but of the other books which appeared during the course of the study, the most helpful were "Working with Child Abuse" by Brian Corby, which contained some useful comparative figures on abusing families (Corby 1987) and Cooper and Ball's "Social Work and Child Abuse" in the Practical Social Work series, which covers much of the same ground as David Jones' book but in a fresh and helpful manner (Cooper and Ball 1987). It aims "to restore a sense of perspective" (Ibid, back cover) and largely succeeds in this aim, while providing a helpful practice guide for practitioners and saying some sensible and helpful things about Registers and the management of child abuse. Nigel Parton's "Politics of Child Abuse" is, as one might expect from the title, more polemic and has some hard things to say about the greater likelihood of working class children being registered than their middle class peers (Parton 1985) - an assertion that was not totally born out in the present study. Many of the other books which appeared during the period of the study were concerned with child sexual abuse and thus of little relevance to the current study, although they were of vital importance to the revision of the Guidelines which was being carried out as this study was being completed.

Only Dingwall, Eekelaar and Murray describe attempts to produce procedural guidelines and therefore I found their book particularly interesting and helpful, when considering how the negotiations progressed, although they, of course, do not deal with the content of the Guidelines. Two American books, which describe themselves as manuals, contain interesting and helpful advice and suggested topics which Merton's guidelines eventually incorporated. But "Social Work with Abused and Neglected Children - a manual of inter-disciplinary Practice" (Faller 1981) is 250 pages long and "The Child Protection Team Handbook - A multi-disciplinary Approach to managing Child Abuse and Neglect" (Schmitt 1978) is over 400 pages. Neither, therefore, is the concise guide intended to be of practical help to a busy practitioner that Merton hoped its guidelines would be, although they are useful reading for the specialised

practitioner or anyone charged with coordinating child abuse practice.

Procedural guidelines produced by other Area Review Committees will be dealt with later in more detail, but they are many and varied and much thought and ingenuity has clearly gone into their production. Some are serious instruction booklets, others use different coloured or sized paper to draw attention to different topics. There is considerable overlap in their contents as one would expect and whole sections are often identical with other areas. Another factor is that many would appear to have been produced by committees or by people principally concerned with management. For example, several contain lists of the Area Review Committee membership, which is hardly the first piece of information needed by a Health Visitor or Social Worker faced with suspicious bruises on a child. The DHSS manual "Working Together" (DHSS 1988b) charged Area Child Protection Committees (the successors to Area Review Committees) with reviewing and revising procedural handbooks, giving considerable advice about the content of such Guidelines, but this was not, of course, available at the time the guidelines were first being written.

No complete study of the extent or incidence of child abuse in this country existed until this study was being completed, when the Department of Health published the first national survey of Register statistics (DoH 1989). This refers to the situation in March 1988, a period five years after the completion of the data from Merton's Register. Moreover, the difficulty which has always beset the comparison of Register statistics persists, in that there are no nationally agreed criteria for defining child abuse or the cases which should be registered. The DHSS recommended some in 1980 (DHSS 1980) and again in 1988 (DHSS 1988b) but they have not been universally adopted. There are no mandatory reporting laws in this country (as there are in parts of the United States) and, even if there were, it is a commonly held belief that there are far more cases of child abuse than ever get reported. Even the number of child deaths due to abuse is hotly debated as was shown by

the articles and correspondence in the Guardian newspaper in November 1983, following NSPCC claims that 63 children died and 50,000 were injured each year at the hands of their parents (Guardian 30.11.83, 7.12.83, 14.12.83).

The NSPCC have produced four studies based on the information available from the Registers run by their Special Units throughout the country (NSPCC 1975, 1977, 1980 and 1984). In 1984 they calculated that these covered 10% of the child population and they provide some helpful comparisons. There are problems in that the registers that the studies are based on did not all use the same criteria for registration, nor is the information they contain directly comparable in other respects. For example, the NSPCC studies do not mention de-registration, Case Conferences or Keyworkers. Nor is there any attempt to relate the facts and figures to the particular area concerned. That is understandable and reasonable: the NSPCC studies, and particularly the most recent one, Trends in Child Abuse, was aiming to give a picture of the national scene (NSPCC 1984,6).

I was able, in the course of this study, to get access to two unpublished studies based on information culled from particular child abuse Registers. One was a study of child abuse referrals and initial Case Conferences in the London Borough of Lambeth, (Lambeth 1982) the other concerned children on the register in Strathclyde (Strathclyde 1982) but was based on a questionnaire sent to social workers, rather than on the information directly available from the register.

The part of the present study, therefore, which is concerned with the data available on Merton's Register is not directly comparable with any other studies. It does not seek to describe the national scene (although, where appropriate, comparisons will be made). It is instead an attempt to describe the kinds of families, children and situations which gave cause for professional concern about the possibility of child abuse in one London Borough between 1970 and March 1983.

The other part of the study - the attempt to chronicle how the same London Borough eventually produced a handbook of guidance for practitioners - follows on from where Dingwall, Eekelaar and Murray's description leaves off: with the actual writing and production. I am aware that a four year study of child abuse procedures in a local authority was carried out by Roger Bacon and Iain Farquahar, while they were with the Child Care and Development Group at Cambridge, but unfortunately their work has never been published, and the accounts of it that have been made available - through lectures and reports - have concentrated on discussing the way Case Conferences and social workers followed these procedures, rather than on their work on "how procedures for dealing with and defining child abuse were derived" (Bacon and Farquhar in BASPCAN News 13, 1984, 4).

6. Outline of the Study

As has already been explained, the present study arose from the deliberations of the Working Party appointed by the Borough Review Committee in 1981. That Working Party only met on two occasions, but it immediately became clear that, in order to produce practical guidelines that were designed for local staff, it would be necessary to look, not only at similar guidelines produced elsewhere, but also at the actual situation in Merton with regard to abused children. A study of the register would, hopefully, produce information about the type of children abused, their families' problems, the reasons they were registered, how long for and who had expressed the first concern. This information had considerable implications for the contents of any guidelines. Conversely, any attempt to produce criteria for registration or to draw attention to worrying signs and symptoms was bound to affect the numbers of children registered.

a. Methodologies

Two very different methodologies were needed. The guidelines had to be written, discussed, negotiated through

committees, seen into print and put into use. Simultaneously with the negotiations, individual draft sections had to be piloted to discover whether they were practicable and helpful, in addition to being acceptable, in theory, to committees. Before any writing was done, an analysis of five other procedural handbooks was made. Based on this analysis, a preliminary list of topics to be covered was drawn up and drafting began. In response to discussions with working practitioners, to the questions which arose from the training sessions with which I became increasingly involved, other areas of concern were identified, material drafted and tested out. The first draft was already complete when a neighbouring borough expressed an interest in sharing in the production, thus necessitating a fresh round of consultation and revision. When the script was complete there was still layout and design to be considered and the draft then prepared for the printer. Once the printer had produced the final copies, they had to be distributed, introduced and explained, with several training sessions to ensure that practitioners of all the agencies involved were clear about the contents of the guidelines and how to use them. Clearly, most of the work necessitated considerable activity, but it was felt that by carefully observing and recording this activity, the lessons which were learnt in Merton could be made available to others, who might wish to undertake a similar project.

The production of the Guidelines involved action in creating a manual where none had been before. The theory of action research normally postulates both researchers and action people - the researchers identifying the key areas where action needs to be taken and the action people devising and implementing new developments. In this instance, the research - both studying other peoples' guidelines and analysing the data on the Register were done by the same person who was largely responsible for writing the guidelines. Nevertheless, the production of the guidelines would not have been possible without several key factors which have been identified as criteria for planning action-research. (For a summary of these criteria, I am indebted to a paper prepared by Geoff Poulton of Southampton

University). Firstly, there needs to be a cause, which motivates a commitment to take action. The cause, in this case, was abused children and the need to devise practical and helpful tools for front line professionals working with them. There need to be resources which enable the action to take place. In this case, the resources were partly human, partly financial. A small group of people, with a commitment to improve services and the knowledge of what was needed, encouraged me to write and produce the Guidelines. The financial provision to make their publication possible was forthcoming partly from joint Social Services and Health Authority funds and partly from the University of Southampton whose participation in publishing and marketing the Guidelines made a far bigger print run possible. The need to demonstrate effective strategies was met by the piloting of sections of the Guidelines in draft, which was sufficiently successful to increase the pressure to complete the project. The political power, sympathetic to the action which makes the latter possible, was provided by both councillors and senior management who, constantly fearful of a child abuse tragedy, were anxious to improve standards of service and to be seen to be taking the problem seriously. Geoff Poulton also speaks of the need for a "desire to measure outcomes effectively" (Poulton 1976). That was less obvious in this case. There certainly was a general hope that "things would improve" with the production of the guidelines, but there were no plans formulated to try to measure any improvement. But perhaps this arose indirectly with my subsequent appointment as Custodian of the Register, with a brief to monitor "adherence to procedures" (i.e. to those procedures which were laid down in the Guidelines). Somewhat surprisingly, Poulton puts the need for a theoretical base for action last. The theoretical base in this case was surely the DHSS direction, already several years old, for Review Committees to produce written guidance, coupled with the evidence which came from the inquiry reports and from the research generally, that work with abusing families was more likely to have a successful outcome if it was undertaken within a clear framework of agreed procedures (DHSS 1982 passim).

The examination and analysis of the Register required a very different approach. The Register in Merton was, at that time, kept on a set of cards in a metal card index file. There were just under 350 cards, referring to both active and inactive cases. They contained basic details of names, addresses etc and some narrative about events. Each of the cards was examined and a questionnaire was drawn up, covering the basic factual data which was supposedly recorded, together with items about the reason for registration and the history of the time spent on the Register. This questionnaire was filled out on behalf of each family (but not each child) on the Register, the answers were coded and transferred to computer. (In order to preserve confidentiality, each case was assigned a number.) Twenty six different variables had been identified and the computer programme allowed these to be counted, analysed and compared in different ways. (A blank copy of the questionnaire can be found in Appendix A).

The methodology for dealing with the register data was, therefore, one commonly used when studying material contained on index cards, although the presence of narrative material allowed for some extra flexibility. No attempt was made to go back to original casework files, partly because of the numbers involved and the consequent time factor, but principally because the aim was to analyse the material available on the Register itself. For one or two factors (notably the previous Social Services involvement with a family and any subsequent legal proceedings), the information was double checked, for the first 100 cards examined, against the Central Index of cases which was also kept, like the Register, at Social Services Head Office. (In fact this proved time-consuming and added little extra information.) In one or two cases, where the information given in the Register was ambiguous or clearly wrong (e.g. the child's gender was not given and could not be determined form the forename or a date of birth was clearly inaccurate) the cards were again checked against the Central Index. Apart from these checks, the data used in this part of the study was essentially that contained on the Register at the end of March 1983 and would, therefore, have been available

(with permission) to anyone wishing to look at the format and content of a Child Abuse Register.

b. Summary of contents

The two chapters which follow this introduction deal with the Register, the way it was kept and the information it contained. They include an attempt to draw from these findings some conclusions about trends and patterns in Merton as well as trying to produce a profile of the sort of children and families, who caused concern. Patterns of referral, types of abuse, the length of time spent on the Register and the reason for Deregistration, where known, are examined. Where possible, the findings are related to the wider scene by comparing them with such other studies as are available. In particular, an attempt is made to determine whether numbers on the Register were affected in any perceptible way by events elsewhere. Because of the quantity of material in these chapters, each section, and in some instances, each subsection, is briefly summarised, in addition to a concluding summary for each chapter itself.

The following chapters describe the writing of the Guidelines and their content, the problems encountered in negotiating them through meetings and into print and the reasons for the choice of format. (A copy of the actual booklet produced is included in a back pocket). These chapters are shorter and do not contain so much detailed material so there are no sectional summaries, only a concluding one at the end of each chapter.

The final chapter summarises the lessons learnt and the application of the findings, as well as describing the developments which followed even before the study was written up. Areas for further study or future research will be suggested and an attempt made to evaluate any wider issues involved.

CHAPTER II THE CHILD ABUSE REGISTER

1. Introduction: Central Register Systems

Registers of children considered to have suffered - or to be in danger of suffering - abuse at the hands of their carers, have been known over the years as At Risk Registers, Non-Accidental Injury Registers (often shortened to NAI Registers), Central Registers or Child Abuse Registers. (At the time of writing, the latest DHSS advice is to designate them Child Protection Registers (DHSS 1988b. Para 5.30).) In Merton, the Social Services department fluctuated between At Risk Register and NAI Register, although, colloquially, it was often referred to simply as The Register (ignoring all other registers, such as that recording the names of the physically handicapped).

This confusion about terminology is reflected in confusion about the purpose and content of the registers. The 1974 DHSS circular stated simply that "a central record of information in each area is essential to good communication among the many disciplines involved in the management of these cases", (DHSS 1974b para 17) but gave no specific guidance about either the sort of information it was envisaged should be recorded or the criteria for inclusion on such a record. By 1976, the next DHSS circular was directing that "All areas which have not yet established a central register should now do so." (DHSS 1976 para 17). (This piece of advice was not followed in the Wandsworth, Merton and Sutton area - each constituent borough kept its own register.) The same circular recognised that existing registers varied "greatly in comprehensiveness ..., access to those outside and criteria for inclusion" (Ibid para 19) and gave examples of these variations. It recognised too that "criteria for inclusion are themselves a problem" (Ibid para 23) and, in an attempt to "establish some minimum requirements" to be "satisfied by all register systems" (Ibid para 23), advocated that they should contain details of injured children up to the age of 16, that they should be kept on an area basis (i.e. an area co-terminous with Area Review Committee boundaries), that certain basic data (which

was specified), should be included and there should be a built-in procedure for regular review (Ibid para 23).

The 1974 circular talked only of physical injury to children. By 1976, there was a recognition of other forms of risk, which, although not precisely defined, were clearly seen as different in both nature and degree from physical injury. Entries on the Register "relating to children who are known to have been injured should be clearly distinguished from those entries which concern children, who for whatever reason (e.g. neglect, failure to thrive) are believed to be at risk but where non-accidental injury has not been proved" (DHSS 1976 para 23.v). Moreover, authorities were warned that, before they decided what to include they "should consider how to ensure that the children believed to be in the greatest danger will be recorded without entailing an unrealistic workload in the review of cases" (Ibid para 23.i). It was not until the 1980 circular that forms of abuse, other than physical injury, were recognised as being as potentially serious and damaging in their after-effects as bruises and fractures. Authorities were then asked to "consider for registration" (DHSS 1980 para 2.2) children who had suffered from physical injury, physical neglect, failure to thrive, emotional abuse or who lived in the same household as a person previously involved in child abuse. (The circular was much criticised for not adding sexual abuse to this list, but it was argued that this would "raise complex issues" (Ibid para 2) - which were not specified - and it was not until 1986 that sexual abuse was "brought into the system" - and, in fact, rated a whole chapter in the draft guide "Working Together" which accompanied the draft circular issued that year (DHSS 1986 a. and b.).

There was never any advice about the form that the register should take. Its confidentiality was to be carefully guarded (DHSS 1976), it was to be maintained by a "designated officer" (Ibid Para. 22), who, by 1980 was described as a "custodian" who "should, where possible, be a senior officer with considerable experience in the field of child abuse" (DHSS 1980 para 3.1). The data to be included

was also specified (in 1976, 1980 and 1986). But authorities were left to devise their own method of recording this and of finding a suitable format.

2. Merton's Register

a. Criteria and Categories

The earliest entries in Merton's register dated from 1970, four years before the first mention of central records in a DHSS circular. The departmental Procedure Orders, which were issued within the Social Services department over the years, advising social workers what action to take when faced with cases of alleged child abuse, were revised several times, generally in the wake of a new DHSS circular. The earliest version to survive is dated 20 November 1974, but indicates at the beginning that it is a revision, so clearly there had been an earlier version or versions. (For copies of the Procedure Orders issued between 1974 and 1980, see Appendix B.) (In the absence of any Guidelines, the Social Services Department's Procedure Orders are the only written record of prescribed practice in the Borough.) Like the circulars, it was not until 1980 that Merton made any attempt to define precisely the criteria for inclusion on the register (and then it simply followed the DHSS definitions). But Merton did give detailed instructions about the various categories of seriousness under which registrations were to be recorded. (Presumably this was to try to fulfill the instruction to "clearly distinguish" those children who had been physically injured from those who were "at risk" (DHSS 1976 para 23.v) - although this was not how they worked in practice.)

Initially, there were to be four categories:

"A) Where there is certainty that non-accidental injury has occurred.

B) Where there is near-certainty that non-accidental injury has occurred.

C) Where injury has occurred and there is reason to suspect that it may be non-accidental.

D) Where there is no evidence of injury but certain of the factors associated with the "battered baby syndrome" have been clearly identified" (Procedure Order I, 1(2)d, Appendix B).

The difficulty of distinguishing between these definitions clearly made them unworkable in practice and, by 1976, they had been reduced to three by amalgamating the first two (to "where there is certainty or near-certainty ...") and altering the fourth one to read "Where there is no evidence of injury but certain of the circumstances in which non-accidental injury is likely to occur have been identified or are suspected" (Procedure Order 2, 1(2), Appendix B) (my emphasis). Clearly Merton, like the DHSS, was principally concerned with physical abuse. Neglect, emotional abuse or failure to thrive are not mentioned. The "certain circumstances" of the last category are those which are seen as likely to lead to physical injury. But the ambiguous drafting of the last few words - it is unclear whether it is the injuries or circumstances which may be suspected: a strictly correct grammatical interpretation favouring the latter - opens up the possibility of registering almost any child about whom a professional may be concerned for whatever reason. Yet, it was not until 1980, following the DHSS circular of that year, that Merton officially (i.e. in Social Services' operational instructions to staff) recognised neglect, failure to thrive and emotional abuse as criteria for registration in their own right (Procedure Order 3, 1(2), Appendix B). In 1984, sexual abuse was officially added to the list - two years ahead of the DHSS advice to do so (Guidelines, Section 2.1.e). But the first case of sexual abuse had been registered in 1975 and one of emotional abuse in 1972!

Indeed, as will be seen shortly, although the great majority of children, whose names were placed on the Register, were held to have suffered or be at risk of physical injury there were also a considerable number who were held to be at risk for other reasons and their names were included on the Register as well. (This makes direct comparison of some of the findings of this study with the NSPCC studies difficult, since some of the Special Units, on whose registers the

earlier NSPCC statistics were based, only registered physical abuse. While it is possible that they too had a discrepancy between theory and practice, that is not acknowledged.)

The failure to keep strictly to the criteria for registration also extended to a failure to categorise the registration according to the procedures laid down. Early on in my examination of the Register, it became clear that a few cases were registered Category I (i.e. "where there is a certainty or near-certainty that non-accidental injury has occurred") where no one was suggesting that the child had been hurt in any physical sense, but where the professionals were worried about a child's development or the unsatisfactory conditions in the home. Conversely, some cases were registered as Category III ("where there is no evidence of injury but where certain of the circumstances in which non-accidental injury is likely to occur have been identified or are suspected") when there was clear evidence not only that an injury had occurred but that it had been deliberately inflicted. (The most extreme example of this was one case, registered in Category III, where a father had actually pleaded guilty in Court to a charge of causing his daughter Actual Bodily Harm.) (It is tempting to speculate that what happened in practice was that the allocation of category reflected, not factual certainty about the nature of an injury, but the degree of anxiety evinced during the Case Conference - thus a situation in which abuse was openly recognised could be seen as less worrying that one in which parents refused to acknowledge any problems or the possibility of abuse. This could form an interesting topic for a future study.) The identification of this confusion led to the further reduction in the Guidelines, which form the other part of this study, of the number of categories. There are now only two categories in which different types of abuse may be registered:

1) actual, know, identified abuse
2) anxiety about, fear or danger of possible abuse.
(Guidelines, Section 6.2)

Further research would show whether this proved any more satisfactory in practice and therefore more likely to be

adhered to. There is some evidence that there is less confusion, but that there are still occasional mismatchings. (Cases which arouse particular anxiety are still most likely to be registered Category I, regardless of whether it is possible to prove abuse has taken place.)

b) The Actual Register

At the point at which this study took place, Merton's Register took the form of a card index, filed in a steel box. (Legend within the department had it that the original registrations had been kept in a cardboard box on the window-sill of a ground floor office and that it was only as a result of the emphasis on confidentiality in the 1976 DHSS circular, that it was moved away from the window and into a locked container!) The steel box, clearly labelled "non-accidental injury" was kept on the desk of the Assistant Director's personal secretary. (It was kept locked at all times when not actually in use, but the key - also clearly labelled - was in the drawer directly below. This drawer was not normally locked.)

Within the steel box, at the cut-off point of the study - March 1983 - were 348 cards. They were filed in several sections. The main division was between Open and Closed cases. Within the Open section, there were four sub-divisions by Area Office responsible for the supervision of a case. (A case would initially be allocated to the Area Office within whose geographical boundaries the family lived, but, if the family moved from Wimbledon to Mitcham, for example, the Wimbledon office would normally retain responsibility, at least in the short term, and therefore the case would still remain in the Wimbledon section.) Within the Closed section there were two main sub-divisions each further sub-divided into four. The first Closed sub-division was for those cases closed within the past year, in sub-section by Area. The second was for all the other closed cases, again sub-divided by Area.

This system of filing the information made sense if the principal aim was to compare quickly the number of cases

carried by the different Area teams, but it made answering a query about an individual child complicated and time-consuming. One of the primary purposes of registers is to be available to professionals who may be faced with a possible case of child abuse and wish to ascertain whether there have been previous concerns about the child and, if so, who is dealing with the family. To answer such a query, the Custodian of the Register might have had to check each section in turn. Obviously, the search would begin with the sections dealing with the area in which the home address was geographically located - first the Open section, then the Closed One Year, then the Long Term Closed. If nothing was found, it was possible the family might have moved, or that the address given was incorrect, or that the family were being dealt with by an Area team in whose catchment area they no longer lived. In theory, all 12 sub-sections might have to be checked before a definitive answer could be given. It is hardly surprising that, over the years, few inquiries were made and also perhaps as well that those that were made would have been dealt with on a call back system - officially to check the bona fides of the caller, but in practice probably greatly reducing their telephone bill.

Of the 348 cards in the box, twenty should not have been there. The decisions recorded on them indicated that Case Conferences had decided NOT to register. Nevertheless, the cards, with full details of names, addresses etc. had remained within the Register box. (For the purposes of this study, they were ignored and the data gathered from the remaining 328.) When one realises that there were 14 cases which were subsequently deregistered, because it was considered the original assessment was wrong, almost 1 in 10 (9.77%) of the cards contained in the box referred to families were child abuse was believed not to have taken place.

The cards were completed by hand (and some were consequently easier to read than others). All contained a family name and address in the top left hand corner. On the right there were details of the person originally referring the child, the name of the current keyworker, the General Practitioner

(if known) and the Health Visitor. Below the family composition was given in detail. Supposedly, the names, ages and occupations of both parents were entered, although frequently these details were incomplete and, in some cases, missing totally. Then the children's names, with their dates of birth, were given, generally, although not always, in order of age. Those of the children, who were the subject of concern and whose names were being placed on the Register, had their names underlined in red and a note of the category of registration placed alongside.

Under these details was the date of the first Case Conference and a brief resume of the reasons for concern and the decisions made by the conference. Following that there were dated entries for review conferences, court hearings etc with a note of their outcome. A varying amount of detail was given about each of these events. The earlier cards were filled in by the then Deputy Director himself, who clearly made the notes largely for his own benefit and often in his own form of shorthand. Most of the cards were, however, completed by a series of secretaries or clerks, working from the minutes of Case Conferences, but often clearly not completely sure what was relevant to record in summary. Consequently some of the cards had several pages of addenda stapled together. Across the top of the card was pencilled the date when the hospital and the children's home holding duplicated copies of the Register had been notified. (These duplicates were for consultation out of office hours and were kept in abbreviated form, recording only basic data about names and addresses, together with the name and contact point of the Keyworker.) When the case was removed from the Open section, the date of deregistration was similarly recorded with a note that the duplicate registers had been amended accordingly.

There was, therefore, a considerable amount of information available on the register, which was generally speaking only seen by the secretary to the Assistant Director or, occasionally, by the Assistant Director himself. The secretary was responsible for abstracting from the Register, the quarterly statistics for the Borough Review Committee.

(These consisted of the numbers and ages of the children on the Register and the different categories in which they were registered). Apart from preparing the statistics, the secretary was the person who would normally answer any queries from people with a "bona fide reason to know" (Guidelines, Section 6.3) whether a child's name was on the Register (generally a doctor, head teacher or social worker from another agency). The inquiry should, in theory, have come to the Assistant Director as Custodian of the Register, but, as it was dealt with on a call back system to ensure confidentiality, his secretary would normally check the Register and supply him with the information - generally a simple negative or affirmative, plus, if relevant, the name and contact point of the Keyworker. On occasion, the secretary herself would return the call.

It appeared that no card had ever been removed from the Register, even when the case had been closed for several years. While one may have certain reservations about the accuracy of some of the entries (some of these have already been detailed, such as the confusion over categories, others will be referred to in the detailed findings presented later), it nevertheless remained a record of 328 families about whose handling of their children, professionals felt sufficient concern, whether reasonably or not, to consider that those children were at such risk of injury or lasting damage (or, in many cases had already suffered injury or lasting damage) as to warrant inter-disciplinary discussion and regular monitoring. This record therefore predated and also spanned, a period which included the issue of the major DHSS circulars, the public concern following the Maria Colwell case and the other public inquiries and the heightened professional anxiety that these caused. It was a period when a great deal was written about the problem - and during which there was an increasing awareness of the lasting damage that can be caused to children by more insidious forms of mistreatment than physical violence. It was also a period, when many children's names were placed on Registers and much information was recorded. But comparatively little of it has been analysed and most of the studies which do exist refer to the inner city areas of

Strathclyde or Lambeth or the conurbations covered by the NSPCC Special Units.

All the information contained on the individual cards was, of course, available elsewhere, for example, on the files held in the Area Offices. But only on the Register was the information gathered together in one readily accessible place and identified as related to a common problem. Until the present study, no attempt had been made to analyse the information (apart from collating the quarterly statistics). This study tries to do this and to look for underlying trends, to consider any relevance for resource planning and to see if there are any lessons to be learnt which might contribute to an improvement in the professional assessment or handling of cases of child abuse.

c) Three Caveats

In looking at the information contained on the Register, I was constantly aware that what was being recorded was the names of children about whom professional concern was felt over a set period. Some of these children had, without a shadow of doubt, been physically injured by their parents - others were clearly in considerable danger of being injured. All were the focus of professional attention. It is impossible to say how many other children suffered - or were in danger of suffering - during the same period but never came to the notice of the professionals. There may have been only a few or there may have been many: one will never know. It must, therefore be clearly recognised that any statistics, or conclusions from these statistics, refer to children and families whose names were placed on the Register and considerable caution must be exercised about making any generalisations about abused children as a whole. It is perfectly fair to say (in relation to the Merton figures) that more children were thought to be at risk following the Maria Colwell inquiry and report. It is not fair to say that child abuse in Merton increased following the Maria Colwell case. What is being measured is awareness of a problem, not necessarily the extent of the problem itself. As Cooper and Ball say, in a book that was

published as this study was entering its last stages: "At Risk registers register concern rather than incidence of child abuse ... and their recorded figures need cautious analysis" (Cooper and Ball, 1987 p.17).

Secondly, there seems to be a general confusion, or ambiguity, about whether the Registers are records of children at risk or families which contain children at risk. The DHSS circulars would appear to imply the former, without being explicit. The Family Rights lobby and those who argue that registers infringe civil liberties would appear to believe it is parents, and therefore families who are being registered. Other studies have concentrated largely on the children - the NSPCC data focuses principally on the children as does the Strathclyde study which states "a household containing four children on the register is, not one, but four cases" (Strathclyde 1982). The Lambeth study, however, like the present one alternates between the two - considering the characteristics of the children individually, but the families as units containing a number of children (Lambeth 1982). In Merton, the children from one family were all registered on one card. There were 328 cards - i.e. 328 family names - on the Register. There were in fact 531 children, who were held to be at risk, out of a total of 743 contained within those families. The study therefore looks at both children and families. For most of the analysis, in particular subjects such as type of injury, referral source, family characteristics etc, the statistics used are family ones. (Where there was any discrepancy within the family, the data was taken for the child first referred within that family). For other parts of the study, e.g. the ages and sexes of the children, the data was taken for the larger group. (In each case, the total considered is made clear.)

Thirdly, for the purposes of the analysis, the Open and Closed sections were, generally speaking, treated as a whole. (Obviously the Open section was excluded when considering de-registration.) However, for some of the data, which was either frequently missing (e.g. the age of the parents) or for which it was necessary to undertake a

search of the Head Office Central Index to supplement or confirm the information on the Register (e.g. Court Orders made) or where the collection of information was too time-consuming and what was wanted was a general indication rather than an absolute figure (e.g. the number of Case Conferences), only the first 100 cards in the Register were considered. This means that, for those topics, the Open section accounted for the greater proportion of the data and that, as on the whole they represented the more recent cases, the conclusions may be applicable to the situation current in the early Eighties, rather than to the whole period covered by the study.

Summary

It will already be apparent that there was considerable confusion surrounding both the purpose and the management of Merton's Register. David Jones has written that "it would appear that many registers were established in haste, with insufficient attention to the implications of the structure and systems adopted and to the purpose they were to serve" (Jones, Hill and Thorpe 1979,2). While there is no evidence that Merton's Register was established in haste, the confusion contained in it certainly suggests that the purpose it was intended to serve was never really thought through. There was the confused and time-consuming way it was organised, for a start. There was confusion about the criteria and categories for registration and the failure to remove cards from the Register when a case was deregistered (or even when it had never been registered in the first place) indicated a confusion about what Deregistration actually meant. Nevertheless, W.H. Ireland's comment (quoted in Jones, Hill and Thorpe, 1979, 10) that registers are "a working repository of information about reported cases" is certainly true of Merton's register. The cards in the Register contained a mass of information and it is with that information that this chapter and the next one are concerned.

3. The Register - Annual Statistics

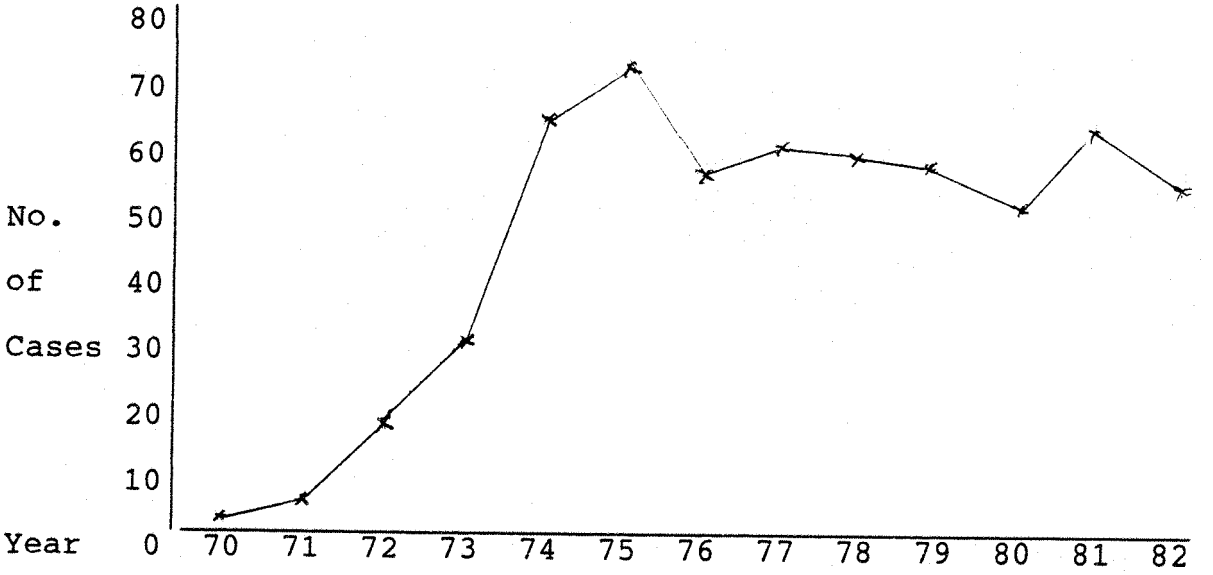
a. Total numbers - the overall picture

The first two entries on the register were made in 1970 - the year of the first DHSS circular ("Battered Babies"), addressed to Children's Officers and Medical Officers of Health (DHSS 1970). The following year there were 5 entries, in 1972 there were 11. Thereafter, the numbers built up more rapidly and after 1973 (when there were 16 new registrations), there were never less than 23 new registrations each year.

Once the numbers had built up, the actual totals remained remarkably steady. One might have expected the rising trend of the early Seventies to be maintained and numbers to continue to increase. But, as Table I, which gives the total number of families on the Register each year between 1970-1982 (the 7 cases registered in the first quarter of 1983 were excluded) shows, although there were ups and downs, the variation was only between a 1975 high of 73 and a 1980 low of 52, a spread of 19. The average number of families on the register during the 1974-82 period was 61.5.

Table 1 Annual Totals on the Register (1970-82)

(N = 321 families)



It is hardly surprising that 1975 should be the peak year or that 1974 should have been the second highest with a total of 66. 1974 saw the publication of the Maria Colwell report, following extensive publicity, and the issue of the DHSS circular which has already been mentioned several times and which established Area Review Committees, which in their turn led to the formalisation of registration processes (DHSS 1974b). Four inquiry reports were published in 1975 and one of these, the Lisa Godfrey report, was concerned with events in Lambeth, a neighbouring London Borough and therefore inevitably involving people and places known to Merton professionals (Lambeth 1975). (The other three reports referred to John George Auckland (DHSS 1975), Richard Clark (Scottish Office 1975) and Steven Meurs (Norfolk 1975)).

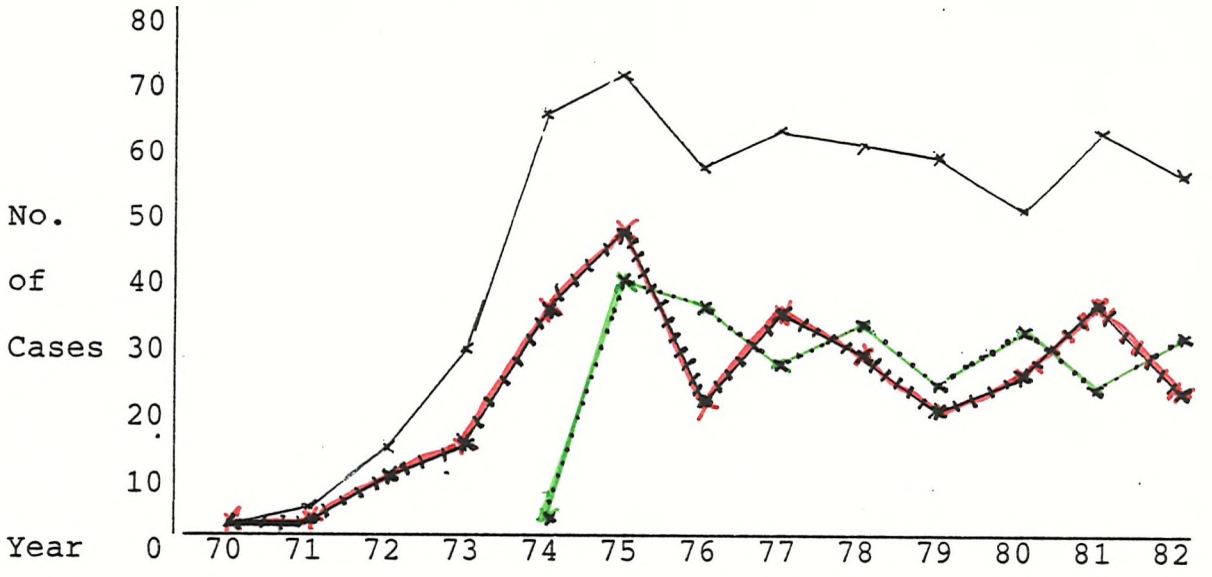
1980, by contrast, saw a dip to the lowest point for 7 years. However, this was abruptly followed in 1981 by a rise of 12, which gave the third highest total since the Register began. The NSPCC statistics for 1977-82 show a similar rise in 1981 (NSPCC 1984,4). (There had been earlier NSPCC studies but they covered much smaller catchment areas, had different criteria and are not directly comparable.) The NSPCC recorded their dip in 1979, rather than 1980, but then showed a steady rise, which, unlike Merton's, continued into 1982 (Ibid, 4-5). External events which may have had some influence on these figures, by dint of the impression they made on the professionals likely to be involved with children and to attend Case Conferences, include the publication of the DHSS circular widening the criteria for registration in the early autumn of 1980 (DHSS 1980) - its full effect would not have been felt until the winter of 1980-1 - and the publication of the Malcolm Page inquiry report in March 1981 (Essex 1981) and the Maria Mehmedagi inquiry report in June 1981 (Southwark 1981). The former dealt with an Essex case, involving a typical "problem" family and a baby who died of hypothermia, despite considerable professional involvement and aroused much anxiety among both social workers and health visitors. The latter was another inquiry to take place almost on the doorstep, so to speak - that is, in nearby Southwark. It

seems a reasonable hypothesis to suggest that there may well have been an increased awareness and concern among professionals during 1981. Further credence is lent to this theory - that events, which receive national prominence or happen in the vicinity or to professionals who may be readily identified with, would seem to have some relationship to the rate of registration - by the drop in registrations during 1980. The only external event which might have effected 1980 registrations was the publication of the Darryn Clarke inquiry report (DHSS 1979) in November 1979. This referred to a tragedy which had taken place in Liverpool and was thus likely to seem far removed from Merton. One other point may be worth making - the numbers on Merton's Register rose in 1975, 1977 and 1981. Each of these years followed the issuing of a DHSS circular. It would seem that these may focus attention on child abuse and lead to an increased consciousness of the purpose of Registers. It has been interesting to note, in this context, a rise on Merton's current Register following the most recent DHSS advice (DHSS 1988b).

b. Annual variations

Table I may imply a comparative lack of change but Table 2 shows that, in fact, there were a constant stream of additions and removals and that it was the fluctuations in these which paradoxically kept the totals comparatively steady. Between 1974-1982, there was an average of 32 new cases added to the Register each year and each time the number of new cases rose above 32, the total on the Register also rose. On the other hand, although only 3 cases were de-registered prior to 1975, between 1975-1982, the average number of removals from the register was 32.5 per year, thus making it immediately clear why the overall figure remained comparatively static.

Table 2 Annual Totals on the Register (1970-82)
with Registrations and Deregistrations compared (N = 321)



(Key Total on Register
New Registrations
Deregistrations)

Peaks in deregistrations, however, seem to have lagged slightly behind peaks in additions. In each year following an above average number of registrations, apart from 1982, there were an above average number of deregistrations. Even in 1982, it was only 0.5 below the average. The dip in the 1980 total seems largely accounted for by an above average number of deregistrations (34) in a year following an unusually low number of additions (23).

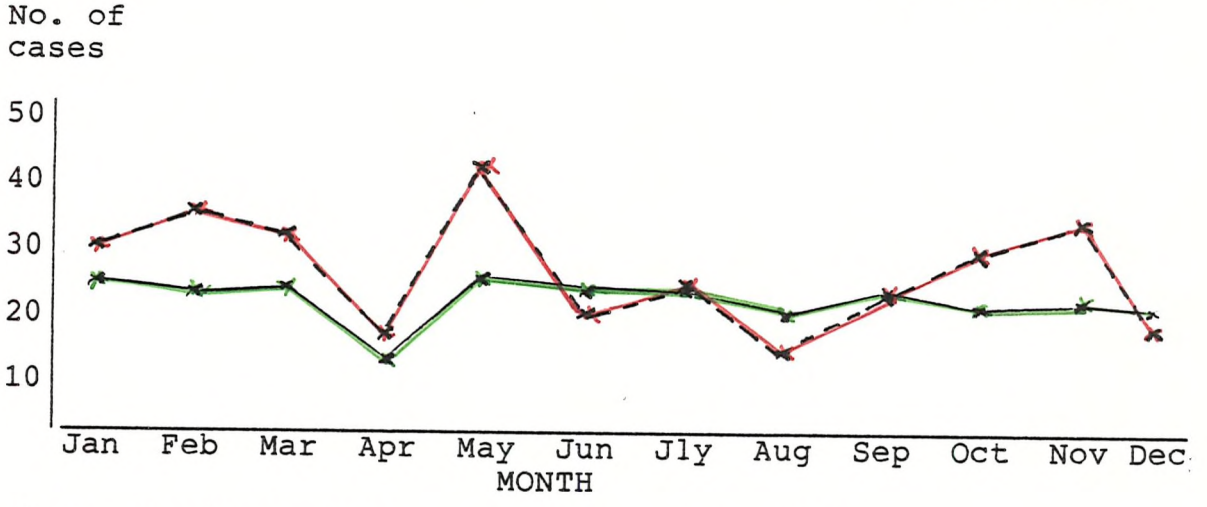
There would thus appear to be a symbiotic relationship between additions and removals. It is tempting to speculate that this is caused, in part at least, by the sheer impossibility of coping with an ever-increasing number of registered cases of child abuse, without corresponding increases in staff and resources. Further research would be needed to establish this, but some support is lent to the hypothesis by the Lambeth study, Child Abuse Referrals, which dealt only with the years 1980-1981, but which showed that, while twice as many families were referred in 1981 as the previous year, the actual number of registrations only rose by one. What happened was that the number of referrals

which led to registration fell from 71% to 37%, although in the opinion of the researchers there appeared to be no significant difference in the type of case referred (Lambeth 1982).

c. Monthly variations

During the course of the study, it became clear that children appeared more likely to be registered at certain times of the year than at others. Further research would be needed to clarify the significance of the findings shown in Table 3, which shows the variations in the numbers registered or deregistered by calendar month. In theory, the average monthly rate for the 328 registrations and 269 deregistrations should be 27.3 and 22.4 respectively. In practice, the monthly totals for registrations ranged between a low of 14 in August to a high of 44 in May. (When the figures are further broken down into category of abuse, Category III is marginally more volatile than Categories I + II but not significantly so.)

Table 3 Month of the year in which cases were registered or deregistered



(Key: Registrations N = 328
Deregistrations N = 269)

The figures show that more family names were added to the Register in certain months than in others. It is impossible to deduce from that that child abuse is more likely to take place in May than August or April. Indeed, one could only

say that registration was more likely to take place in May or November than in August or April, if one was able to compare the number of referrals with the number of registrations and see whether the proportions of the referrals registered varied accordingly. Unfortunately, that information was not available. The source of referrals will be looked at later, but had the Education department been responsible for a higher percentage of the referrals, one would have been tempted to suggest that child abuse would be less likely to come to the attention of professionals in the school holidays. But schools referred less than 10% of the cases and any way 63% of the children registered were under school age.

The fluctuations in monthly deregistrations is much less, apart from a striking low in April. There was a range of only 15 (compared with a range of 30 for registrations). April had only 12 and May had 27. Again if the figures are broken down into categories they do not reveal any significant differences.

Perhaps the only conclusion one can safely draw at this stage is that May would seem to be the busiest month for Case Conferences making decisions about putting names on the Register or taking them off and that, by contrast, April is a time when the fewest decisions are made. Families are less likely to be registered in August than in any other month, although April and December (both holiday months for staff as well as clients) have low totals as well. In addition, one can note that, the peak of May notwithstanding, 55.8% of registrations take place between October and March, with the summer months accounting for only 44.2%.

d. Categories

It has already been explained that there were, for most of the time of the study, three categories on the Register, which were intended to indicate whether abuse had definitely (or almost definitely) taken place, was thought to have taken place or was thought likely to take place. As has

also been indicated there was, in practice a certain amount of confusion and overlap, although it was clear that the categories represented an attempt to grade the seriousness of concern felt by the Case Conference. For the most part in this study, Categories I and II have been combined and taken to represent those cases where it was held that abuse had (probably) occurred as against Category 3 where there would seem to have been anxiety, rather than actual occurrence. (In the very early years, as had been said above, there were 4 categories on the Register - for the purposes of this study, those cases marked Category 4 on the cards were counted as Category III.) Where, within a family, siblings were registered in different categories, the highest category was taken. The 7 cases where no category was recorded have been counted as Category III.

When one is considering fluctuating figures on the Register and the reasons why they might fluctuate, it is important to look at the different patterns of registration according to category. Although the rate at which the categories were registered did not, as has just been said, vary significantly on a monthly basis, there was more variation from year to year. In fact it was the Category III cases which largely contributed to the annual fluctuations observed in Table I. Between 1974-1982, the number of cases registered annually in Category I or II varied between 9 and 20. (If 1974 when there were only 9 Category I + II registrations were to be disregarded, the range was 14-20). The variation for Category III cases, on the other hand, was between 6-32. It was largely Category III cases which contributed to the dramatic rise in the total numbers registered in 1974 and 1975 (the figures for those two years were 28 and 32 respectively). It will be shown later that Category III contained a high proportion of cases in the "anxiety" group - as indeed it was intended to do, being seen as a category where there was risk of abuse rather than a proven allegation. In addition, Category III contained a large number of cases where the reason for registration was not recorded, which would suggest that there also were cases where there was general anxiety, rather than defined concern. It would seem, therefore, that fluctuations on the

Register were caused by a varying number of cases of a type which might be held to reflect the feelings of professionals rather than actual proven abuse.

Summary

This section of the study has shown that there were variations in the Register statistics: variations in the rate of registration by month, year and by category. These variations suggest that there may be external influences at work which determine whether a child is registered at a given time. What those influences are can only be guessed at - cynically one might be tempted to suggest that patterns of staff leave might have something to do with monthly fluctuations - and more research, on the lines of Lambeth's (which compared referrals and subsequent registration rates) is needed. Meanwhile, the next section looks at the reasons why children's names were placed on the Register.

4. Reasons for Registration

Initially, it was assumed that the reasons for registration would be much the same as the types of abuse recognised by the 1980 DHSS circular, i.e. physical or emotional abuse or neglect or failure to thrive (DHSS 1980,2.2) with the possible addition of the sexual abuse that that circular had not separately recognised. However, as the cards were examined, it became clear that the reasons given were much more complex and 20 different ones were identified, in addition to a group categorised as Other. (This included 3 cases notified by other local authorities of families in a Merton Women's Refuge, a child locked in a cupboard, an attempted strangling, an accident (sic!), a mother's unsubstantiated allegation against a father and one case where a child had died in suspicious circumstances, but where the family claimed diplomatic immunity.)

These reasons were placed in rank order as shown in Table 4, 7 cases where neither a category or reason was given having been excluded.

Table 4 Rank Order of Reasons for Registration

Reason	Number of Cases
Bruises	128
Reason not known	35
Fractures	26
Fear of abuse	22
Burns	12
Emotional abuse Parent's mental health	11
Poor care with some bruising Anxious mother Other reasons	9
Suspicion of abuse	8
Failure to thrive Inadequate mother	7
Poor care with leaving alone Matrimonial violence	6
Sexual abuse	5
Drug taking (by parent)	4
Poisoning	3
Poor care with emotional abuse Member of a household with an abusive adult Neglect	1
TOTAL	321

From this, it is immediately clear that by far the most common cause for referral to the Register was bruising, which forms 39.8% of the total (44.75%, if one excludes the 35 cases where the reason was not known). Neither the Lambeth nor the NSPCC studies have comparable figures: in the case of Lambeth, because the figures are given for referrals, not registrations (i.e. they include cases which were not placed on the Register) and in the NSPCC study, because the statistics were drawn from the Registers kept by their Special Units, some of which did not recognise forms of abuse other than physical abuse. But the Strathclyde study, which was based on answers to questionnaires sent to social workers, rather than directly on the information contained on the Register (and might therefore have had more detailed information) found that 41% of cases were reported as having bruising (Strathclyde 1982, Table 5) - a figure very close to the Merton one. (On the other hand, the Strathclyde study reported 29% of cases as showing Emotional

Neglect and 17% as showing Physical Neglect (Ibid, Table 5) - findings in strong contrast to Merton's 3.8% for Emotional Abuse and 0.34% for Neglect.)

Because several of the reasons overlapped or were very similar and to make the analysis easier, the 21 reasons were then placed into 8 groups as follows:-

Group A	PHYSICAL	Bruises, Burns, Fractures, Poor care with some bruises and Poisoning.
Group B	NEGLECT	Failure to Thrive, Neglect, Poor Care with leaving alone
Group C	PARENT RELATED	Matrimonial Violence, Parent's mental state, Anxious mother, Inadequate mother, Drug taking by parent, Household containing an abusive adult
Group D	PROFESSIONAL ANXIETY	Suspicion of abuse, Fear of abuse.
Group E	EMOTIONAL	Emotional abuse, Poor care with emotional abuse.
Group F	SEXUAL	Sexual abuse.
Group G	OTHERS	Other reasons, including referrals from other local authorities.
Group H	NOT KNOWN	

Table 4a shows the result of this re-grouping in rank order.

Table 4a Revised Rank Order of Reasons for Registration

	Reason for Registration	No. of Cases	Percentage of Total
Group A	Physical abuse	178	55.5
Group C	Parent related	38	11.8
Group H	Not Known	35	10.9
Group D	Professional anxiety	30	9.3
Group B	Neglect	14	4.4
Group E	Emotional abuse	12	3.7
Group G	Others	9	2.8
Group F	Sexual abuse	5	1.6
	TOTAL	321	100.0

The predominance of Physical Abuse is immediately apparent - 55.5% of the cases on the Register were there because of physical injury. The other most striking feature - particularly to anyone looking at the figures from the perspective of the second half of the Eighties - is the small number of cases of Sexual Abuse.

Table 4a shows the overall picture but if the figures are analysed either by the year of registration or by the category of registration other, subtle variations emerge, which make the situation appear more complex. This is particularly marked if Group D (the Professional Anxiety group) and Group H (the Not Known group) are combined on the assumption that a lack of a specific reason for registration is more likely to indicate a certain anxiety or fear of abuse than anything else.

Group A obviously formed a steady core of the registration whichever way one looks at it, producing between 13-21 registrations per year during 1973-81. Perhaps surprisingly, the lowest numbers of Group A registrations were in 1975 and 1976, although 1975 was the year in which the highest number of registrations (49) were recorded overall. The peak years for Group A cases were 1981, with 21 cases and 1977 with 20 - the latter being also

significant in that all the Group A cases that year were registered in Category I or II.

The combined Groups D and H show the greatest volatility, ranging from a low of 2 in 1981 (which, as has been seen, was otherwise a high year for registrations and especially for Group A registrations) to a high of 25 cases in 1975, when they accounted for 51% of all the registrations for the year. They were at their second highest in 1974, when they formed 27% of the total registrations. It has already been shown that 1974 and 1975 were years in which, following the Maria Colwell inquiry, there was particular concern about, and professional consciousness of, child abuse. The large numbers of Groups D and H registrations in those two years would appear to confirm the hypothesis that there may, at such times, be a tendency to "play safe" and put children on the Register without a clear assessment of the form or degree of risk involved.

Of the other groups, only C, the Parent-related group, contributed a significant number with 12 of the registrations spread pretty evenly over the years. The other groups were so small that one cannot draw any firm conclusions from their occurrence, apart from noting that Group B, Neglect, provided a steady 1-3 registrations per year, but Group F, Sexual Abuse, only featured in 1975, 1978 and 1981. Group E, Emotional Abuse, had never had more than one case per year, until 1981, when there were 6 registrations in that group. This was the year following the DHSS circular which officially recognised Emotional Abuse as a form of abuse in its own right (DHSS 1980, 2.2.c). While there was only one Group E registration in 1982, some indication that it might become an increasingly important cause of concern, may be contained in the fact that of the 7 registrations made in the last 3 months of the study (Jan-March 1983) no less than 3 were for Emotional Abuse. By March 1989, six years later, Emotional Abuse accounted for 12% of the total Register.

If one turns to the Categories of registration and distinguishes between Categories I and II on the one hand

and Category III on the other (seeing the former as the more serious or proven cases and the latter as the "risk") other points emerge. Group A, which provides 55.5% of the overall registrations, dominates the Category I + II scene with 82% of all the registrations. In Category III, Group A takes second place to Groups D and H, which account for 34% of the Registration against Group A's 28%. Clearly, Physical Abuse is considered the most serious form of abuse. (The other groups, which contributed between them only 9% of Category I + II - Groups D and H having the remaining 9% - had 38% of the Category III registrations, Group C, the Parent related group contributing half of that.)

In recent years, some commentators, and particularly those concerned with civil liberties, have criticised Registers for being too vague and all-embracing in their criteria for inclusion. As long ago as 1978, the British Association of Social Workers was pointing out: "these registers could easily drift into an overburdened and increasingly irrelevant list of children about whom professionals are concerned" (BASW 1978, 15). Geach, in a paper entitled "Child Abuse Registers - a time for change" speaks of "vague criteria" and "nebulous" concepts of "at risk", which he considers have "swelled the numbers on the Registers" enormously (Geach and Szwed, 1983, 45). Geach also alleges that, in 1979 the "at risk" (i.e. Category III) category on registers "was at least two times the size of other categories put together" (Ibid, 45). This was certainly not true in Merton: in 1979 Category III only accounted for 28% of the registrations; the overall figure for 1970-82 was 51%.

The debate about vagueness would appear to have had some effect on the practice in Merton. When the cases which were in the Open section of the Register are examined, the breakdown by reason for registration is somewhat different than for the Register as a whole. Group A, Physical Abuse still dominates, with 59% of the registrations (although interestingly, there has been a slight decline in the percentage of cases in the higher categories by comparison

with the overall situation - only 77% of the Category I and II cases are from Group A, a drop of 5%).

But, much more interestingly and perhaps linked to the debate over the danger of over-registering children about whom professionals are concerned - the combined Groups D and H have shrunk from 20% of the Register as a whole to 5% of the Open Section. The fall would appear to have been largely offset by a 10% growth in the proportion of Group C, the Parent-related group. This group also took over the domination of Category III in the Open section, with 43% of the Open Category III cases. While the numbers of Category III cases in the Open section were small (only 23 cases) and one should therefore be wary of attaching too much importance to them, it is tempting to speculate that generalised anxiety had metamorphosed into a more specific form of professional anxiety, focussing on specific parental problems, such as mental illness, drugs or marital violence, which may - but do not necessarily - place the children of such parents "at risk".

Summary

Physical abuse - bruises, burns, fractures and poisonings - accounted for over half the cases on the Register and for over three-quarters of those considered most serious. However, within this general picture there were other trends. Fluctuations in the Professional Anxiety/No Reasons given groups were marked and, in years of high numbers, they were the highest of all. They also had - in the historical overview - the largest proportion of Category III cases, being overtaken, in the Open section (which contained the more recent registrations) by Group C, the Parent-related group. While the situation in Merton was never such as to justify the fears expressed by Geach, the fluctuations in registrations and in the reasons given for registering children do support the hypothesis that levels of professional anxiety also fluctuate.

5. Deregistration

It was not until 1980 that the DHSS gave any advice about de-registration. In the circular issued that year, it recommended that the decision to deregister should only be made at a Case Conference (unless it was unanimously decided by all the agencies involved that the original decision was made in error) (DHSS 1980 para 4.4). Secondly, the DHSS recommended that following deregistration, a child's name should remain in an inactive section for a further 2 years or until the child was 5 years old, whichever was longer (Ibid para 4.5) - an indication that the old association of child abuse with babies still survived in some quarters! Merton, in practice, had been deregistering children since 1973. That is, a decision was taken generally, but not always, at a Case Conference that a child's name should be removed from the Register. While this meant that no further formal monitoring went on (in the form of inter-disciplinary Case Conferences) and the parents, if they had been told that their children's names were on the Register in the first instance, would be informed that the names had now been removed, in practice all that happened - so far as the actual Register itself was concerned - was that the card would be moved from the Open section at the front of the box to the "Closed within the Past Year" section in the middle of the box and then, a year later, to the Closed section at the back of the box. So far as it was possible to tell no card had ever been removed from the box altogether and destroyed as the DHSS recommended should be done (Ibid para 4.5) after the required inactive period. This meant that 269 Closed cards were available for this study.

The overall situation with regard to the numbers deregistered has already been referred to in the discussion of the Register in general. Other aspects of deregistration which were examined and which remain to be considered were the reasons given for deregistration, the year in which deregistrations occurred, the length of time spent on the Register (including the length of time the Open cases had already spent) and, finally whether there were any significant trends to be observed when the time spent on the

Register was examined in relation to either the reason for registration or the reason for deregistration.
Unfortunately no comparable analysis was found in any of the other studies, so it is not possible to say whether these findings are typical.

a. The Reasons for Deregistration

The study of the Closed section revealed 9 common reasons for removing a child's name from the Register. There was also a large group of cases where no reason was given or identifiable and 6 cases, where the rationale could not be classified and which were therefore labelled "Other". (The explanations given for these cases were:- "parents say there is no problem", registration (which had taken place two days previously) was said to have been "for information only", another family "will be more careful in future" (and presumably avoid the "twice weekly bruising" that had been noticed on their child), a fourth where it was recorded "mother inadequate but child not at risk" and two cases which simply read "not at risk".)

The nine other reasons, which were identified and studied, were:-

i. PROGRESS. This involved what was perceived as changed attitudes and relationships within the family.

ii. SITUATION IMPROVED. Changes had occurred, but these were changes of circumstances or material matters which had been placing a family under a stress and thus leading to the abuse e.g. a housing transfer, where inadequate housing was felt to be a contributory factor.

iii. LEFT AREA.	These cases were normally closed, following a referral to another local authority, providing there was no likelihood of return, even where the situation was not improved.
iv. CHILD REMOVED FROM HOME.	Some children remained on the Register for a considerable period after their removal from home, but their names were only removed from the Register when rehabilitation had been completely ruled out.
v. NO FURTHER INJURY.	This appeared to be a more tentative reason than Progress and appeared to indicate that the professionals were not so wholeheartedly satisfied with the outcome, but no actual injuries had been observed.
vi. ADULT LEFT HOME.	The adult held responsible for the abuse was no longer a member of the household.
vii. OLD AGE.	The child reached the age of 17 and no longer came within the criteria for registration.
viii. NO COOPERATION.	This will be referred to again, but indicated non-cooperation on the part of the families, not the professionals.

ix. WRONG REGISTRATION. Since removal from the register, because of a decision that the original registration was held to be a mistake, took up to 3 years, this group was included, rather than discarded with the 20 cases previously referred to where the decision of the original Case Conference had been not to register. The Wrong registrations had, after all, been included in the quarterly statistics for the period of their registration.

The 269 cases were arranged in rank order as shown in Table 5.

Table 5 Reasons for deregistration - Rank Order

Reason	No. of cases
Progress	56
No reason given	50
Situation Improved	38
Left Area	33
Child Removed	29
No Further Injury	27
Wrong Registration	14
Adult left home	8
Other	6
Old Age	5
No cooperation	3
TOTAL	269

As was observed earlier when considering the reasons for Registration, some of the groups were similar or overlapped and so, for the purposes of further analysis, they were grouped together, although the No cooperation group, small

as it was, was left on its own as a distinct, if anomalous, entity.

The variables were therefore grouped as follows:-

Group I	PROGRESS	This embraced the Progress, Situation Improved and No Further Injury groups, indicating a more or less satisfactory outcome.
Group II	REMOVAL	This combined the Child Removed and the Adult left home groups, since in both cases a family group had effectively been broken up.
Group III	LEFT AREA	
Group IV	OTHER	This includes both the previous Other category and the previous Old Age group.
Group V	NO REASON GIVEN	Despite a suspicion that this group contained many cases where it was felt progress had been made, it was decided to keep it as separate entity, because it was impossible to know for certain.
Group VI	NO COOPERATION	
Group VII	WRONG REGISTRATION	

This regrouping led to the revised rank order shown below.

Table 5a Reasons for Deregistration - revised Rank Order

Reason		No. of Cases	Percentage
1. Gp.I.	Progress	121	44.9
2. Gp.V.	No reason given	50	18.6
3. Gp.II.	Removal	37	13.8
4. Gp.III.	Left area	33	12.3
5. Gp.VII.	Wrong registration	14	5.2
6. Gp.IV.	Other	11	4.1
7. Gp.VI.	No cooperation	3	1.1
TOTAL		269	100.0

The revised rank ordering clearly shows the importance of the Progress group by comparison with the others. 121, or 44.9% of the cases had been deregistered because the situation was now considered satisfactory. (If one excludes the 50 cases where no reason was given for deregistration and the 14 Wrong registrations, this proportion rises to 59%.)

The reason for deregistration was not articulated in almost 1 in 5 of the cases and nearly 14% of families were disrupted by the removal of a child or the departure of an adult, although both these groups showed variations according to whether the family had been registered in Category I or II or in Category III. More names were removed from the Register because child or adult had left the home in the higher categories than in Category III (19% as against 9%). Conversely 23% of Category III deregistrations gave No Reason as against only 13% of those in Category I or II. (This presumably, and hopefully, reflects the need to be surer that an originally higher level of concern has been completely resolved.)

Only 12% of the families were deregistered because they had left the area. There has been reference earlier to references in the literature about families moving frequently (Straus in Kempe and Helfer 1980, Jones 1982). From this one might have expected the figure to be higher than 12%. (It was not possible to discover how often families had moved <u>within</u> the borough, thus remaining on the Register despite a move. The presence of considerable quantities of correction fluid on some of the cards indicated that this might be so in some cases. Nor was there any indication whether many of the families had recently moved into the area when registration took place.)

b. <u>The Year of Deregistration</u>

The number of cases deregistered each year between 1973 and March 1983 was discussed above with reference to the number registered each year during the same period. These cases

were also analysed with reference to the reason for their deregistration. The steady number of cases deregistered for Progress reasons was quickly apparent. Apart from 1975 and 1982 - the first and last full year considered - the percentage of cases registered for Progress never fell below 46% (in 1979) or rose above 62% (in 1977). (1973 and 1974 were disregarded for this purpose - the total number of deregistrations for those years was 4 and clearly the system was only just beginning to operate.)

1975 was remarkable not only for the small number of cases (24%) which were deregistered for Progress reasons, but for 3 other factors. Firstly, more cases (42) were deregistered that year than any other. (It was also, it will be remembered the year in which more cases were placed on the Register than any other.) Secondly, more cases (14 or 33.3%) were deregistered without a reason being given than in any other year. Furthermore, many of these cases had originally been registered without any reason being given for the registration (30.4% of the Group V Deregistrations in 1975-6). Thirdly, 4 of the 1975 deregistrations resulted from a decision that the original registration had been wrong. It would seem possible that, in 1975, there was still considerable confusion, uncertainty and anxiety in the wake of Maria Colwell.

No reason for the small number (9 or 28%) of Deregistrations for Progress in 1982 suggests itself. The most significant feature of the 1982 Deregistrations was the high number (10 or 31%) of Deregistrations in Group II, the Removal group. This appeared to have been caused by the deregistration of several families, some of whose children had already been in care for several years.

Otherwise the proportions of the different groups deregistered from year to year remained reasonably static.

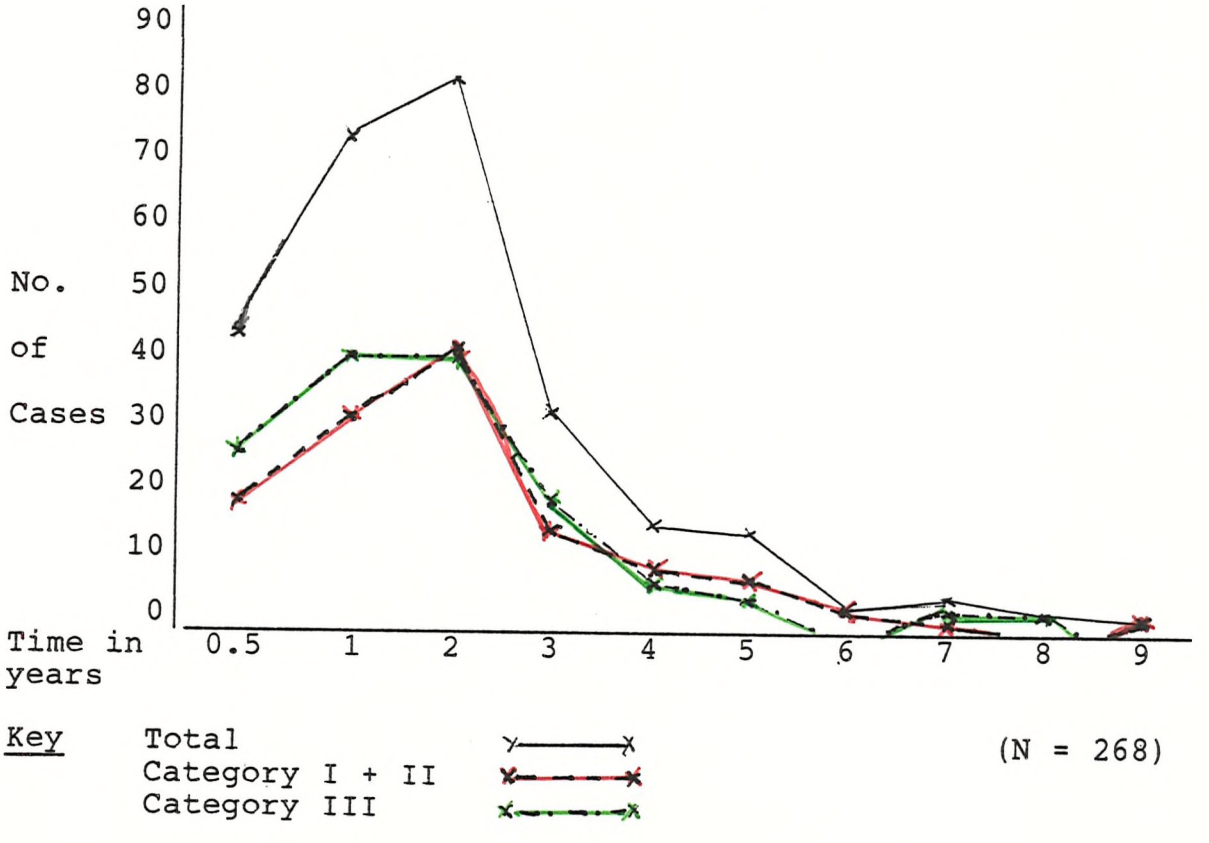
c. Time Spent on Register

The Deregistered cases were further examined to discover how long they had been in the active section of the Register.

One case had no indication of the date of deregistration or any indication that this had ever formally taken place; Case Conferences were no longer being held and the card was in the Closed section, but because of the lack of any indication of date it was excluded form this part of the study, leaving 268 cases for analysis.

The average time these cases had spent on the Register was 1.97 years, with the Category I + II cases showing a slightly higher average of 2.1 years as against the Category III figure of 1.9 years. Table 6 shows the distribution of cases by the time spent on the Register and shows a peak at 2 years. However, had all those cases deregistered in under a year been combined and not divided into less than 6 months or 6-12 months, the graph would have shown a peak at the start and a steady downward slide thereafter. In fact 201, or 75%, of the cases were deregistered before the end of the second year. When the figures are broken down into categories, Cat. I + II is, as one would expect, slower to get going, but by the end of the second year has caught up on Cat. III.

Table 6 Time Spent on Register



The 59 cases in the Open section were also examined to provide a comparison and this is shown in Table 7. It should be borne in mind that this includes cases registered in the previous 6 months, where no review had yet considered the possibility of deregistration: this, one might have expected, should lower the average time. However, the overall average was 2.4 years (with Cats. I + II averaging 2.7 years against Cat. III at 2.02). While these averages were undoubtedly inflated by the 4 cases which, between them, had spent a total of 33 years on the Register, it was also true that only 66.1% of the Open cases had been registered for less than 2 years, despite the number of new cases which were included. The authors of the Strathclyde study, who looked only at open cases, commented that: "in general the cases had been on the register for a considerable time" (Strathclyde 1982, 6). Yet their average time was only 16.5 months (i.e. a year less than Merton's average) although they admit to a great variety by district, with the Ayr division averaging 26 months, much closer to the Merton figure (Ibid, 6).

In Strathclyde they found that 25% of the open cases had been on the Register for longer than 2 years: the comparable Merton figure was 36.6%. Strathclyde had a high - 25% - proportion of "non-physical" cases (i.e. neglect, emotional abuse etc) and found that these developed over a longer period of time and tended to stay on the Register for longer: 35% of these cases had been on the Register for more than 2 years (Ibid, 6). As will be seen in a moment, the situation in Merton was different.

The two cases which had been on the register for 11 and 9 years were noted with concern. While one should not be tempted to hypothesize on the basis of two isolated cases, they posed questions about the likelihood of cases which were not deregistered in the first 6 or 12 months continuing in the Open section for considerably longer than normal. Testing this theory conclusively would need far greater numbers in the Open section than was available (or else a sophisticated sampling at given points of time), but to try to discover whether the possibility would reward further

study, the average time spent on the Register were worked out again, excluding the groups who had only been on for a limited period (or, in the case of the Open Section, had been registered within the previous 6 or 12 months). The results are shown in Table 7.

Table 7 Average time spent on the active Register.
(Time given in years)

	CLOSED CASES	OPEN CASES	DIFFERENCE
A. Overall Situation			
Total	1.97	2.4	0.43
Cats. I + II	2.1	2.7	0.6
Cat. III	1.9	2.02	0.12
B. Excluding all cases on the Register for less than 6 mnths			
Total	2.3	2.6	0.3
Cats. I + II	2.4	2.9	0.5
Cat. III	2.2	2.2	-
C. Excluding all cases on the Register less than 12 months			
Total	2.9	3.5	0.6
Cats. I + II	2.95	4.1	1.15
Cat. III	2.86	2.7	- 0.16

Table 7 shows that there was a difference of 0.43 (or about 5 months) between the length of time those cases which were now deregistered had spent on the Register and the length of time already spent by the cases still on the Register. As one would expect, the differential was bigger in relation to Cats. I + II and less in relation to Category III.

When all the cases which had been on the Register for less than 6 months - whether now in the Closed or Open sections - were excluded, the differences narrowed. But, when those cases which had spent less than 12 months on the Register (whether now current or closed) were excluded, two factors emerged. Firstly, the average time spent on the Register by the cases in the Open section was already 7 months (0.6 years) longer than the closed cases and, secondly, the gap was over a year (1.15 years) so far as Categories I + II were concerned (although the Open Category III cases had not

yet reached the length of time of the closed cases). The figures in regard to the Categories I + II cases tend to confirm the hypothesis that, if a case remains in the Open section, Category I or II, for more than a year, the average time before it will be deregistered increases rapidly. A more detailed study would be needed to test this conclusively.

i) The Effect of the Reason for Registration on the time spent on the Register

The time spent on the Register was examined for both the closed and open cases to see whether the reason for registration had any apparent effect on the length of time spent on the active Register.

It has already been pointed out that Physical Abuse, or Group A, accounted for the majority of Registrations (54% of the overall total, 59% of Open cases). It has also been seen that the great majority (75%) of the cases were off the register within 2 years of being placed on it. Only 12.6% of cases remained on for more than 3 years. But nearly three quarters of these (25 out of 34 or 74%) were from Group A. In the Open section the figure was even higher - 9 out of the 10 cases which had been on the Register for more than 3 years were from Group A. The other groups show no immediately obvious patterns and certainly do not repeat the Strathclyde study's finding that non-physical cases stayed on the Register longer (Strathclyde 1982, 6). In the Closed section one Neglect case had spent 8 years on the Register (but no other Neglect case had spent longer than 2 years). In the Open section, only one non-physical case (and that was from Group H - No Reason given) had been on the Register for more than 3 years.

However, when the average times for each Reason for Registration group was worked out, they showed a spread of 1.44-2.16 years (i.e. 17-26 months). (It will be remembered that the overall average time spent on the Register was 1.97 years.) These average times arranged in rank order are shown in Table 8.

Table 8 Rank Order of average times by Reason for Registration

	Group	Average Time	No. of Cases
1.	A. Physical abuse	2.16	142
2.	B. Neglect)		
	E. Emotional abuse)	2.05	10 (each)
4.	F. Sexual abuse	2	3
5.	D. Professional anxiety	1.82	28
6.	C. Parent related	1.73	26
7.	H. No reason given	1.69	41
8.	G. Others	1.44	8
TOTAL			268

While the very small number of cases involved in Groups E,F and G mean that any conclusions based on these figures would be highly tentative, the inescapable conclusion is that Group A cases spend longer on the Register, suggesting that they are seen as the most serious or the most intractable. (The Group A cases in the Open section, even including those registered within the previous few weeks, it will be remembered, have an average time of 2.77 as against the overall average of 2.4.)

If the average times for the different Groups are also worked out with reference to the cases in the Open section, most of them show, as one would expect, a shorter time on the Register than the closed cases. Only in Groups A,G and H are the average times higher, in relation to the Open cases, than for the Closed cases. Group A has already been dealt with and, as the largest group, largely accounts for the higher overall average time. Groups D and H must be treated with extreme caution since there was only one case from each group in the Open section. Nevertheless one may well be concerned that even one case can spend five years on a Child Abuse Register without a reason having been given for its inclusion in the first place.

It has been said that the other groups showed shorter average times than the closed cases in the same reason groups. The difference, however, was slight in relation to Groups B,C and E and this would suggest that most of these cases would actually stay on the Register longer than the average. The situation seems to be, from all this, that the likelihood of staying on the active Register increases with the time already spent.

ii) The Effect of the Reason for Deregistration on time spent on the Register

The time the cases spent in the active section of the Register was also analysed by the Reason for Deregistration to see if there were any lessons that could be learnt from this. All the groups, with the exception of VII, the Wrong registrations, showed a similar pattern of peaking at either 1 year or 2 years and then declining rapidly. Group VII one is relieved to note, peaked at 6 months (i.e. as soon as possible) so that at least most of the mistaken registrations were rectified quickly, although 3 cases did take 3 years before being deregistered, which does cause one concern, which will be returned to shortly.

Group V, the No Reason given group, figured particularly strongly in the first 2 years, just as, earlier, it was shown that those cases which were placed on the Register without a reason being given were predominantly deregistered within the first two years. It would be interesting to explore Group V further to see whether perhaps these cases had been originally registered with less conviction than other cases as a result of an incomplete assessment or in a time of particular public anxiety. Such an exploration would require examining both the minutes of Case Conferences and case files and was clearly beyond the scope of this study, but some support is lent to the hypothesis by the fact, mentioned earlier, that 29.2% of cases deregistered without any identified reason being given had originally been placed on the Register without an identified reason.

Some members of Group II (the Removal group) spent a long time on the active section of the Register. One case was there for 9 years, 35% for 3 years or more. This did not necessarily mean that the children were removed from home long after being registered or that the adult responsible for the abuse took years to leave the premises. The circumstantial evidence on the cards pointed to two other explanations. Firstly, these were, generally speaking, the cases viewed most seriously where children had been severely injured and which one would expect to spend longer on the Register. But secondly, and more importantly, many children's names remained on the Register for a considerable period after they had been removed from home. In some cases, the hope was that rehabilitation would be possible and it was some time before it was finally acknowledged that it was not. In other cases - and it seemed more frequently - there was never any intention of returning the children home: they became the subject of Care Orders and the possibility of Deregistration would seem simply to have been overlooked. Children in Care are the subject of statutory six-monthly reviews and probably planning for that child's future in care took up most of the time and attention of these reviews. A copy of the review form had to be completed, but minutes were rarely produced in addition, so a clerk would send a copy of the review form through to the Custodian. It was clear that the Register only served to remind people why the child had originally come into Care and there was no regular reassessment of the current risk to a given child.

The average times spent on the Register by each deregistration group were also calculated and arranged in Rank Order as shown in Table 9.

Table 9 Rank Order of average times on the Register by Reason for Deregistration

	Group		Average time (years)	No. of Cases
1.	II	Removal	2.35	37
2.	I	Progress	2.33	121
3.	IV	Others	1.91	11
4.	III	Left area	1.79	33
5.	VII	Wrong Registration	1.6	14
6.	V	No Reason Given	1.42	49
7.	VI	No cooperation	0.83	3
TOTAL				268

Table 9 highlights the time spent on the Register, on average, by families where children were removed or adults left home, although the Progress group came a close second, separated by 0.02 years (or about 7 days). These two groups accounted for 57% of all deregistrations and were responsible for pulling up the overall average time on the Register to 1.97 years, since they both average more than 4 months longer than any of the other groups, and were the only ones to spend an average time of over 2 years.

The most surprising group, although by far the smallest, comprising only 3 cases, is Group VI, deregistered for lack of cooperation. Two of the three cases were graded Cat. I and were registered for Physical Abuse (both for bruising). The third was from Cat. III and had been registered for "Fear of abuse", the Professional Anxiety group. The average time these three cases spent on the Register was 0.83 years or about 10 months. Clearly, this is too small a group to be statistically significant, forming less than 1% of the whole sample, but some support for the finding does come from one further case, classified in the Progress group, because the primary reason given for deregistration was "No Further Injuries", but where there was an additional comment - "Family unworkable with". This case was registered after 9 months.

While one obviously cannot draw any hard and fast conclusions there are bound to be queries raised about the logic of deciding a child is not at risk because the family will not cooperate with professionals. Indeed, such was the concern among management, when in the course of this study, I drew attention to these cases, isolated incidents though they may have been, that an instruction was specifically inserted in the Guidelines: "In any case, lack of contact or lack of cooperation is never an adequate reason for deregistration" (Section 6.4.5). So it will not be possible to mount a future study to test the hypothesis, raised by these figures, that a family which does not cooperate will have their name removed from the Register on average 18 months quicker than a family which makes Progress!

Cynicism apart, it is also a matter for concern that Progress should be so slow - the cases in this group may represent a triumph of professional help and perseverance, but one wonders whether the families concerned would not have been glad to have had their names removed more quickly. Another group which causes some concern is the group deregistered because it was decided that the original registration was wrong. It was commented on above that the highest number of deregistrations within this group took place within 6 months. Nevertheless, the average time was 1.6 years, which suggests that some initial assessments are either very superficial or very slow. Alternatively, it may be that while there was not solid evidence, even at the beginning, to support the assessment, other worrying factors contributed to the decision to register without appearing on the notification and further research would be needed to establish this. In the 1984 NSPCC study 42 children were notified to the register with injuries which were subsequently proved to be accidentally caused and an additional case was notified in the Failure to Thrive category which later turned out to be medically caused. "Only 8 of these 43 children were deregistered as soon as their injuries or their condition were found to be accidental. The element of neglect present in several cases caused many of them to stay on the register" (NSPCC 1984,

23). It may be that this is what happened in Merton, albeit without being so clearly spelled out.

To sum up this subsection, when the average times spent on the Register were compared for the Reason for Registration against the Reason for Deregistration, the latter had a far wider spread of average times, as can be seen by comparing Table 8 with Table 9. The Reason for Deregistration analysis had a spread of 1.52 years (or just over 18 months) whereas the Reason for Registration groups had a spread of only 0.67 years or a day over 8 months. This would suggest that the events after registration (including progress or lack of it) are more significant in determining the time spent on the Register than the incidents or problems which led to the Registration.

d. Deregistration considered in relation to the Reason for Registration

As well as comparing the times spent on the Register by comparison with reasons for going on or coming off it, the Reasons for Deregistration were analysed by comparison with the Reasons for Registration i.e. did the type of abuse appear to have any effect on the reason for deregistration? Group A, Physical Abuse, because of its very size, formed the largest proportion of each Deregistration group too. Nevertheless, that proportion varied from a high of 72.7% of Group IV, the Other group, down to a low of 48.8% of the Progress group. In fact, only in relation to the Progress group did Group A account for less than half the Deregistrations. The other groups were spread more or less evenly across the Deregistration groups, although Group D, the Professional Anxiety group, figured prominently in the Progress section and combined with Group H, the No Reasons given group, contributed just under a third (31.4%) of the Progress Deregistrations. It has been mentioned earlier that many of the cases which were registered without a reason for the registration being identified were also deregistered without a given reason, although a higher proportion of the No Reason given for Registration group were actually deregistered for Progress.

The Progress group, it has already been emphasised, was the most numerous. It is also of most interest to professionals and all who want to see a successful outcome to the handling of cases of child abuse. So the Progress figures were looked at in particular detail to see what types of cases stood the greatest chance of being deregistered for Progress. The results are shown in percentage form in Table 10. Overall 44.98% of the cases which had been deregistered were considered to have improved. Table 10 shows that cases registered because of Sexual abuse, Professional Anxiety or Emotional Abuse or where No Reason for the registration had been given were most likely to be deregistered for progress and those registered for Parent-related reasons, for Physical Abuse or for Neglect were, sadly, less likely to be considered to have made progress. (As in so much of the study, the small numbers in some of the Reason for Registration groups must make one caution about these results, particularly in relation to Groups F, E and B, but one may still be concerned that Physical Abuse should appear to be more intractable than the others.)

Table 10 Percentage of cases in each Reason for Registration Group, deregistered for Progress - results in Rank Order.
N = 269, Overall average = 44.98%

	Group		Percentage	Total No. of Cases
1.	F.	Sexual abuse	66.6	3
2.	D.	Professional anxiety	64.3	28
3.	E.	Emotional abuse	50	10
4.	H.	No Reason given	48.8	50
		AVERAGE	44.98	-
5.	C.	Parent related	42.3	26
6.	A.	Physical abuse	41.3	121
7.	B.	Neglect	30	10
8.	G.	Others	25	8
TOTAL				269

Summary

To sum up this section on Deregistration - a great many questions were raised and a few trends could be noticed: some families spent a very long time on the Register, the reason for Deregistration seemed more important than the reason for Registration so far as time on the Register was concerned, cases registered for Physical Abuse or Neglect were less likely to be deregistered for reasons of Progress than the average, those cases which were in the Open section had already been there for an above average length of time and, particularly in the Physical Abuse group, were likely to stay for a very long time if they were not deregistered within their first year.

However, on a more optimistic note one should point out that nearly half (44.9%) of the cases were deregistered for good progress (and, if one excludes the 50 cases where no reason was given or the registration was wrong, that percentage rises to 59%). In addition, one should note that over three quarters (79.4%) of the cases that ever went on the Register were off before the conclusion of the study. While, as one might expect, the more serious Category I cases had the lower deregistration rate (73.5%), both Category II and Category III had over four fifths of their cases deregistered (80.6% and 82.4% respectively). Moreover, within individual groups some scored exceptionally well. Neglect, which, when placed in its generic group with Failure to Thrive and Poor Care/Leaving alone, did badly in the Progress stakes, had a 100% overall record of deregistration when taken alone, as had Fear of Abuse. 92% of the children who had received Burns were ultimately deregistered and 91% of those judged to be Emotionally abused, while Fractures and Bruises had overall deregistration rates of 88% and 81% respectively. Civil libertarians would probably feel that the fact that such high proportions were deregistered was more important than the reason for the Deregistration.

The number of cases (50) where No Reason was given for the Deregistration does however raise other questions. Does it mean that the cases had all done well, that there was no

continuing anxiety and that properly they belong in the Progress group (where they would boost the numbers to a creditable 63.6% of all deregistrations)? Does it mean that there was an ambivalence and vagueness in the professionals' attitude to those particular cases - a feeling that they should not be on the Register though they could not articulate a reason for taking them off? Might it reflect changes in key personnel who, not having been involved at the beginning, did not share the original cause for concern and judged the family by different standards? Much more detailed study would be needed to answer these questions: meanwhile they stand as a reminder of the difficulty of giving precise and consistent answers to questions about Child Abuse.

6. The Referrers

Much emphasis has been placed, both in inquiry reports and in the literature, on the importance of multi-disciplinary cooperation in the management of child abuse. In most areas, as in Merton, Social Services Departments administer the Register as well as taking responsibility for convening, chairing and minuting Case Conferences and providing the great majority of the Keyworkers. Other agencies and professionals are clearly recognised as having an important part to play in managing detected cases - hence the convening of multi-disciplinary Case Conferences and Reviews. In addition Social Service Departments rely on the other agencies and the general public to bring many of the cases to their notice in the first place. As will be seen later, 30% of families registered had had no previous contact with Social Services. Even when there was contact, it could not be presumed that it would always be Social Services who were the first to become aware of the possibility of abuse. In order to ascertain what part was played by other agencies or people, it was necessary to discover who (or what agency) made the referral, which led to the initial Case Conference being convened and the child's name being placed on the Register.

There was a space on the Register card for the referrer's name and 304 of the 328 cards had been filled in. (There was one anonymous referral, which was counted as "known" to distinguish it from the 24 cases where there was no indication.) The known referrers were grouped by agency or profession and studied to see the number of cases they referred, whether there was any obvious pattern in the type or timing of referrals and, specifically (although it could only be done in a limited and somewhat superficial way) who was responsible for making those referrals, which appeared to be more middle class.

a. Who they were

Nineteen different referral sources were initially identified and arranged in rank Order as shown in Table 11.

Table 11 Rank Order of Referrers

1.	Health Visitors	49
2.	Hospitals	45
3.	Internal social services	35
4.	Schools	32
5.	Not Known	24
6.	Parents	23
	Area Health Authority	
8.	Other local authority	21
9.	Other social work agency	17
10.	Psychiatrist	12
11.	Neighbours	9
12.	Day nurseries	8
	General Practitioners	
	Relations	
15.	Other	6
16.	Police	4
17.	Childminders	2
18.	Self	1
	Anonymous	
	TOTAL	328

Some of the referrers are clearly distinct professional groups, others are not. For example, in the Hospital group, the hospital itself was generally named, but not the person who made the referral, so it could have been a paediatrician, a nurse, a hospital social worker or any of a number of different specialists. The Area Health referrals came through the District Community Health Physicians, who act as school doctors, clinic doctors and also go into Day Nurseries. It could be that some of their referrals should have more properly been classified as Education or Day Nursery. Similarly some of the internal Social Services cases may have actually originated with an Officer in charge of a Day Nursery (or a childminder) ringing the social worker responsible for the family. The Psychiatrists also posed a problem. Some of them worked in hospitals, some in Child Guidance clinics, some in both. Should they therefore be classified with the Hospital group or with Schools (since the Education department are responsible for Child Guidance clinics)? Ideally, one would have wished to classify throughout by professional specialism and perhaps cross reference for place of work, but in practice this proved both too complicated to do and impossible to be sure of accuracy. Moreover, it soon became clear that, because of the overlapping and in order to provide reasonable sized groups for analysis, it made sense to consolidate the groups further and to cluster them, where possible, by professional bias or, failing that, into a more manageable general group.

Health Visitors, Hospitals, Area Health Authority and General Practitioners were therefore collected together, with the Psychiatrists, into a Medical group (despite the possibility of thus including some hospital social workers, who were actually employed by Social Services). Other Local Authorities (which, in practice, meant other social work departments who were responsible for referring both children who had been abused in their area but had moved longterm to Merton and children who had moved temporarily, perhaps to live in a Women's Aid Refuge) were lumped together with Merton Social Services into a general Social Services group. This also included the previous Other Social Work agency group (which had been made up, in its turn by Probation

officers, Family Service Unit, Family Welfare Association, Welcare and the NSPCC - the latter having, most surprisingly, only ever referred two cases). Education took in the Day Nurseries and Childminders as well as Schools - despite the argument that Social Services had more responsibility for the Under-Fives than Education did, it was felt that what they really had in common was that they all provided day care for children and did not have a home visiting role. Police and Parents remained distinct groups, but Neighbours and Relatives joined the single self-referral and the single anonymous referral in the "Others" group. (The original 6 Other cases were 3 cases referred by private solicitors, acting in divorce cases - not necessarily with their client's knowledge, one from the Community Relations Council, one from a private foster parent and a sixth from the Royal Courts of Justice). The revised rank order is shown in Table 11a.

Table 11a Rank Order of Referrers - Consolidated Groups

	Group	Number	Percentage
1.	Medical	137	45
2.	Social Services	73	24
3.	Education	42	14
4.	Others	25	8
5.	Parents	23	7.6
6.	Police	4	1.4
	TOTAL (Not Known excluded)	304	100.0

Looking at Table 11a, the predominant part played by the medical profession in referring cases of child abuse is immediately apparent. Some writers have commented on "the medicalisation of child abuse" (Geach and Szwed 1983, 42), on "child abuse as a disease" ((Parton 1985, Ch.6) and how doctors have seen it as "an illness ... in a diagnostic category in its own right" (Ibid, 132). Given that 45% of all the known referrals in the present study originate in a medical setting, one may perhaps understand why the medical profession has also been inclined to dominate thinking on causation and treatment. Despite the fact that, as we shall

see later, more than 60% of the families were already known to Merton Social Services department, only 24% of the referrals originated from the Social Services group, even when the other social work agencies were included. The part played by the police was also less than one might have been expecting, although one should perhaps remember that the study ended in 1983 and, at that time, working relationships between the police and the other child protection agencies were less close. An analysis of more recent referrals might well be different, particularly since the establishment of specialist Child Protection Teams in the Metropolitan Police during 1988-89. The part played by parents in referring themselves may initially seem to be high, comprising 7.6% of the total. However, the Merton figure is actually a great deal lower than the figures reported in other studies: Lambeth identified 27% of referrals as coming from parents, the NSPCC 25.4% and even Strathclyde, while considerably lower than those two, had 15% (Lambeth 1982,4, NSPCC 1984,25, Strathclyde 1982, Table 9).

The explanation for the difference may lie partly in the way the different studies defined referrers. In both Lambeth and Strathclyde, the researchers asked "Who first brought the possibility of child abuse to the attention of ... authority?" (Lambeth 1982,4, Strathclyde 1982,6). That might mean that, if a parent presented a child to a hospital casualty department as having had an accident, which the hospital diagnosed as being non-accidental, the parent still counted as the referrer. Similarly the NSPCC study asked for a referral history of how the abuse came to light and who referred on to whom. This on occasion clearly involved a chain of two or three agencies or individuals and, although the NSPCC looked at who started the chain, it is not totally clear whether that person was always aware of the possibility of abuse as opposed to an incident which required medical treatment (NSPCC 1984,25). In Merton, the "referrer" was seen as the person who drew the Social Services department's attention to the need to investigate an allegation of abuse. If a parent took a child to hospital for treatment and the hospital felt the injury

could be non-accidental and contacted Social Services, the Hospital counted as the referrer. Therefore the present study is not strictly comparable, in this respect, with the other studies. Nevertheless, it still seemed worthwhile to look at the other studies' results and note areas of difference or similarity and these are shown in Table 12.

Table 12 Referrers by comparison with other studies
(Percentages of total referrals)

	Study			
Group referring	Merton	NSPCC	Lambeth	Strathclyde
Medical	45	12.8(1)	21	25
Social Services	24(2)	N/K	4(3)	20(4)
Education	13.8(5)	22.3(6)	22(6)	14(7)
Parents	7.6	25.4	27	15
Police	1.3	N/K	0	6
Neighbours & Relatives	6(8)	8.9	7	9
Self	0.3	3.4	10	1
Other	2	N/K	11(9)	11
Total	100	72.8(10)	102(11)	100

Notes

(1) Includes Health visitors and hospitals only.
(2) Includes other local authorities and other s/w agencies.
(3) Area social workers only.
(4) Area social workers, plus RSPCC.
(5) Includes day nurseries and childminders.
(6) Includes day nurseries.
(7) Schools only.
(8) Includes one anonymous ref.
(9) Includes 3 N/K.
(10) Source of 27.2% of referrals not given.
(11) Sic.

Sources: NSPCC 1984, Lambeth 1982, Strathclyde 1982.

The first notable feature is the lower level of Medical referrals in the other studies, although this is almost certainly explained as above. (In addition, the

professional organisation is clearly different in Scotland, since the Strathclyde study records 10% of referrals coming from District Nurses, who do not feature in any of the English studies.) The NSPCC figure for Medical referrals seems particularly low, but only includes Health visitors and hospitals: there may have been more medical sources in the 27% of their referrers who are not identified in their study.

The Education authorities in other areas appear to be more alert to the possibility of abuse. Merton's 13.8% is much lower than the NSPCC's or Lambeth's and while it is very similar to Strathclyde's 14%, it should be remembered that Merton's figure also included day nurseries and childminders. However, Merton's study covered a much longer period than the others (particularly than Lambeth's and Strathclyde's), and it will be shown later that Merton's schools became increasingly alert to the problem, so that a more recent analysis might produce more comparable figures.

The NSPCC do not give any figures for social work referrals, although it is not clear whether this is because the referrals were perceived as being made <u>to</u> Social services or whether the figure is simply part of the 27% that was omitted. Lambeth's 4% seems to be low, but did not include any other social work agency or department. It was suggested above that Merton's figure for referrals from the Police was low (1.3%) - but neither the NSPCC nor Lambeth record any Police referrals.

However, not every single group showed such wide fluctuations. Within the Neighbours and Relatives group at least, there was a degree of unanimity with only a span of 3 percentage points between the four studies.

b. <u>Who referred what</u>

Both the Lambeth and NSPCC studies looked at who referred <u>to whom</u>, but neither they, nor the Strathclyde study looked at who referred <u>what</u>, which was the next area considered in the

present study. It is not possible, therefore, to say whether what follows is in line with what happens elsewhere.

It has already been shown that Medical staff were responsible for 45% of the referrals. In fact, they also referred more of every type of abuse except for Groups F and H (Sexual Abuse and No Reason given). The total lack of any sexual abuse referral seems surprising in view of the lead given by the medical profession in more recent years in diagnosing sexual abuse. 48.2% of the Medical referrals were for Physical Abuse.

Social Services was the only referral agency which did not have the highest number of its referrals in Group A (Physical Abuse). This is not altogether surprising - social workers are probably less likely than most other professionals to be the first person to see a bruised or injured child, since the child is neither likely to be brought to them for treatment nor do they have the same opportunity to observe a bruise or other injury in the course of every day contact as, for example, a teacher has. What might cause more concern to Social Services management is the revelation that Social Services was responsible for 54% (23 out of 42) of the Group H (No Reason Given) referrals - a result hardly flattering to the assessment skills of the social workers concerned. These were the families, presumably, that the social workers were already working with. They were concerned enough to convene a Case Conference which led to the child's name being placed on the Register and yet were unable to articulate a clear cause for concern.

Support for the view, expressed above, that teachers (and day carers generally) are well placed to observe signs of physical abuse is provided by the fact that 86% of Education agencies referrals were in the Physical Abuse category. Their focus on the child, rather than the family generally, is also shown by the lack of any referrals from Education in the Parent-related group.

The Police, as has already been noted, made only 4 referrals. All were for Physical Abuse. In view of the role played by the police in dealing with domestic disputes, drugs and sexual offences, it is noteworthy that none of their referrals were in those groups, although, as has been said, an impressionistic view is that an analysis of current referrals might well show a changed pattern, particularly with regard to sexual abuse.

Parents, not surprisingly, did not refer any of the Neglect cases, but did refer 2 out of the 5 Sexual Abuse cases, which might be considered surprising. One further point is perhaps worth making. The major proportion of the Group D (Professional Anxiety) cases were referred by the two professional groups most actively involved with Child Abuse - the Medics and Social Services - who between them accounted for 23 of the 30 cases (77%). It will be remembered that the Professional Anxiety group was originally formed from two others - Suspicion and Fear of Abuse - which were seen as an indication of anxiety rather than a factual assessment of abuse. The analysis of the source of the referrals reinforces the accuracy of the description - Professional Anxiety. The figures were further analysed with reference to the seriousness of the abuse (i.e. which category of registration was subsequently used). Of the 304 cases with identified referrers, fractionally over half (50.6%) were registered in Category I or II. This analysis showed that Medical and Social Services referrals were less likely than other agencies to be registered in the more serious categories. (Only 39.5% of Category I + II referrals were from the Medical group as against 51% of Category III referrals, the comparable figures for Social Services were 19% and 29%.) Conversely all the other groups, with the exception of Parents, were more likely to see their referrals registered in Categories I or II. All the Police referrals were, together with 81% of the education referrals (the latter accounting for 22% of Category I + II, but only 5% of Category III). The Parents were pretty evenly divided with a very slight bias to Category III.

The finding in regard to Social Services was not surprising. It has already been shown that Social services was the only referral group which did not have the highest number of its cases in the Physical abuse, Group A. It has also been shown that Group A accounted for 82% of Category I + II cases. However, the finding that Medical referrals were more likely than the average to be registered in Category III is more unexpected, since 59.9% of Medical referrals were for Physical Abuse. Many of these concerned children who had been seriously injured but it would appear that the Medical profession (like Social Services) were more willing than the other agencies to refer less serious cases. (It may be that this was because, as will be seen in a moment, the Medical professionals also became aware of child abuse earlier than their colleagues in other professions and were therefore less hesitant about referring any case which caused them concern, rather than waiting for "proof" of abuse. A follow-up study might show that, some years later, other agencies were also referring the less serious along with the serious.)

c. Who referred When

The year of referral has already been looked at with regard to fluctuations on the Register and to see which type of case was referred when. It was re-examined at this stage to look at the rate at which different agencies made their referrals. This showed that, so far as the smaller referral groups were concerned, there was a steady trickle over the years with no particularly obvious patterns. It was the three main groups of Medical, Social Services and Education which proved more interesting. They dominated the referrals and the fluctuations in the number of cases they referred were largely responsible for the overall fluctuations on the Register.

The numbers referred by the Medical professions have already been mentioned: what became apparent at this stage was that, not only did they make more referrals than other groups but that they made them sooner. The Medical group were responsible for 26 out of the 33 referrals made before

the end of 1973. By the end of the following year, when Social Services had made a total of 5 referrals and Education had made their first 2, the Medical group had made 49. (If the Medical group is broken down to its constituent parts, it becomes clear that it was the Hospitals and Health Visitors, who were largely responsible for this - 64% of the Hospital referrals and 69% of the Health Visitors' ones were made before the end of 1977, although only 55% of the total number of Registrations had taken place by then).

Social Services started in 1974 but made their highest number of referrals in their second year (17 out of 72 or just under 24%). Education also started in 1974, although the Schools were quicker off the mark than their Day Nursery or Childminding colleagues: the former did not make their first referral until 1977, the latter till 1981). It has frequently been pointed out that 1975 was the year in which the highest number of Registrations took place and the subject will be looked at again in a moment. Apart from 1975, the other peak years were 1977 and 1981 - both years in which Education made an above average number of referrals. These years were, as was shown earlier, years in which a large number of Group A, Physical Abuse, referrals were made (20 in 1977, 21 in 1981). It was pointed out that these were the type of referral most commonly made by the Education group. It was also shown earlier than the Education authorities in Merton were responsible for a lower rate of referral than the Education groups in the other studies; an indication that that might have changed had the study continued longer is shown by the fact that 16 out of 41, or 39%, of the Education referrals were made in the last two years of the study.

The year following the publication of the Maria Colwell report and the DHSS circular, "Non-Accidental Injury to Children" (i.e. 1975), was the year when the highest number of Registrations took place and, therefore, the referral pattern for that year is particularly interesting. The Medical group had their third highest year and Social Services their highest of all. The combination of the two groups was responsible for 38 of the 49 referrals, that is

over 77%. When the reasons for referral were looked at, it will be remembered that in 1975 two groups - Group D, Professional Anxiety and Group H, No Reason Given - accounted for over half the registrations (25 out of 49). Who these referrals were made by was therefore looked at and the results shown in Table 13, (where the referring groups are further subdivided into their constituent agents).

Table 13 Referrers of Group D and H cases in 1975

Group	Number	Subtotal
Medical		
Health Visitors	2	
Hospitals	4	
G.P.	1	7
Social Services		
Internal	6	
Other local authorities	4	
Other social work agencies	4	14
Education		
Schools	2	2
Referrer not known	2	2
Overall total		25

From Table 13 it can be seen that the Medical and Social Service groups were responsible for referring 85% of the D and H cases in 1975. (Their overall responsibility for these type of cases was 79%.) Social Services accounted for a particularly high proportion of these 1975 referrals. Their contribution was 56%, as against their overall rate of 44%. The Medical group was actually below their usual rate (28% rather than their average 34%). Additionally, when one looks at the D and H referrals in the context of the other referrals made by the two groups, Social Services' contribution becomes particularly significant, since the 14 cases shown in Table 13 accounted for over 80% of the Social Services' referrals for 1975, but only a third of the Medical ones. Clearly Social Services (and it should be noted that these referrals were not only made by Merton Social Services but also Other Social Work Agencies) were particularly concerned and anxious about child abuse that

year. That the anxiety was general to Social Workers and not just specific to Merton Social Services is shown by the breakdown of the 1975 referrals shown in the Table. Of the 14 in the Social Services group, 6 were made by Other Local Authorities - and 4 of these were in Groups D or H - and 4, all in D or H, were made by Other Social Work Agencies. That is 23.5% of all the referrals ever made by Other Social Work agencies.

d. Who referred who - an attempt to guess at background

Virtually none of the cards on the Register gave any indication of a family's social class or of the father's occupation. Even a reference to the father being in or out of work was exceptional. The only indication of background which could be gained was from the address. At the time of the study, Merton had not begun to sell off council houses in any numbers and it was possible to be reasonably certain, in most cases, which was council property and which was more likely to be owner occupied. (It is possible that a very few of the latter were privately rented rather than owner occupied, but the privately rented sector was small and was, on the whole, clear. Where it was not clear, the case was excluded.

The actual location of the homes will be looked at in more detail in the next chapter when an attempt will be made to describe the type of family whose children's names were on the Register. At this stage all that was being done was a crude endeavour to see if it were possible to determine whether families, who appeared to be more likely to be middleclass, were more or less likely to be referred by any particular professional group. It appeared possible in 204 out of the 328 cases to determine whether a family lived in their own home or in a council property. (It was further possible to divide the latter into a property on one of three large council estates or a council house in a smaller development.) Whereas, as was said in the Introduction, in Merton as a whole, 61.7% of the general population lived in their own homes and only 21.8% lived in council

accommodation at the time of the 1981 census, in this study of families with children on the Register, 61.1% of them lived in council housing and only 30.9% in their own homes.

The 204 cases were analysed with reference to their referrers and it became immediately apparent that the bulk of the Own Home referrals came from the Medical profession - 38 out of the 63 or just over 60%. No other group referred any substantial number: Social Services referred 11 cases but otherwise the highest number from any one group was 4, although one might note in passing that the Police had the highest proportion of all since 2 out of their 3 referrals from an identified housing background lived in their own homes.

The Medical Own Homes referrals formed the bulk of all the Own Homes referrals. This is not surprising. Children, whatever their home background, are seen by doctors and health visitors or taken to hospital when they are hurt. However, they also go to school and come into contact with the other agencies which make referrals (although middle class children are less likely to encounter social workers). None of the referrals from Education sources, however, came from a private school. One might have expected that the Medical group would be responsible for many, if not most of the Own Home cases. One would not necessarily have expected that 46.9%, or nearly half of the Medical group's own referrals would come from the Own Homes sector. Far more detailed research would be needed to confirm that these children were from a different social class than the children from the council houses. All these results can suggest is that there appears to be some grounds for saying that, so far as the Medical professions are concerned, children are almost equally at risk whether their parents own their own homes or not, but as far as other referral groups (with the possible exception of the police) are concerned, children from council housing are more likely to be thought to be at risk.

The 141 families from council housing were further studied to determine whether they lived on a large estate or in

other council housing. 83, or 58.9% were from the estates. They were most likely to be referred, and their children's names placed on the Register, by either Social Workers or Health Visitors. (Health Visitors were separated out from their medical colleagues for this analysis only, because of their role in visiting families at home.) Social Services' referrals from council housing were composed of 69.4% of cases from the three estates; the Health Visitors had 66.6%. The rest of the Medical group, even without their Health Visitor colleagues, were above the mean, with 60.7%, but all the other referral groups had a lower than average number from the estates, with Education having the lowest number of all at 45.8%. It would be tempting to suggest that schools see the children primarily as children and that their home surroundings may be less obvious, but, while that could form a hypothesis for further study, the present study cannot do more than note the differences in the referral rates and to say that it appears, from the figures, that the Medical profession was the most likely to refer families living in their own accommodation and that Social Services and Health Visitors referred a higher than average number of families from the large estates.

Summary

To conclude the section on referrers, it is necessary to recap briefly on some of the points which emerged. Chief among these is the prominent role played by the Medical professions in referring cases of suspected child abuse and in doing so before the other professions had really come to terms with the extent of possible abuse. The Medical professions in Merton seemed even more alert than those elsewhere, although one must beware of drawing too firm conclusions on the basis of other studies which collected somewhat different data. In fact three agencies were responsible for the bulk of the referrals: Medical, Social Services and Education. Both the Medical and Social Service groupings were more likely than the others to refer what have been termed the "anxiety" cases and they were also the most likely to refer the cases which were registered in Category III, the least serious category. Other groups were

more likely to refer a higher proportion of serious cases. This does not necessarily mean that a larger share of the Medical or Social Services referrals were frivolous, although it may suggest that they were more willing to take action before a situation became really serious and it has also been suggested that they were more likely to be responsive to the pressure of public opinion and be quicker to refer in certain years. More concerning, in relation to Social Services, was the latter's responsibility for over half of the referrals where No Reason was identified for the registration.

The Medical professions were most likely to be responsible for referring those families who lived in their own homes and therefore appeared to be likely to be more middle-class and a large proportion of Medical referrals, in fact, came from that background. Many of the council tenants on the Register, however, came from one of three large estates and they were most likely to be referred by Social workers or Health Visitors. It is not possible to say, on the basis of this study, whether abuse is more or less likely to occur on the estates. Abusing families may have been placed there because of particular housing policies, or the referrers may have been more inclined to see problems because of where they lived. A more detailed study would be necessary to establish this. Meanwhile, the next part of the study attempts to consider the professional input generally.

7. The Professional Input and Social Services' Responsibility

The multi-disciplinary involvement with child abuse cases has already been apparent from the study of referrers, but the management of child abuse does not stop with a referral which leads to a Case Conference and the subsequent placing of a child's name on the Register. Many of the professionals will continue to be involved with the family until Deregistration and beyond. We have seen that some of the cases remained on the Register for many years. The demands that these cases made on professional time as a result is not recorded in any way which can be readily measured, apart from studying the time spent in Case

Conferences. (Even a detailed study of case files would be likely only to reveal the number of contacts, not the amount of time they took.)

Since the main responsibility for the management of Child Abuse fell on the Local Authority in theory, and therefore on the Social Services Department in practice, and because this study was mounted from within the Social Services department, it was decided to look more closely at Social Services' own role. The part the Department played in maintaining the Register has already been described and later chapters will detail the role Social Services played in the Borough Review Committee and the writing of the multi-disciplinary guidelines. In addition, Social Services were responsible for convening, and generally chairing, Case Conferences and were principally responsible for providing the Keyworker - the professional most closely involved with a family, whose name was on the Register and responsible for keeping all the other professionals informed about current developments. The consequent workload for the Department was considerable. In order to see whether this workload was distributed evenly across the district offices, the cases were studied again with reference to their location within the Borough. Moreover, it has already been indicated that the incidence of registration fluctuated from year to year and <u>appears</u> at least to be affected by the level of professional anxiety. If, as has been suggested, Child Abuse Registers record abuse which has been discovered and diagnosed by the professionals (rather than all the abuse which has happened), plus the names of children who are considered, by professionals, to be at risk, one might discover that there were fluctuations across the Borough that seemed greater than one might expect from the demographic factors prevailing.

a. <u>Social Services - the incidence of Registration across the Borough</u>

During the period of the study, the Social Services Department in Merton contained 4 Area Offices - identified for the purpose of the study as Areas A,B,C and D. In

September 1983, that is 6 months after the cut-off period for the collection of data, these areas were reorganised into 3 districts, corresponding to the three constituent boroughs of Mitcham, Morden and Wimbledon which had been amalgamated in the local government reorganisation of the early Seventies to form the London Borough of Merton.

To discover whether there were any significant trends in the distribution across the Borough, either in the number or type and category of registrations, the cases were analysed by reference to the Area office which dealt with them. A preliminary plotting, on a borough map, of the address of each family in the Open section of the Register at March 1983, not only caused some consternation among the then Area Managers, but showed that there did seem to be some concentrations of families on particular estates and even in one particular block of flats. In order to examine this in more depth, the addresses of all 328 families were analysed to see whether this was a permanent tendency or a passing phase. (As a further check, a quick survey of Open cases done 5 years later, in March 1988, showed some interesting changes.)

The first part of this part of the analysis - the allocation of each case to the Area responsible for it - immediately showed some wide variations. Area B had 149 cases, 45% of all the cases ever registered, more than the combined totals of Areas A and D and almost 5 times the number in Area C. The position in regard to the Open cases was broadly similar. Area B consistently registered more families than any of the other areas. In fact the numerical superiority was even greater in relation to the Open cases as Table 14 shows:-

Table 14 Numbers of Cases on the Register in each Area (Percentages in brackets)

Area	All cases, 1972-83 N=328	Open Cases, March 1983 N=59
A	73 (22.3)	12 (20.3)
B	149 (45.4)	29 (49.2)
C	31 (9.5)	4 (6.8)
D	75 (22.9)	14 (23.7)

Although Area B had an even larger share of the Open cases than of the Overall Register, the pattern in both the Open and Overall Register was similar. Less than 4 percentage points separate the two sets of figures in relation to any of the Areas and in the case of Areas A and D, the figures were even closer and more consistent. Area B's domination was both historic and current.

A similar pattern of domination in Area B is apparent in Table 15, which shows the same breakdown by Area, but this time with reference to the category of Registration. It has already been shown that 161, or 49.1%, of the cases were registered in Cat. I + II. The analysis by Area shows that Area B had a higher than average proportion of its registered cases in Categories I or II in sharp contrast to Area C which had only just over a third. In fact Area B had more cases in the higher Categories than any of the other areas had ever registered at all. This is shown in Table 15.

Table 15 Percentage of Cases in different Categories in each Area

Area	Cat. I + II	Cat. III	Number of cases
A	43.8	56.2	73
B	55.7	44.3	149
C	35.5	64.5	31
D	46.7	53.3	75

By this stage, it was becoming clear that Area B not only had the greatest number of cases, but, the Area itself at least believed, a high proportion of serious cases. In order to try to understand how this situation might arise, the figures were further examined to discover the reasons why the different areas registered their cases. With regard to Areas A,B and C, the patterns were, in fact, broadly similar, although as one might expect from the fact that Area B had been shown to have the most Category I + II cases, so it also had the most Group A, Physical Abuse cases (60% against Areas A and C's 58% and the overall average of 54%). Apart from that the most obvious differences between

these three areas was that Area C had an unusually low percentage of Group C, Parent-related cases (6.5% against an average of 12%) and Area A a low proportion of Groups D and H (Professional Anxiety and Not Known) - only 15% against an overall average of 22%.

Area D, however, showed considerable variation from the others. A low proportion (39%) of Group A, Physical Abuse, was compensated for by an above average score in each of the other groups, particularly the Anxiety groups (D + H), which formed 31% of its total registrations.

In terms of the actual numbers registered for the different reasons, as opposed to the percentage of each areas' cases, Area B had registered more than 90 Group A, Physical Abuse, cases - more than all the other areas combined and more than twice as many as Area A, which had the next highest number (42). Area B dominated each of the four most numerous Reason for Registration Groups, although Area D ran it a close second in Group D, the Professional Anxiety group, with 11 cases against Area B's 12. Area A was third or fourth in the ranking order for all reasons except Physical Abuse, as has been mentioned. What was remarkable about Area A was that it had registered 6 out of the 12 cases of Emotional Abuse and it had the lowest number of cases registered with No Reason given. This latter fact, coupled with the low number of registrations for Professional Anxiety in Area A, which has already been mentioned, suggests that this area was more specific about its reasons for registration than the others were.

Area C had very few cases in either Group C (Parent Related) or Group D (Professional Anxiety), but it did have 6 cases where No Reason was given. This may not seem a large number but it was 19.4% or almost 1 in 5 of its total cases. Surprisingly Area C had only 1 case in Group D, Professional Anxiety, while Area D's 11 cases have already been noted - the highest proportion of any of the areas, which, coupled with its 12 No Reason Given cases, produced the 31% of its total registrations noted above. Area D appears to have been more of a maverick than the other three Areas.

To explain these differences and variations conclusively is far beyond the scope of this study, which can only begin to suggest a line of possible inquiry for future research. Undoubtedly there were some demographic differences, which will be explored in more detail in a moment. There could also be differences in professional practice or of emphasis between the Area teams. Bearing in mind that the Register is a register of concern and detected abuse, one must be careful to avoid any assertion that there is more or less Child Abuse in certain parts of the Borough. The only confident assertion one can make is there were variations in the registration rate between different parts of the Borough and that the Area which registered the highest number of cases also felt it had a higher proportion of more serious cases. It also had the largest number of cases where No Reason was given for registration. On the other hand, the Area with the least number of cases had only one case where the cause of registration was Professional Anxiety. These factors would tend to suggest a hypothesis of professional variation.

Two further factors would tend to confirm a possible basis for such a hypothesis. The first is demographic, the second is what had happened five years later. The problem with the population figures is that the census data is based on geographical districts which did not correspond very closely with the Social Services Area boundaries. However, the reorganisation which was already being planned when the collection of the data finished and which took effect 6 months later, changed the four former Areas into three new Districts, conforming with the old boroughs of Mitcham, Morden and Wimbledon which had been amalgamated to make the London Borough of Merton. These three districts contained virtually identical ward boundaries to those used in the 1981 census and so the population figures are readily accessible and comparable.

Broadly speaking, the Social Services reorganisation involved the amalgamation of the old Areas A and D into a new Wimbledon District, while Area B became Mitcham District

and Area C Morden. There were a few minor additional adjustments of a few streets here and there, principally from the former Area D to the new Morden District - this might have meant the transfer of a few Register cases, but, judging by the number of Open cases in the relevant streets at March 83, it is likely to have been a maximum of 3 and therefore not of major significance.

One of the intentions of the reorganisation was to produce 3 areas which were more nearly equal in size than the previous four had been. Looking at the figures in Table 16, one can see how the effect was to produce two Districts - Mitcham and Morden - of virtually identical population size and a third District, Wimbledon, that was nearly a fifth as big again as either of the other two. Since this is the district which was made up of the amalgamation of the two former Areas A and C, it will be apparent that, during the period covered by the study, Area B (subsequently Mitcham District) was far more populous than either of them and it is therefore not so surprising that it contained a larger number of Registrations.

Table 16 Population of the 3 Districts at the time of the 1981 Census

District	Total Population	0-4 yrs	5-15 yrs	Total under 15	% of pop. under 15
Wimbledon	63,158	3,410	7,707	11,117	17.6
Mitcham	50,782	3,245	8,108	11,353	22.4
Morden	51,158	2,429	6,758	9,187	17.9

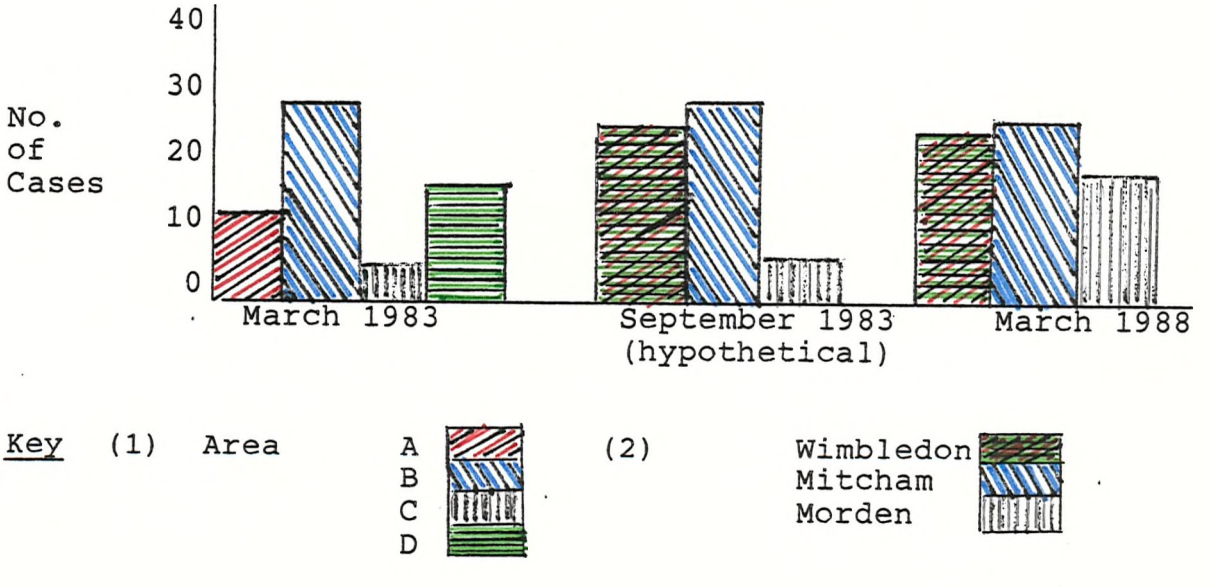
(Source: 1981 Census figures)

Table 16 shows not only total populations but the percentages and totals of children. From this it becomes apparent that Morden, although numerically larger than the Mitcham District, contained a small percentage of under 15 year olds, by definition suggesting an older population structure and therefore a population which contained less children to be considered At Risk. The difference, however, was less than 5% and would not have been expected to produce

a registration rate only just over a fifth of Mitcham's (31 cases between 1972-83 against 149).

The Wimbledon District also had a lower percentage of under 15 year olds than either Mitcham or Morden, but Wimbledon had a larger number of under 4s and one will see later that younger children were more likely to be considered at risk, so the two Districts were well matched so far as population went and this is reflected in the Registration figures when one combines those of the former Area A and D, making a total of 148 cases against Mitcham's 149. So, on purely demographic grounds, one would feel the situation in those two Districts was as one would expect, but that the Morden numbers were not nearly as high as one might have hypothesised. This study does not pretend to be able to pinpoint the factors which cause children to be considered at risk (although the next chapter will attempt to profile the kinds of children and families who were though to be in danger) and a more detailed demographic study would no doubt turn up considerable variations of class, income or other factors between the different Districts. So far as housing went, Morden does contain council estates but does not contain any of the three big estates mentioned above, with their high rise blocks.

Table 17 Numbers on the Register by Area at March 83 Sept 83 (hypothetical) and March 88



However, Table 17 supports the view that there might be an explanation other than a geographical one. This shows the number of Open Section cases at the close of the study, March 1983, by Area, with the hypothetical position at reorganisation 5 months later. This shows that, as was suggested above, in relation to all the cases ever registered, that the Wimbledon and Mitcham Districts were closely matched, but the Morden District lagged far behind. However, the Table also shows the actual situation 5 years later, in March 1988. Wimbledon has closed the gap marginally on Mitcham and only two cases separate the two Districts, which have maintained the sort of numbers one would expect. The overall numbers on the Register have gone up and the increase is accounted for by the increased number of cases in Morden which has more than 4 times as many cases on the Register as in March 1983. Clearly, the demographic factors may have changed somewhat but far more detailed study of the individual cases would be needed to ascertain whether there was any radical difference in the type of case. The increased level of media attention in the years preceding March 1988 might have raised professional consciousness, but in that case one would expect all the Districts to show an increase, whereas Wimbledon and Mitcham show a slight drop.

It has already been suggested that a hypothesis of professional variation might explain the variations between the areas and districts and both the fact that the population of Morden was not so very different from the other two Districts and the changed position 5 years later tend to support this. Furthermore, shortly after reorganisation, Morden's long-serving Area Manager retired. He had been the only professionally unqualified member of the management staff for some years and was succeeded by a District Manager who was both professionally qualified and experienced in working with Child Care problems. Any attempt to explain the variations more conclusively would need to consider the effect of the change of management experience and style.

There is a further factor to consider. This study deals with Registrations, not with referrals. One cannot really hypothesise about professional variation or the possibility of one Area showing greater anxiety than the others without information about the number of child abuse referrals. Any future research which wished to examine the possibility of professional variation should look at referrals : firstly, at the percentage of such referrals which resulted in a Case Conference and, secondly, at the percentage of those referrals which were conferenced where the decision was not to register.

b. The Time spent in Case Conferences

The 1974 DHSS circular advised that "a case conference is recommended for every case involving suspected non-accidental injury to a child" (DHSS 1974, 14) and a list of the agencies who would normally expect to be included was given. The DHSS further recommended that the Case Conference should retain "overall concern for the management of the case and should be prepared to reconvene at each successive development" (Ibid, 15). So, although, a specific review system was not spelled out, it was clearly envisaged that the Conference would have some sort of review function. (In fact the 1980 circular stated "all cases should be reassessed at least once every 6 months" (DHSS 1980, 3.3a). This was seen as being done in the first instance by consulting the different agencies involved and calling a Case Conference if any of the professionals or the Register Custodian thought it necessary (Ibid, 3.3.b). In Merton, the system was that only a Case Conference could place a child's name on the Register and that the first review would be called after 3 months and at 6 monthly intervals thereafter. There was provision, by agreement, to review a case on paper in certain circumstances, but the normal expectation was of a review in the form of a reconvened Case Conference.

Therefore all the families, whose children's names had been placed on the Register had been the subject of a Case Conference. (There was one exception to this - the study

turned up one case in the Open Section - where it had been for 5 years - which had never apparently been conferenced at all, in complete contradiction to Merton's procedures: it was subsequently removed and, for the purpose of this study has been classified as a wrong registration.) As well as being the subject of an initial Case Conference, all those families who had been on the Register for longer than 3 months, should have been the subject of at least one review.

Even before the DHSS had issued the 1980 circular allowing for the possibility of paper monitoring, there had been complaints in some quarters about the cost of the Case Conference system in terms of both time and money. Geach details examples of these complaints and gives an estimate (at 1980 rates) of a cost approaching £750 per conference (Geach and Szwed, 1983, 53). The investment of time by professionals, who may have to cancel other important commitments to attend, has not been quantified.

In view of these criticisms, it was decided to try to discover the average number of conferences per case and to try to estimate the time and cost involved. The information proved time-consuming to collect, since it was necessary to read the Register cards with great care, checking the entries and dates against the Central Index to discover which entries referred to meetings and which to written information. The analysis was therefore confined to the first 100 cases on the Register, in the belief that these were broadly typical of all the whole. The first 100 included all the Open cases, some of which had only been on the register a matter of weeks and had therefore not yet been reviewed. They were, however, offset by a hard core of long-lasting cases which had been in the Open Section far longer than most of the closed cases had ever been.

63 of the cases were from Categories I + II, the rest from Category III. This was a higher proportion of more serious cases than on the Register as a whole (which divided 161:167) but would not appear likely to make any significant difference to the number of conferences, since the

difference in the average number of meetings for the two sets of categories was only 0.04.

Altogether a total of 400 conferences and reviews had been held, making an average of 4 per case. Although the average number of conferences per case was very close, whether the case was registered Category I + II or Category III, there was a much wider range in the number of conferences held for the more serious group (1-17 as against Category III's 1-9). In addition there had been, in 41 cases, paper reviews (i.e. an exchange of views without an actual meting as recommended by the 1980 circular). These were held for 28 of the Category I + II cases and 13 of the Category III cases, making it slightly more probable that a serious case would be reviewed on paper than that a Category III one would (68.3% of the paper reviews were for the Category I + II cases which made up only 63% of this part of the sample). In addition, the Category I + II cases had more paper reviews per case than the Category III cases. A total of 97 paper reviews were recorded, 72 for Category I + II, 25 for Category III, making an average of 2.6 for the Category I + II cases and 1.9 for the Category III ones.

Three quarters of the paper reviews were done in Area B, which has already been shown to have had by far the largest number of registrations and could therefore be considered to be under the most pressure in relation to child abuse. To try to save professional time by conducting paper reviews may therefore have been understandable, but raises two concerns.

Firstly, the fact that more were held for the more serious cases makes one wonder whether these cases were really so worrying as the category of their registration would suggest. (It is of course possible to argue that they at least got reviewed and that the Category III ones possibly got left - it was amply clear from the dates that review conferences were regularly overdue.)

Secondly, if, as in the most extreme case, 11 paper reviews were done on one family, was it really necessary to keep the case in Category I of the Open section for over 11 years?

It is impossible to estimate the time or cost involved in paper reviews, but a total of 400 conferences for the 100 cases looked at postulates a possible 1312 for the register as a whole between 1970 and March 1983. If Geach's figure of £750 per conference is anywhere near accurate, this supposes a cost of £984,000 - little short of a million pounds and averaging out at £3,000 per family. (It must be remembered this is for meetings only - not for direct work with the family.)

The cost in terms of professional time is also mind-boggling. Castle found that 50% of conferences lasted between 1 and 2 hours (Castle 1976,7). Even if one assumes an average of one hour (which from bitter personal experience would seem a massive underestimate), the investment of professional time is massive. Few conferences are attended by less than 6 people, many by a dozen or more and the occasional one by over twenty professionals, some of them senior consultants or managers. At the conservative estimate, then, that each conference was attended by only 6 people and lasted only one hour, that still amounts to 7,872 man hours spent on Case Conferences or Reviews.

8. Conclusions

This chapter has been about the professional management of child abuse and, in particular, about the use of a Register of cases as a method of identifying concern, coordinating professional activity and monitoring progress. Throughout, there has been a constant emphasis on recognising that the Register was a record of professional concern and not necessarily an accurate record of the amount of abuse within Merton. We have seen how the Register numbers fluctuated and how numbers went up at times of high public attention, but also how there seemed a self-correcting mechanism, so that the numbers did not stay unduly high. The reasons for placing names on the Register, and for removing them, were

examined to see what trends could be detected that might have helpful implications for the professionals involved. Some of the results were encouraging - more cases were removed from the Register, because they were thought to have made progress, than for less optimistic reasons. Others were less encouraging - some cases spent many years on the Register and those that were thought to have made progress spent longer on the Register than those that did not cooperate. Physical Abuse accounted for by far the largest number of cases and was viewed more seriously than other forms of abuse, staying on the Register longer. A far higher proportion of cases in this study were referred to the Register by Medical professionals than in any other study and the Medical group also referred most of the families which lived in their own, as opposed to Council, houses.

Throughout this part of the study, there was a difficulty in forming consistent conclusions. The variations between different districts, between registration rates in different years and at different times of year and between the reasons for registration in different years all contributed to the impression that the Register was a record of professional concern and that concern was not static and predictable. There could be no doubt about the huge investment of professional time and resources in the assessment and monitoring of child abuse. The next chapter attempts to look at the type of families and children who were on the receiving end of this attention.

CHAPTER III - PROFILE OF THE FAMILIES AND CHILDREN

1. Introduction

The DHSS had recommended the setting up of Registers in 1974 and in 1976, the advice was more directive : "all areas which have not yet established a central register should now do so" (DHSS 1976,17). However, it was not until 1980 that the DHSS gave any detailed attention to the purpose of a Register system. According to that year's memorandum there were three reasons for maintaining a register:-

"a) to provide, for the use of all agencies, a central register of children who have been or may be the victims of abuse and who are the subject of serious professional concern.

b) to provide a record of enquiries to the register to enable workers to bring together fragments of information which viewed in isolation present an incomplete picture but which seen as a whole may confirm or dispel a suspicion of abuse; and

c) to provide statistical data on the incidence of child abuse for planning purposes, to provide material for training and research and to help to prevent duplication of services by different agencies" (DHSS 1980,1.2).

The idea of Registers as a source of research data and information about the types of children and families considered at risk has not been much discussed in the literature, which has been more concerned with either criticising them (Geach and Szwed 1983) or describing them (Parton 1985). Stevenson and Hallet did, it is true, in the same year as the DHSS memorandum, refer to registers as "a source of epidemiological data for statistical and research purposes" (Stevenson and Hallett, 1980,8) without exploring the idea any further. Jones, in a paper on Child Abuse Registers, added Research at the end of a list of fourteen functions of a Register but also stated that "inaccurate data is a poor basis for service evaluation planning and research" (Jones, Hill and Thorpe, 1979,9) - a proposition with which one must agree.

However, the NSPCC, Lambeth and Strathclyde studies have shown what can be done using the material available on the Registers, limited though it may be. Looking at the Merton Register it was immediately obvious that there was a wealth of material about the children and their families. Provided that one bears constantly in mind that "At Risk Registers reflect concern rather than incidence of abuse" (Cooper and Ball, 1987,17), there is surely a value at looking at the sort of children and families who cause that concern and the forms that that concern takes.

Therefore the 328 families who featured on Merton's Register form the next part of the study. An attempt was made to analyse who they were, where they lived and what the professionals thought were their most obvious problems. The ages of the parents, the size of the families, the marital state of the parents, the position of the child causing concern within that family, the sex and ages of the children were all looked at to try to discover whether the situation in Merton was similar to that found in other studies, or whether there were factors peculiar to the local situation - which might or might not have relevance for other parts of the country.

For this part of the study, the information was principally gathered from the Register cards. In theory, all the basic information of names, ages, etc. should have been available there, but as been already pointed out, in practice, some of it was missing, or clearly wrong. In those instances, a check was made with the Central Index, which appeared to be more accurately maintained. Information about parents, and particularly about fathers, was, as other studies have found, frequently missing. (Hallett and Stevenson 1980, Lambeth 1982) It was decided to analyse the age of the parents involved, but this information was so frequently missing that even a combination of the Register and the Central Index yielded - in relation to the first 120 families, the ages of only 95 mothers and 53 fathers. Information about parental occupation, on which to base an estimate of social class, proved impossible to ascertain without consulting individual files or social workers. The

only way that even a crude estimate of social class could be made was through an attempt to analyse the type of housing that a family lived in. (This was particularly disappointing - my own experience, as a social worker employed in a more affluent part of the borough, was that there were a significantly higher proportion of families from the Registrar-General's Social Classes I and II than was found, for example, in the NSPCC studies. This could not be conclusively verified in the present study.)

From the narrative information available on the cards, it was possible to gather some rudimentary information about those who were thought to be responsible for causing abuse and also to pinpoint what was seen by the professionals as the families' main problems. (It was felt that an analysis of the latter could be particularly useful in thinking about the type of response or resource likely to be most effective in dealing with problems of abuse.) In order to try to discover how likely families were to be already involved with Social Services before there was a concern about possible abuse, the Central Index was checked for previous contacts with reference to the first 100 families. Finally, to see how often concern over possible abuse led to the removal of children and for how long, that was also checked as was the frequency with which court proceedings were initiated.

2. Where the Families lived - a) the type of housing

The literature on child abuse regularly emphasises the part that stress plays in triggering an abusive episode (e.g. Gil, 1970, Kempe and Kempe 1978); poverty and poor housing are usually cited as common examples of such stresses (e.g. Jones 1982, 148, Faller, 1981, 9). However, writers are divided between those who believe that abuse is more likely to occur in poor working class families and those who believe it occurs in any class and that poverty is a common cause but not a "necessary" one. An example of the former view is to be found in a study by Smith et al of 134 Birmingham children who had been abused which concluded "the parents...were predominantly from the lower classes" (Smith quoted in Lee, 1978, 127). Again, Pelton, who wrote of the

"myth of classlessness", sees child abuse and neglect as strongly related to poverty in terms of prevalence and severity (Pelton quoted in Parton 1985, 153-4).

Other writers have been more concerned with the types of abusing parents and their psycho-social functioning, believing that "abusive parents come from all walks of life, rich and poor, well educated and uneducated, from all races and religious backgrounds" (Kempe and Kempe 1978,22).

Both sides agree that child abuse is more likely to be reported where the families have lower socio-economic status. The NSPCC describe their constant finding that most families are from the Registrar-General's Social Classes IV and V (although this actually showed some signs of lessening in the 1982 figures) as "over-representation" (NSPCC, 1984, 12). Parton, who feels structural inequality is a cause of much child abuse, believes that "the most deprived sections of the population" are both more likely to suffer the stress which lead to child abuse and are further disadvantaged as "they are more likely to be selected for 'compulsory' intervention by the state" (i.e. to become the subject of professional concern and have their children's names placed on a Register) (Parton, 1985,164).

Housing circumstances can at best be only a very rough guide to economic status or social class. Nevertheless, in the present study it was the only possible one. Since the period being look at ended in March 1983 before the policy of selling off council housing was well established, the type of housing was perhaps a slightly better indicator of family circumstances than it might be in the current situation.

It will be remembered from the 1981 census figures quoted in the Introduction that in the Borough as a whole at that time, 61.7% of the population lived in their own homes and 21.8% in council housing. The situation among the Register families was different. Only 30.8% of the families lived in their own accommodation. (Even if, as seems highly unlikely, all the families, whose housing circumstances

could not be identified had in fact lived in their own houses, the proportion would have been only 57%, still below the census figure.) However, in view of the general agreement that abuse is likely to be underreported among the more socially advantaged, one might perhaps be surprised that the figure is as high as 30%. The NSPCC, which reported a steady increase in the number of council tenancies between 1975-82 (65.5%-75%) (NSPCC, 1977, 1980, 1984), found in 1982 that only 13.4% of families with children on the Register were living in their own homes (NSPCC 1984, 18) and the Strathclyde study gives a figure of 15% owner occupiers (Strathclyde 1982, 2). Lynch and Roberts found, in a small sample of 33 families, that 18% were owner occupiers (Lynch and Roberts, 1982, 140). So the figure in Merton would seem to be higher than elsewhere, which is only to be expected since the proportion of owner occupiers in Merton as a whole was higher, in 1981, both than the rest of London (49%) and the country as a whole (55%).

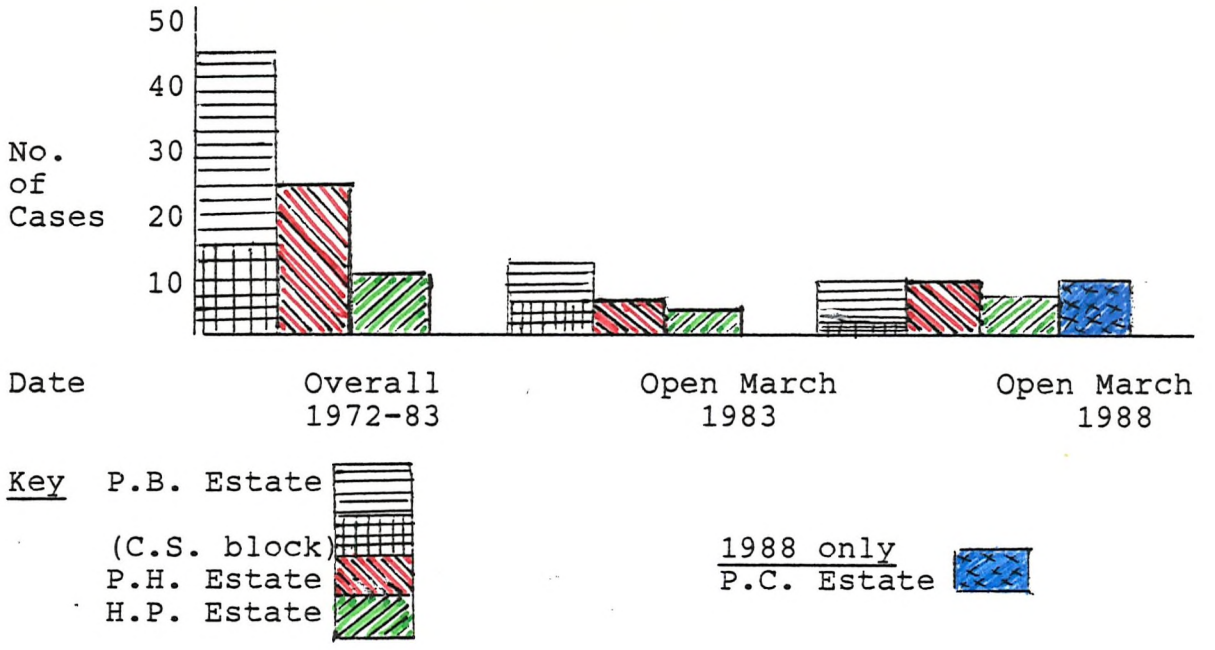
The further breakdown, into the categories of abuse appeared at first sight to support Pelton's view (cited above) that child abuse is related to poverty not only in terms of prevalence but severity. The families who lived in private accommodation were more likely to be registered in Category III where they made up 34% of the registrations, than in Category I or II where they accounted for only 27% of the cases. This would seem to suggest that, not only is child abuse seen as less common among the more affluent, but it is seen as less serious. However, this was not true for the whole period of the study, but only for the early years. The average yearly referral rate for families in private housing was 5, with a peak of 10 in 1974. (It has been pointed out earlier that they were most likely to be referred by the medical professions.) Up to 1976 the cases were far more likely to be registered in Category III - 24 of the 26 families concerned. But from 1976 onwards, the picture changed - in that year 4 out of the 5 families were registered in Category I or II and between 1976 and March 1983, 24 families living in private accommodation were registered in Category I or II as against 13 in Category

III. Whether this signifies a genuine change in the seriousness of the incidents which led to registration or whether it indicates a perceived change or a readiness on the part of professionals to take private house abuse more seriously it is not possible to say. But it does suggest that in Merton at least "battering is" not "a mainly working class phenomenon" (Smith op. cit.).

A further breakdown with regard to the public sector tenants showed 59% of the families identified as living in council housing were placed on one of the big estates and that these families were more likely to be registered in Category I or II than their counterparts in other council housing. In fact, families from the estates made up 45% of the Category I and II families whose housing situation was known. Clearly abuse on the estates either was, or was perceived as, more serious.

The figures relating to the Estate families were therefore looked at in greater detail, as shown in Table 18. Three estates featured in the original figures. Two were in the Mitcham area. The PB estate was composed of several high rise blocks, with a few lower rise interspersed. The PH estate contained less high buildings, but was made up of blocks built round squares with long balconies. The third estate was in the Wimbledon area, the HP estate; it was smaller than the other two and made up of a mixture of high and low rise blocks. The Table also shows the overall picture on the estates from 1972-83. Within the PB figures the number of cases which came from one single block (the CS block) are crosshatched. Overall 14% of the families registered during these years came from the PB estate and one third of these - or 4.9% of the total registrations - came from one single block of flats. It was an area which caused particular concern to Social Services - 25.7% of all the internal Social Services referrals to the Register were for families living on the PB estate.

Table 18 Registered Families on Council Estates 1972-83



According to the 1981 census figures the PB estate had 5.8% of the population of Merton and 6.8% of those under 15 years of age, yet over the years it accounted for 14% of the registrations. In fact the PB and PH estates were very similar in size and nature. PB was slightly larger (9,543 inhabitants against PH's 9,204) but PH, which only accounted for 8.2% of all the registrations, actually had a slightly higher proportion of under 15s - 24.3% against PB's 22.4% (Census 1981).

The third estate, the HP estate, was, as has been said, smaller, and detailed census figures were not available in relation to it. Nevertheless, over the years it contributed a reasonably constant 5% of the registrations and between March 1983 and March 1988, when the numbers on the other two estates dropped, the number on the HP estate increased.

This study can not explain these findings but can only draw attention to them. Far more sophisticated research would be needed to determine the full significance of the findings and the reasons behind them, examining the individual cases in detail as well as well as examining housing policy for the period. Meanwhile it should not be overlooked that the situation can change in a comparatively short space of time. Table 18 also shows the situation with regard to Open cases

in March 1983. The PH estate has dropped more, proportionately, than the PB estate and is only accounting for 29.4% of their joint registrations as against 36.98% of the overall joint registrations. But over the next 5 years the situation on the PB estate changed even faster. The Table also shows the situation with regard to Open cases on the Register in March 1988, five years after the study finished. The two Mitcham estates now had only 7 cases each and accounted for only 20.9% of all the Open cases as against 28.8% 5 years earlier. But in the meantime, a smaller estate of low rise (3 storey) flats in the Wimbledon area, which had not previously figured on the Register in any significant way, had 7 families registered - the same number as each of the two much larger Mitcham estates. Moreover, the CS block on the PB estate now had only one case on the Register.

b. The type of housing and the Reason for Registration

In an attempt to throw a little more light on the situation, the figures were also looked at in conjunction with the Reason for Registration. So far as the families who lived in Council housing were concerned, the reasons for registration occurred in proportions virtually identical to the study as a whole. (The greatest variation was an increase of one and a half per cent in the proportion of cases registered for Parent-related reasons at the expense of an equal drop in the proportion of cases registered because of Professional Anxiety.)

The Private sector showed more variation. Group A, Physical Abuse, only accounted for 48% of the registrations (against the overall figure of 55%). An apparently high number (17.5%) in the combined B,E,F and G groups, was largely accounted for by the high number of G (Other reasons) cases. 5 out of the 6 Group G referrals lived in private accommodation. (The reasons given were one attempted strangling, one where another child in the family had died in very suspicious circumstances, but the family claimed diplomatic immunity, a child locked in a cupboard, a

mother's allegation that her husband had abused the child and an incident described by the referring hospital as an "accident".) The private housing sector had a low proportion of families registered for Parent-related reasons (8% against the overall figure of 12%), but it is the 27% Groups D and H (Professional Anxiety or Reason Not Known) cases, which one would like to be able to explain. (The overall figure was 20%, for council tenants it was only 18.5%.) Why should the more middle-class families arouse such a high level of unfocussed anxiety? One is tempted to speculate that it was harder to identify reasons but that the anxiety remained. Parton quotes research by Straus and Gelles to the effect that families with lower incomes are more likely to be violent towards their children than white collar workers (Parton 1985, 158-161). Obviously housing tenure does not necessarily equate with income or class, but it would certainly appear that, in Merton, families who lived in council tenancies were perceived as being more likely to be physically abusive than their privately housed neighbours.

Summary

So far as the type of housing, in which the families lived was concerned, almost a third of this was private accommodation - a higher figure than that recorded in other surveys. Of the rest, a quarter came from one of three named council estates, although it appears that the focus of anxiety shifted between estates over time. 43% of all the families on the register lived in council property, although the 1981 census found that, generally speaking, only 21.8% of Merton's population did. It therefore seems clear that families living in council housing are more likely to find their children's names on the Register than their counterparts in the private sector and that those on certain big estates are even more likely to arouse professional anxiety.

The families who lived in the private accommodation appeared to be less likely to have their children's names placed on the Register because of Physical Abuse and were also less

likely to have the names placed in the more serious Categories I or II. However, they were more likely than their council house compeers to be the focus of Professional Anxiety and, it was seen in a previous chapter, they were more likely to be referred by a member of the medical profession. While the number of families living in their own accommodation was lower than for the borough as a whole, it was still high enough to contradict any lingering belief that child abuse is confined to deprived areas.

3. Previous Contact with Social Services

In order to try to shed further light on the type of families, whose children were registered and to discover whether they were so-called "typical Social Services clients", the Central Index was checked to ascertain the referral history of the first 100 families on the Register. Case Conferences are theoretically held "immediately" an allegation of abuse is made, but in practice there is generally a delay of a week or more, while the situation is investigated and before the relevant professionals can be gathered together. It was therefore considered that any initial referral which occurred 6 weeks or less before the Case Conference indicated that the possibility of abuse was either the reason for referral or became immediately apparent to the allocated social worker. The 30 families where there had been no contact with Social Services earlier than 6 weeks before the registering Case Conference were consequently counted as "not previously known". In addition, a further 6 families had had only the briefest of passing contacts (e.g. a request for a list of registered childminders or a holiday playscheme place) and there was no active involvement until the events leading to the conference. This means that 36% of the families were not known, or certainly not "clients", prior to the allegation of abuse. The NSPCC and Strathclyde studies do not give any information about previous Social Services involvement but the Lambeth study found that 22% of its cases were not previously known to Social Services and a further 20% were closed cases (Lambeth 1982). Brian Corby found that 38% of families had not been known previously to Social Services

(Corby, 1987, 38). So the Merton figure would appear to be not unreasonable, although high by comparison with Lambeth. (However, Lambeth do not detail the nature and extent of the closed cases' previous contact so it is impossible to place much significance on it.)

Nevertheless, while 36% had had little or no contact, 21 families had been known to Social Services for more than 3 years, although not, in every case, continuously. Moreover, of the families which were previously known to Social Services, the majority (47 out of 64) had been known to the Department for more than a year.

The figures were also broken down in relation to the type of abuse. Since Group A, Physical Abuse, accounted for 55% of the overall registrations, it was no surprise to find it dominating each of the time groups as well. (In fact it accounted for 62% of these cases - a higher figure, because these were predominantly Open cases and, as was seen earlier, Group A cases tended to spend longer in the Open section.) What is interesting, in regard to Group A, is not that it contributes between 57% and 73% of the cases which were unknown or had had less than 3 years contact, but that it only contributed 42% of the cases which had been known to Social Services for more than 3 years - a substantial drop. Instead this section contained a third of all the families registered because of Parent-related concerns, 3 out of 7 of the Emotional Abuse cases and both the two Sexual Abuse cases which were in the Open section.

That Sexual Abuse should come to light only after several years of involvement with a family is not unexpected in view of the emphasis in the literature (Kempe and Helfer 1980, Glaser and Frosh 1988) on the secrecy surrounding sexual abuse within the family. Emotional Abuse and the abuse resulting from Parent-related concerns, such as marital violence or parental drug addiction, are also insidious and may be less immediately apparent than Physical Abuse. Further study of these particular families might well reveal that Social Services' involvement had concentrated on the

parents' problems and only gradually had the effect on the children become apparent.

One other factor emerged during the analysis of the time of contact with Social Services. With regard to the category of Registration, the shorter time the family had been known, the more likely they were to be registered in Category I or II. Only 38% of the families registered in Category I + II had been known for 2 years or longer, as against 48.6% of those registered in Category III.

Summary

Over a third of the families who were registered had had no significant contact with Social Services before abuse was alleged or suspected and those who were well known were more likely to be registered in a less serious category. This would suggest that one could not describe the more serious cases as "typical Social Services clients", although one might feel surprised that a fifth of the families had already been receiving help of some kind for more than 3 years at the stage when their children were considered to be at risk.

4. Family Size

Much has been written, particularly in the early literature, about the greater incidence of child abuse in larger families. The first NSPCC study, Child Victims of Physical Abuse, talked of "this over-representation of large families" and refers to the findings of Gil, Skinner and Castle and Oliver (NSPCC 1977, 18). The 1984 NSPCC study repeated the phrase "over-representation of large families" and found that there was an average of 2.8 children per family in their survey of 4,679 children, with a range of 1-12 children per family (NSPCC 1984, 16). The Strathclyde study says that "the average number of children in the house is 3" (Strathclyde 1982, 2) and the Lambeth figures show an average of 2.3 children per family (Lambeth 1982, 15), although Brian Corby found only 2.12 children per family (Corby 1987, 33). All these figures are above the national

average for the 70s and early 80s: the 1971 census gave an average figure of 2.0 children per family but by 1981 this had decreased to 1.9 (Social Trends, 1983, 26).

No Merton family on the Register had more than 8 children and the average number of children per family was 2.27, very close to Lambeth's. (There were 328 families on the Register, containing 743 children, of whom 531 were the focus of concern and registered.) The number of families where there were 3 or more children was higher than in the Borough as a whole. According to the 1981 census, 21.8% of Greater London families had 3 or more children, although the proportion in Merton was only 20% (Census 1981). The figure for the registered families in the study was 32.9%, virtually the same as Lambeth's 33% (Lambeth 1982, 16) and close to Corby's figure, based on a much smaller sample, of 28% (Corby 1987, 34). By contrast the NSPCC found that 48.9% of the families had three or more children (NSPCC 1984, 16). This is particularly surprising since, using data from the 1981 General Household Survey, (quoted in Social Trends, 13), it is possible to calculate a figure of 17.4% for the country as a whole, a lower figure than the London one given above (Ibid, 26). Since the NSPCC finding is based on figures from all over the country rather than just London, one might have expected the Merton and Lambeth averages to have been higher than the NSPCC's.

When the size of Merton's families was further compared with the NSPCC and Lambeth studies as well as with the UK national statistics, it became apparent that the difference between the NSPCC figures and the others was principally in relation to both single child families and very large families with four or more children. So far as one child families went, Merton's registered families exactly matched the national proportion of 37.5%. Lambeth had 3 percentage points less but the NSPCC were 16% below Merton and the UK as a whole. So far as two child families went, all the Register studies were close to each other (between 27-29.5%) and all were well below the UK figure of 41.6%. The situation was reversed for 3 child families, with the three Register studies still close to each other although the

NSPCC was beginning to inch ahead - the range now was 17.5-22%, with the UK dropping to 14.5%. For four child families, all the Register studies exceed the UK average, the NSPCC spectacularly so. The UK figure was 4.4%, Lambeth's 14%, Merton's 14.6% and the NSPCC 25.5%. (Lambeth, 1982; NSPCC, 1984; General Household Survey, 1980). (Not all NSPCC studies, however, report the same findings: Baher, who analysed a group of families attending an NSPCC centre in West London was "surprised" to find 52% of the children were only children and only 20% of the families had 3 or more children (Baher 1976, 30-1)).

In view of the figures given in the main NSPCC studies it is hardly surprising that they have talked about the "over-representation of large families" (NSPCC 1980, 14; NSPCC, 1984, 16), but the Merton figures can only be interpreted to show a slight bias, compared with national figures, towards larger families being registered and a similarly slight bias away from two child families. When Merton's figures were further broken down with reference to the category of registration, it became apparent that the larger a family, the more likely it was to be registered in Category I or II. Category III dominated the smaller families and then started to decrease, accounting for less than half of the 4 or 5 child families and none of the 3 very large families (one each with 6,7 and 8 children).

The reason for this became apparent when the Reason for Registration was looked at in comparison to family size. Physical Abuse, which has already been shown to be most likely to be Registered in Category I or II dominated the larger families. If those families where there was no reason given for the registration are disregarded, the percentage of families with 4 or more children, who were registered for Physical Abuse, is 75.6%. There were only 10 families with more than 4 children where the reason for Registration, if it was known, was <u>not</u> for Physical Abuse. By contrast, Group D, Professional Anxiety, was largely confined to the smaller families as was Group C, the Parent-related group.

When the percentage of each family size group was analysed in relation to the four main Reason for Registration groups, it appeared that only children were the most likely to be registered for Neglect (57.5% of the Neglect cases came from single child families). Only children were as likely as the average to be registered for Physical Abuse, but less likely than average to be registered because of Professional Anxiety. Two-child families on the other hand seemed most likely to be registered for Parent-related reasons or because of Professional Anxiety and unlikely to be registered for Neglect. Three child families showed a close conformity to the average figures, while the high incidence of Physical Abuse among the largest families has already been mentioned. What might seem more surprising was the single registration for Neglect among the large families. This certainly lends no support to any suggestion that large families may be seen as feckless or neglectful.

The fact that the large family section was composed predominantly of physically abused children may perhaps explain the NSPCC findings of large numbers of big families. Some of the Registers, on which the NSPCC statistics are based, for all or part of the time covered by the studies, only recognised physical abuse as a criteria for registration. Therefore, the NSPCC may indeed be correctly recording a large number of physically abusive families with 3 or more children. What they may be doing is under-recording the smaller families, which boroughs like Merton and Lambeth considered met their criteria for registration, by showing signs of Emotional Abuse or Neglect.

a. Increases in Family Size during Registration

Among predisposing stress factors, which are thought to increase the risk of children being abused, pregnancy has often been cited. Baher et al, in their study of the NSPCC Research Department's work state that "pregnancy was the major source of stress in eighteen cases" out of twenty-five (Baher et al 1976, 37). Similarly Jones suggests that unwanted or difficult pregnancies "occur more often than chance in abusing families" (Jones et al, 1982, 143).

Because of the possibility that pregnancy could be a cause of stress and because the average family size was smaller than expected, the data on the Register was examined to see how many families had a subsequent child during the period of registration. (The family size discussed above was the family size at the point of Registration.)

In fact only a further 32 children were born to 29 families - 17 in families where previously there had only been one child. Three families had two further children, transforming them into 4-, 5- and 7-children families respectively. There were 9 others - 3 children were born into 2-child families, 5 to 3 child families and the last one to a five child family.

The effect on the total family size pattern was not very dramatic. The percentage of single-child families fell by just over 5% and that of 3 child families by just under 1%. The proportion of 2 child families rose by just under 4% and of families with 4 or more children by 2.2%. The average family size rose slightly to 2.36.

Only 19 of the 32 new children's names were placed on the Register. In 8 of the families, pregnancy was cited as a cause of parental stress leading to the abuse, but only 2 of the children in these cases were subsequently registered.

The Central Statistical Office gave, in 1982, a general fertility rate of 64.9 births per thousand women of childbearing age (Social Trends, 12, 20). In view of the fact that, as was shown in the last chapter, the <u>average</u> time that a family's name remained on the Register was only just under two years, one might have expected a larger number of births - nearer to 42 than the 32 which actually occurred.

Since less than 9% of the families had further children during the period of registration and since even the extra births only raised the average family size to less than 0.5 above the national average and still below the NSPCC 2.8, it

would seem that in Merton, abused children came from families which were slightly, but not spectacularly, larger than average.

b. Families with Stepchildren

Ignoring the single child families, there were 222 families which contained more than one child, either at the point of registration or during the period of registration. One in five of these families (21.2%) contained children who were known not to be full blood relatives to each other. Most, but not all, had different fathers, but the same mother: some were step-siblings. As one might well have anticipated, the larger families were more likely to contain these half- or step-siblings than the smaller families. 28.3% of the families with 4 or more children included children with at least one different parent.

There are no comparable statistics available either nationally or from the other studies, so it is impossible to say whether this is a normal situation or not. The families containing step- or half-siblings did not seem remarkable in any other way except that a higher proportion of them (62%) were registered in Group A Physical Abuse (the overall figure was 55%) and they were more likely to be registered in Categories I or II - 62% against the overall figure of 49%.

Summary

The number of large families on Merton's Register was lower than other studies, and particularly NSPCC studies, might have led one to expect, although there were more large families than in the population as a whole and the average family size was slightly higher than the national average for the United Kingdom. However, the number of families which had only one child was identical with the national average. The larger the family the more likely the reason for Registration was likely to be Physical Abuse and the more likely the abuse was to be considered serious and the family registered in Category I or II. Only children, on

the other hand, were more likely to be registered for Neglect. Family size increased less than one might have expected, while families were on the Register and, even with the added births, the average family size was only 0.5 above the national average. Just over 20% of the families contained children who were not full blood relatives but this seemed to have little significance apart from an increased tendency for such families to be registered in Category I or II for Physical Abuse.

5. The Children

The families, as has been pointed out already, contained a total of 743 children. Just under three-quarters, or 71.5%, of these children's names were registered. This indicates that a decision that one child in a family was at risk did not lead automatically to registration for all the siblings: there was clearly some attempt to assess the position of individual family members. Indeed, in many families, where more than one child was registered, the various children were assigned to different categories of risk. That is, the child who was actually a victim of an assault would be registered in Category I but his or her siblings would be registered in Category II or III. (For the purposes of this study, whenever families are being considered, they are allocated to the highest category assigned within the family, but when children are being looked at, they are given their own categories.) The study of the children looked at the number, age and sex of the children and also attempted to see whether there were any "key children", i.e. whether there were any obvious features which marked some children out and made them more likely than their siblings to become the focus of abuse.

a. Sex of the children registered

It was not possible to determine the gender of 5 of the registered children. It was not recorded and their first names gave no clue. Even the Central Index was unable to help. However, the remaining 526 were made up of 289 boys and 237 girls. Table 19 shows how this compares with the

proportions found in other studies and in the UK and Merton generally.

Table 19 Percentages of Boys and Girls on Registers and in the population

	Area	Boys	Girls
I.	Register studies		
	Merton	54.9	45.1
	NSPCC	55.2	44.8
	Lambeth	53	47
II.	Generally		
	UK+	51.2	48.8
	Merton	51.5	48.5

Sources: Social Trends 12, NSPCC 1984. Lambeth 1982.

From this it becomes apparent that the ratio of boys to girls in the general population of Merton was very similar to that in the country as a whole and that, as far as registration went, the NSPCC comment that, "as in previous reports significantly more boys than girls were notified to the Register" (NSPCC 1984, 9) is only marginally (0.6%) less true for Merton. The gap between the sexes is smaller in Lambeth, but still more than twice the gap in the population at large. (Strathclyde gave no figures but simply stated, perhaps surprisingly, "the register is evenly divided between boys and girls" (Strathclyde, 1982, 1).) Lambeth's, Merton's and the NSPCC's figures showed a large measure of agreement and the NSPCC's were consistent with findings from their previous studies (NSPCC, 1977 and 1980). No national figures were available until this study was in its final stages, when the Department of Health issued statistics based on a study of Registers in March 1988. This found that there were more girls than boys on Registers and that the proportion of girls to boys was 52.3 girls to 47.7 boys - an almost exact reversal of the figures given in Table 19 (DOH 1989, 5). The Department's study covered all the Registers in England but because these are the first national figures issued, it is not possible to tell whether the situation has changed during the second half of the Eighties or whether Merton, Lambeth and the NSPCC have been out of step with other areas. Merton's figures, given in the same study, for March 1988 are 26 boys, 25 girls (Ibid,

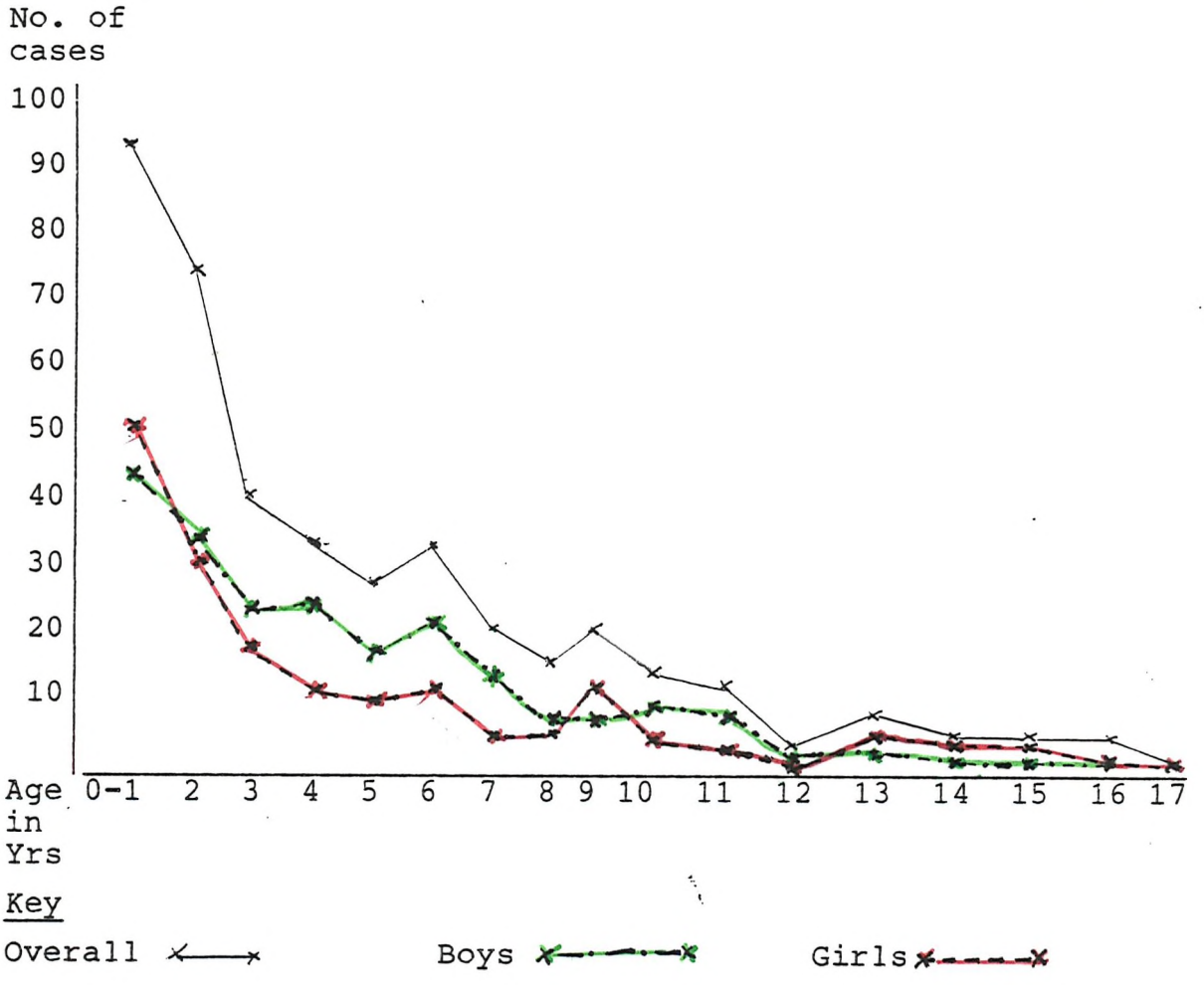
Table 4.11). This indicates that the gap in Merton had narrowed but more boys were still being registered than girls. If the greater registration of girls is a new phenomenon, it is difficult to say why it should be so although two possible factors suggest themselves. Firstly, as will be shown in a moment, girls in Merton's study were more likely than boys to be registered in the older age groups and the registering of older children has increased over the years, with the recognition that child abuse is not just about battered babies. Secondly, the three most recent, and much publicised, inquiries - Jasmine Beckford, Kimberly Carlile and Tyra Henry - have all been about girls.

To return to the situation in Merton at the time of the study: when the categories of abuse were analysed in relation to the sex of the children registered, it appeared that boys were slightly, but only slightly, more likely to be registered in Category III, than I or II (147 to 142). The figures for girls showed a difference of only one between the groups. However, a closer look at the figures showed that boys, who were <u>added</u> to the Register at a later date than the first child in a particular family, were more likely to be added to the higher categories than those originally registered: 4% more boys who were added to the Register were added to Category I or II, whereas the added girls only made a different of 0.1%. This suggests that subsequently added boys are considered to be more seriously at risk than girls.

b. <u>Age of children concerned</u>

417 children from the 328 families were registered at the Initial Case Conferences - the 114 other children were added later, either because they were born later or because the risk to them only became apparent later. When analysing the age of the children, it was these 417 initially registered children who were looked at and the age taken was the age on the date of registration. The result is shown in Table 20.

Table 20 Age of Children first registered (N=417)



This table also shows the ages at which boys and girls were registered. That babies and young children are considered most at risk becomes immediately apparent. The highest number of registration is for the one year olds or younger and, apart from a slight hiccup at 6 years, 9 years and 13 years, the graph descends steadily. Girls of 12 months or less appear to be slightly more at risk than boys, but after that, apart from a slightly higher number of 9 year old girls, boys are registered in higher numbers right through to the beginnings of teenage, when the number of girls increased. It seems that girls are considered most at risk at either end of their childhood.

The figures were also broken down by category of abuse and more differences began to emerge. Overall 64% of registrations were concerned with children under the age of 5, but these were more likely to be registered in Category III than in Categories I or II, particularly if they were

girls: 79% of the Category III girls were under 5 years old, but only 51% of the Category I + II girls were. Categories I + II also contained a higher percentage of older boys: 47% of the boys in the more serious categories were over 5, but only 28.5% of the Category III boys were. Although the recent DoH study found that "younger children were more likely to be on Registers than older children" (DoH, 1989, 1) no other study has broken down the figures by category of abuse so it is not possible to say whether this Merton finding, which appears to show the older children are at more serious risk than younger ones, is typical or not.

One other factor became apparent - although lower numbers of young children were registered in Categories I + II for either sex, the position in regard to girls is that over half of the girls under 5 who were registered in Category I or II were, in fact, aged less than a year. With boys, the figure was just over a quarter. This would appear to reinforce the hypothesis that girls seem to be most at risk at either end of their childhood.

The Lambeth study found an even higher proportion of under 5s than the present study, recording a figure of 68.1% (Lambeth 1982, 8) although only 17% of these were under 12 months as opposed to Merton's 22.8%. Strathclyde does not distinguish the under 5s as such, but gives a figure of 59% for children aged 6 or less and, by comparison with Merton and Lambeth, a very low figure of 8% for babies of 12 months or less (Strathclyde, 1982, Table 2). Clearly north of the border, older children were a focus of greater concern.

The average age of the Merton children was 4.82 for boys, 4.68 for girls. In view of the figures just given for Strathclyde, it is perhaps surprising to discover that the mean ages given in the Strathclyde study are 4 years 10 months for boys and 5 years 6 months for girls (Ibid, 2) - older than in Merton so far as girls go, but not for boys. Lambeth does not give an average age and the NSPCC does not distinguish between the sexes in information about age, preferring to categorise by type of abuse. From these figures it is therefore only possible to deduce that the

approximate average age of the children in the NSPCC study was 5.3 years (NSPCC, 1984). This higher figure possibly indicates yet again the NSPCC concentration on Physical Abuse, since, as will be seen in a moment, in Merton older children seemed at more risk of Physical Abuse than the under 5s.

c. The Reason for Registration by the Age of Children Registered

It will be remembered that the reason for registration was analysed in the last chapter with regard to the numbers of families registered, but it was decided to look at the data again with regard to the individual children registered and to see whether there were any significant differences in regard to the sex or age of children registered for the various reasons. When the children for whom no reason for registration was given or who were registered for "Other reasons" or because they were temporarily transferred into the Borough from another Local Authority were excluded, 347 children remained. These children were divided by sex and the reasons for their registration analysed. The rank order of these reasons was, for boys, exactly the same as it had been for the families as a whole (see Table 4a above), but for girls Group C, Professional Anxiety, was ranked second above Parent-related reasons and Sexual and Emotional Abuse tied for fifth place.

The detailed results showed that Group A, Physical Abuse, accounted for slightly more of the girls' registrations than boys'. This may seem surprising since empirical evidence would suggest that boys were more likely to be the focus of physical punishment than girls, but perhaps the fact that society expects boys to be tougher (and to be treated more toughly?) might account for the fact that Physical Abuse was less often considered as a reason for registration. (In fact, when boys were registered for Physical Abuse, they were slightly more likely than the girls to be registered in Category I or II - 74.5% of the Group A boys as against 72.7% of the Group A Girls.)

More surprising, perhaps, in relation to the Group A cases is the fact that whereas boys seem to be slightly more at risk of Physical Abuse as they get older, girls appear to be markedly so, with an increase of 24 percentage points between the under 5s and the over 11s.

Group B, the Neglect group, showed little difference between the sexes in overall terms, but in the breakdown of age and sex was more common in boys under 5 and girls between 6 and 10. Group C, the Parent-related reasons, showed a higher proportion of boys overall (18% against 12%), particularly little boys, and all the Category I + II registrations in Group C were boys. It appeared to be an important cause for concern among the under 5 girls, with almost 1 in 5 of the registrations, but formed only 5% of the 6-10 year old registrations and none of the oldest age group.

Group D, the Professional Anxiety group, was, on the other hand, much commoner among girls than boys (25 cases against 18 for the boys) and accounted for one in 5 of the youngest group and 1 in 10 of the oldest. For boys, the proportion registered for professional concern rose steadily with age.

More boys than girls were considered at risk of Emotional Abuse (11 boys against 3 girls) and most of these were in the under 5 group, thought they formed a higher percentage of the small 11-17 boys' group.

The numbers of children held to be sexually at risk was, in those pre-Cleveland days, so small, totalling only 5 or 14% of the total, that little significance can be attached to them except to record that the two boys involved were in the 6-10 age group and the three girls in the 11+ age group.

The NSPCC study, found that "boys outnumber girls in practically every age group and type of abuse" (NSPCC, 1984,9) and found the ratio of boys to girls highest in the 0-1 year old Neglect cases and the 5-9 year old Physical Abuse cases (Ibid, 9). The Merton findings agree with the former point - small boys seemed more at risk of Neglect than small girls - but did not completely confirm the

finding in relation to the 5-9 year olds. There were, it is true, numerically more boys in the middle age group registered for Physical Abuse (but there was a year's difference in the age ranges between the NSPCC and Merton). There were 35 boys and only 30 girls involved in this register group and age group in Merton as against the 613 boys and 397 girls in the NSPCC study. But, firstly, that is a closer ratio than the NSPCC's 6 to 4 and secondly, as a percentage of the numbers registered within this age group, 60% of boys and 74% of girls aged 6-10 in Merton were registered for Physical Abuse as against 93% of girls and 97% of boys aged 5-9 in the NSPCC study. (Percentages were calculated on the basis of data given in NSPCC 1984, 4). (The NSPCC figures are consistently weighted towards Physical Abuse - in part at least, because, as has been explained earlier, the criteria in some of their register areas only recognised Physical Abuse. The overall percentage of Physical Abuse cases recorded by the NSPCC for the years 1977-82 was 92.5%. Merton's for the years 1972-83 was 59%.) So the NSPCC figures do not provide a totally helpful comparison, although they too found a higher number of girls being sexually abused than boys (this is a common finding - Glaser and Frosch summarising several studies, felt that "the most reasonable conclusion from the available data is that boys are quite frequently sexually abused, at a rate between a fifth and a half that for girls") (Glaser and Frosch, 1988,13). The only firm conclusions one can draw from this part of the study is that boys were more likely to be registered than girls, but that girls were proportionately more at risk of Physical Abuse and more likely, when younger, to become the focus of Professional Anxiety (although less so after the age of 6). Boys were more likely at all ages to be considered at risk because of their parents' violence, mental state or inadequacy and were also more likely to be considered at risk of Emotional Abuse.

d. Key children

It has already been observed that not all the children in every family were registered. Clearly some children were

considered more at risk than others. In order to see whether, among the children who were registered, some children appeared to be more likely to be the prime focus of concern than their siblings, the data on the families was further examined. It was postulated that such "key" children would be the ones who were the first members of their family to be registered, would be registered in a higher category than any siblings or would appear in some other way to be the particular focus of concern and that, if there were such "key" children, there might be some significant variables which distinguished them from their brothers and sisters. In 58 of the families, there was no identifiable Key child - all the children were registered together for the same reason, in the same category and for the same length of time. In 10 further families, the Key child varied; for example, the child first registered was the first to be deregistered or the categories of registration varied between siblings, with first one, then another being placed in Category I.

This left 260 families. By far the most striking characteristic of these 260 families was that 123 of them (47.3%) contained only one child. (This was 10% higher than in the overall study and in the population at large).

A further 45 children, who were identified as Key children, were the eldest of their families. When one considers that only children are also the first born in their families, this makes a total of 168 of the Key children who were "first children" - 51.2% of the whole survey or 64.5% of the families where a Key child could be identified. (The NSPCC quote a national incidence of 51.1% for first born children (NSPCC, 1984,16) so the overall figure would appear to be in line with national incidence.) Taking the situation overall, the first born position would appear to be the riskiest in the family and looking at the situations when a Key child could be identified, it was definitely the riskiest place to be in a family. (Even if one totally disregarded the single child families, eldest children made up nearly one in three of the remaining Key children.)

As has already been pointed out, the Register had a heavy bias towards younger children so it was hardly surprising to find that 52 of the Key children were the youngest in the family.

No other variable seemed to be so important as family position, but Table 21 gives the rank order of all the variables which were identified for the Key children.

Table 21 Rank Order of Key Children (N=260)

Variable	Number	(Percentage)
Only child	123	(47.3)
Youngest child	52	(20)
Eldest child	45	(17.3)
Stepchild	12	(4.6)
Behavioural problems	8	(3.1)
Different sex from siblings	6	(2.3)
Mentally handicapped	5	(1.9)
Other		
Physically handicapped	4	(1.5)
Total	260	

(The Other reasons included one child who was the only adopted child in a family, two where the Key child was the second child of four, one where the child was the third of four and one where the child's persistent ill-health appeared to make him the focus of concern.)

Stepchildren seemed surprisingly under represented, particularly since 14.3% of the families actually contained stepchildren. Behavioural problems included both disturbed and delinquent behaviour, which attracted particular parental wrath. The children who were singled out as of different sex, all came from the larger families and were the only boy or girl among a group of the other sex.

The small numbers of Key children whose identifying characteristics appeared to be other than birth position made it impossible to draw any firm conclusions about the most likely type of abuse for them, except for observing

that, 70% of them were registered for Physical Abuse and that two of the twelve stepchildren were registered for Emotional Abuse - a hardly surprising finding in view of the problem of emotional bonding between stepparents and children. All the 10 families where the Key child varied were registered for Physical Abuse.

With regard to the Only children, there was a higher proportion of girls than on the Register as a whole: 60 of the 123 were girls, making a percentage of 48.9 compared with 45.1% for the Register as a whole. (It was noted earlier than girls were more at risk than boys in the very early months of life and this may be reflected in the higher number of female only children.)

The Reason for Registration was analysed with relation to Only, Eldest and Youngest children, with the overall situation and the position in relation to families where no Key child was identified included for comparison. Groups G (Other) and H (No Reason given) were excluded. It became apparent that the pattern for Only children was very similar to the overall picture, apart from a slightly greater likelihood that they would be considered neglected and a slightly lower chance of becoming the focus of Professional Anxiety. With the Eldest children there appeared to be a considerably heightened risk of Physical Abuse (75% against the overall 64%) and a higher than average rate of Sexual Abuse (8% against the average 2%). Youngest children, on the other hand were significantly less likely to be registered for Physical Abuse (only 52%) but more likely to be the focus of Parent-related concern (22% by comparison with the overall 14%) or Emotional Abuse (9% against the average 4%). That youngest children should be seen a particularly vulnerable in these areas is perhaps not surprising.

Turning to the families where no Key child was identified, the focus is even more strongly on Parent-related concerns and Professional Anxiety. Together they accounted for 44% of the registrations against the overall proportion of 25%. Physical Abuse was the lowest of any group, but Neglect was

nearly twice the overall average. These findings might well have been anticipated. Families where all the children are considered equally at risk are likely to be those where the concerns are more generalised and less specific than in Physical Abuse with its individually diagnosed bruises and fractures. If the parent is a known drug abuser, all the children may be at equal risk as they may be from marital violence or parental inadequacy. What one might find surprising is that this group contains no registrations for Emotional Abuse. One would have expected that, if Emotional Abuse arose, or was seen as arising, from the inability of a parent to meet the children's emotional needs, all the children in the family would have been seen as equally affected. What the absence of Emotional Abuse in this group suggests - and the numbers are so small that further research would be needed to confirm the hypothesis - is that Emotional Abuse (or, as it may be seen, emotional deprivation) is seen to focus on a particular child - either the stepchildren mentioned above or the Youngest children as here.

Summary

The average age of the children of either sex on the Register was under 5, with girls slightly younger than boys. Small children were clearly seen as at more frequent risk than older ones, although that risk was seen as less serious. More boys were registered than girls, but girls were more likely to be registered in their first twelve months of life or in their teens and were regarded as more seriously at risk during those years. Boys were most significantly at risk in their middle years. Over half the children identified as Key children were their parents' first or only child and, if they had younger siblings, were more likely to be registered for Physical Abuse.

6. The Parents

The analysis of the families also included looking at the parents of the children who were registered - their marital state, their ages and their problems. It has already been

explained that often the most basic data was missing on the Register cards. With regard to parents, information about the father was even more likely to be missing than information about the mother - his name and even more frequently his age were regularly omitted. Occupation - or lack of it - was virtually never recorded unless it was apparently sufficiently unusual to have made an impression: for example one father was described as a "Tax Inspector". Mothers' names were virtually always recorded and their ages reasonably frequently. The departmental Procedure Orders, from 1974 onwards (see Appendix B) anticipated the 1980 DHSS advice on the basic data to be recorded on the Register and asked for the mother's maiden name to be included. Without exception this was only done when the mother had never married i.e. was still using her maiden name.

a. Marital status

In 313 of the cases, it was possible to ascertain the marital status of the parents, at the time of Registration, with a fair degree of confidence. (In the remaining 15 cases, one was a single woman privately fostering a child whose parents were never traced; in the others, the information was either omitted altogether (i.e. a blank space where parents' details were supposed to be) or the situation was so confused with changing partnerships that it was impossible to tell which parent had responsibility even for the day to day care of the child.)

For the analysis of marital status, the cases were allocated initially to one of 5 categories:-

Married (legally or not)
Remarried/cohabiting (where the partner was not the parent of the child first registered)
Divorced/separated (where the parents were not living together, but where the absent parent clearly played an active role)
Single parents (where one parent appeared to be caring for a child with no acknowledged partner)
Widowed parents

The distinction between divorced/separated and single parents seemed worth making, even though other studies have combined them, to test the hypothesis "we find single parents over represented among abusive and neglectful parents" (Faller, 1981, 41) and because, if stress is a cause of child abuse, one would presume that caring for a child or children 24 hours a day unaided would cause stress and the true single parents might form a high proportion of the study.

There turned out to be only three widowed parents, so they were combined with the single parents.

The results of the marital status analysis are shown in Table 22, with the comparative figures from other studies where available.

Table 22 Marital Status of Parents (Percentages)

Study	Married	Remarried/ cohab.	Divorced/ separated	Single
Merton	56.2	21.4	12.5 + = 22.4	9.9
NSPCC	48	29	21	
Lambeth	1/3	1/4	30	
Strathclyde	53	24	19	
Corby	40	12	40	

(Sources: NSPCC 1984, 15; Lambeth 1982, 11; Strathclyde 1982, 2; Corby 1987, 33)

The national statistics do not distinguish between first and subsequent marriages, so far as families are concerned, and do not give precise comparisons for single or separated families, apart from stating that 11% of families were headed by a single parent in 1979 (Social Trends 1982, 34). However, the National Council for One Parent Families calculated in 1981 (basing their figures on the number of child benefit books with only one parent's name on) that 14% of families were headed by single parents and that the proportions were much higher in the London Boroughs, giving a figure of 33.3% for Lambeth and 16.1% for Merton (National

Council for One Parent Families, 1982). It will be seen from Table 22 that the number of registered single parent families in Lambeth was lower than this, but that Merton's combined divorced/separated and true single parent groups exceeded the National Council's 16%. This does not necessarily mean that Merton was actually registering a high proportion - the definition of only one name on the child benefit book would have probably excluded some of the families classified in Merton as divorced or separated.

Strathclyde, Lambeth and the NSPCC all used a definition of "single parent alone" and did not distinguish between the two types of single parent as I had done. Therefore, the figures are not strictly comparable but, generally speaking, it would seem that in Merton single or divorced parents did not make up a disproportionate number of the Registrations by comparison with elsewhere. It seems that they probably accounted for up to 11% more of the registrations than of the population as a whole, although Merton also had an above average number of single parents and the proportion registered was a maximum of 6.3% above that. This would hardly give substance to a statement that they were "over-represented". In fact, the most striking difference between Merton and the other studies, particularly Lambeth's and the NSPCC's was the high proportion of married couples (i.e. families with both natural parents of the children registered). In Merton, they accounted for 56.2% of the total registrations. While it will be shown later that "marital problems" were frequently cited as important, the picture, which emerged from considering this figure of 56%, did not tally with comments such as "an impression of families with unstable marriages and atypical structures and a higher than average proportion of one parent families" (Jones, 1982,139) or "In the literature, abusing parents have been noted for their marital instability with high rates of separation" (Lynch and Roberts, 1982, 159). In Merton, it seemed marriage was more likely than not to be the norm for the parents of registered children. The high rate of marriage is the more striking when one compares the figures for all the children registered who were living in two parent households, i.e. for married and remarried

families combined. The totals for Merton, the NSPCC and Strathclyde are 77.6%, 77.2% and 77% respectively - a remarkable similarity, pointing to the lower than average number of remarried parents in Merton.

In an attempt to see if it was possible to throw any more light on possible connections between marital status and Registration, the figures were further broken down by seriousness of category. From this it became clear that children from families with married parents and children with single parents were more likely to be registered in Category III, the low risk category, than in Category I or II. (58.9% of the former were registered in Category III, 53.5% in Category I + II; for the children of single parents the difference was even more marked: 13.5% in Category III, 6.4% in Category I + II.) The remarried, divorced or separated were conversely more likely to be in the higher risk categories - the remarried particularly so, forming only 17.3% of Category III, but 25.4% of Category I + II. In Merton, therefore, it seemed that a child living in a situation with only their natural parents or without contact with another parent was, or was perceived as being, less at risk than when living with remarried or separated parents. To try to discover why this might be so, the reasons for registration were re-examined.

i. Reasons for Registration and Marital Status

Table 23 shows the result of comparing the reasons for registration and marital status. The figures given are the percentage of each marital status group registered for a particular reason and the overall percentages are also given as a benchmark. The most immediately striking feature, in this table, is that all the Emotional and Sexual Abuse was found in two-adult households, whether the parents were married or remarried. These households were also a commoner focus of Professional Anxiety than the divorced or single families, although the latter - and particularly the single parents - were more likely to be registered for Parent-related concerns. This latter reason accounted for over a third of the single parent registrations. The other striking feature, so far as single parents were concerned,

was the low percentage of Physical Abuse cases. Group A accounted for only 46% of the single parent cases, whereas the average proportion was 63%: both the married and remarried families were very close to the average, but the divorced/separated group had 70% of their cases registered for Physical Abuse. (It was this lower than average number of Group A cases together with the higher than average proportion of Groups B and C, Neglect and Parent-related, cases, which accounted for the fact that the single parent families were more likely to be registered in Category III.)

Table 23 Reasons for Registration and Marital Status

(Percentages)

Reason for Registration	Overall	Married	Remarried/ cohab.	Divorced/ separated	Single
A. Physical Abuse	63	63	63.6	70	46
B. Neglect	4	4	4.8	3	11.5
C. Parent-Related	10	10	11	15	34.5
D. Prof. Anxiety	12	12	11	6	8
E. Emotional Abuse	6	6	4.8	-	-
F. Sexual Abuse	1	0.5	4.8	-	-
G. Other	4	4.5	-	6	-
	100	100	100	100	100
Total Numbers	274*	152	63	33	26

(*Group H, Reason Not Known, excluded).

The higher than average number of cases of Physical Abuse in the divorced group must be treated with caution because of the small numbers involved but this group, and even more the single parent one, do appear to have different characteristics from the other, two-adult groups - perhaps because the stresses the parents face are different in the different circumstances. It also appears that where there

is only one parent a child is more likely to be registered because of concerns about that parent's ability to meet the child's needs - in the single parent families a total of 46% (exactly the same as the percentage registered for Physical Abuse) were registered because they were considered neglected by their parent or that parent had problems which were thought to put the child at risk. More detailed research would be needed to discover whether such children actually suffered more than their peers with two parents or whether, having only one parent, they are thought more likely to suffer should that parent have problems. Possibly the literature talking about the "over representation of single parents" (Faller, 1981, op.cit; Jones, 1982) has had a "knock-on" effect and the children of single parents are perceived as at risk, by virtue of their parent's single status.

The married and remarried groups showed a much closer conformity to the average picture as might have been expected from their greater numbers - the fact that Emotional and Sexual abuse were only registered in two parent households has already been commented on, although it is worth further remarking that 4 out of the 5 Sexual Abuse cases came from the Remarried group. This might well have been expected as the literature, which has appeared since the figures were collected, identifies stepfathers as a common source of sexual risk (Finkelhor, 1986; Glaser and Frosh, 1988).

Summary

To sum up this section on the marital status of parents, it was found that over half the families in the study contained two married parents who were the parents of the children registered. If those adults who were remarried or in stable cohabitations were included (i.e. the families where there were two constant adults, who might or might not be the parents of all the children), the figure rose to over three-quarters. True single parents accounted for less than one in ten of the families and even when the divorced and separated families were added, it seemed likely that the

figure was not as high as some studies would have led one to expect. The children of married or single parents were also less likely to be seen as seriously at risk.

When the reasons for registration were considered, the 2 parent families had a pattern very similar to the overall picture. Only the Divorced/separated and the single parent groups showed marked differences - the former having an above average proportion of Physical Abuse and the latter a markedly below average number. Both these two groups had high levels of registration for Parent-related concerns or Neglect, but neither had any registrations for Emotional or Sexual Abuse.

b. Parental Problems

Henry Kempe, writing about child abuse, spoke of three factors which must be present, in his view, for child abuse to take place: a child, an adult with a capacity to lose control and a stress factor (Kempe and Kempe 1980, 37). In the consideration of the parents, the register cards were examined to see if they gave any indication of particular problems which the parents were facing at the time of registration which might have caused stress and thus triggered the abuse.

In 205 of the 328 cases, parental problems were mentioned and from these 17 variables were identified and are given in rank order of importance in Table 24. (These variables are all relating to problems as seen from the parent's point of view i.e. it is the parent's health or criminal activity which was considered a stress factor; children's behaviour was only included when it was clearly felt by the parent that they were unable to control the child and they had resorted to unacceptable methods of punishment.) Pregnancy was only counted when it was clearly seen as a problem because it was a difficult or unwanted one. Only one variable was assigned per family (unlike the NSPCC and Strathclyde studies which counted all stress factors mentioned), but the combination of marital and psychiatric problems was mentioned so frequently that the combination

was counted as a variable in its own right. It was anticipated that multi-problem families might feature quite large, but in fact only two were identified, so contradicting a possible hypothesis that such families would be more than likely to find their children's names on the Register. (There may well have been more than two, but in that case either Case Conferences were able to distinguish the more pressing of their problems or the agencies were able to keep sight of the purpose of the Register and were careful not to stigmatise the families further.) Five families had problems which did not readily fit into the 16 other categories and therefore were grouped as "Other" - these included a family whether the mother herself had been battered as a child, a parental history of (unspecified) Social Services involvement, a father posted overseas, a previous unexplained child death in the family and a maternal grandmother left to cope when both parents went overseas.

Table 24 Rank Order of Parental Problems (N=205)
(Percentages in brackets)

1.	Marital troubles	61	(29.8)
2.	Psychiatric	50	(24.4)
3.	Marital and psychiatric	21	(10.3)
4.	Alcohol abuse	15	(7.3)
5.	Criminal	10	(4.9)
6.	Accommodation		
	Pregnancy	8	(3.9)
8.	Low intelligence	6	(2.9)
9.	Other	5	(2.4)
10.	Unemployment		
	Attitude to authority	4	(1.95)
	Drug abuse		
13.	Child beyond control	3	(1.5)
14.	Bereavement		
	Multi-problem family	2	(0.98)
	Health		
17.	Financial	1	(0.49)
	Total	205	

The most important stress factor was clearly seen as marital problems (alone they were the highest ranking, together with psychiatric problems they accounted for 4 out of every 10 cases). This is not unexpected - studies on child abuse frequently refer to marital tension as an important stress factor (Jones, 1982, 152; Lynch and Roberts, 1981, 159). The Lambeth study identified 34% of families as having marital problems as their chief stress factor (Lambeth 1982, 18). The NSPCC, who identified as many as ten separate stress factors per family, have no exactly comparable figures but say that, as in previous reports "... marital discord, unemployment of the head of the household and financial problems" were "the most frequently quoted stress factors" (NSPCC 1984, 18). (In Merton the latter two factors did not attract attention.) The situation in Strathclyde appeared markedly different, perhaps reflecting different conditions north of the border. That study identified alcohol abuse as a problem "in half the cases" (Strathclyde 1982, 3), with 60% of the households also containing a person with a criminal record and mental illness featuring in 20% of cases (against Merton's 24%). Surprisingly, Strathclyde refers to "family violence" as being "mentioned in 40% of the cases" but continues "marital problems are much less common", quoting a figure of 8% (Ibid, 3). There is no explanation of whether, in the remaining 32%, the family violence was all directed towards children or whether it was not seen as causing marital problems.

One of the unexpected findings, in regard to Merton, for me personally, was how unimportant many of the other stress factors appeared to be. The top three: Marital tension, Psychiatric problems and the two combined were as one would have expected. Alcohol came fourth but still only accounted for 7% of the problems. (Apart from Strathclyde's findings, the NSPCC, basing their figures on social workers' reports and multi-stress problems, found "heavy drinking" a factor in 20% of cases (NSPCC, 1984, 19). Lambeth does not record alcohol abuse as a problem at all.)

Lambeth recorded financial difficulties in 18% of cases against Merton's 0.5%: possibly a true reflection of the

more affluent economic status of Merton residents. Lambeth also cited "child's behaviour" as a major stress factor in 24% of cases. There may have been a difference in definition here, but the finding is certainly different from Merton's 1.5%. Merton also had a low rate of housing problems beside Lambeth's 14% (Lambeth 1982, 18).

As was pointed out above, the NSPCC found financial and unemployment problems to be major stress factors, whereas in Merton they played a very minor part (or at least did not make a great impression on the professionals). It is possible that a study of more recent cases would tell a different story with regard to unemployment. Three of the four families, where it was mentioned as a stress factor, had been registered in the last 9 months of the study, i.e. in the second half of 1982 or the first three months of 1983.

The parental problems were also looked at with reference to the category of registration. This showed that marital problems (on their own) were likely to feature more frequently in the Category I + II registrations (33% as against 26% in Category III) but that psychiatric problems contributed more to Category III (29% as opposed to 20%). The same situation applied when the psychiatric problems were allied to marital problems - they were more likely to be registered in Category III, perhaps indicating that a parent's psychiatric state was more likely to be a cause for anxiety about potential abuse than actually resulting in identifiable abuse. Alcohol abuse too was seen as a "risk" factor rather than a cause of definite abuse, with 13% of the Category III cases but only 2% of Categories I + II. In the higher risk group too, the assorted problems which made up the rest of the stress factors were responsible for almost one third of the cases, twice as many as in Category III. This would tend to suggest that the stress problems underlying the serious abuse may be more complicated and diverse and that one should beware of assuming that there is a definite type of abusive family, with clearly distinguished problems.

The parental problems were also grouped in relation to the marital status of the parents to see whether the stress factors had a different importance in the different groups. The number of families where both the marital state and a parental problems was identifiable was 201 and was made up of 118 married couples, 42 remarried or cohabiting, 27 divorced or separated parents and 14 single parents. Table 25 shows the rank order of these groups' problems.

Table 25 Rank Order of Parental Problems by Marital Status
(Overall rank order in brackets)

	Married		Remarried/cohabiting	
1.	Marital	40 (1)	Marital	13 (1)
2.	Psych	25 (2)	Psych	10 (2)
3.	Marital/psych.	13 (3)	Marital/psych.	4 (3)
4.	Alcohol	9 (4)	Alcohol.. ..)	3 (4)
			Unemployment)	(10)
5.	Criminal	6 (5)		
6.	Accom)	5 (6)	Pregnancy)	2 (6)
	Pregnancy)	(16)	Drug abuse)	(10)
8.	Child beyond control)	3 (13)		
	Attitude to authority)	(10)		
	Other)	(9)	Rest	5
	Rest	6		
Totals		118		42

	Divorced/separated		Single	
1.	Psychiatric	9 (2)	Psychiatric	4 (2)
2.	Marital	6 (1)	Marital)..	2 (1)
			Accomodation)..	(6)
3.	Marital/psychiatric	4 (3)	Bereavement)..	(14)
4.	Alcohol	3 (4)		
5.	Low I.Q	2 (8)		
	Rest	3	Rest	4
Totals		27		14

From Table 25 it can be seen that the problems of all marital groups were much the same, although, as might have been expected, Marital problems led the rest for the married and remarried groups, but took second place to Psychiatric problems for the Divorced/separated and single parent groups. (The presence of marital problems at all in the latter two groups may cause surprise - they were accounted for by continuing rows with former spouses or by rows with boyfriends for the single group.) Otherwise, the order in the first two groups was virtually identical with the overall pattern and, in the other two groups, the numbers were so small as to make any comment tentative, except that, since the single parent group contained the widowed, bereavement ranked as a more important problem than in the other groups.

The parent problems were also looked at to see whether they were linked to particular types of abuse. In 183 of the cases both the parental problem and the reason for registration were identifiable, but only four of the parental problem groups had 10 or more cases in, so only these were considered. These parental problem groups were Marital, with 54 cases where the type of abuse was also identified, Psychiatric (49), Marital combined with Psychiatric (18) and Alcohol (13). (These numbers are so small that the results must be regarded as tentative.) The Marital problem group had 65% of cases registered in Group A, Physical Abuse, above the average 57% and above the other three groups - Marital/psychiatric had 56%, Psychiatric alone 40% and Alcohol 46%. Not surprisingly, both the Psychiatric and Alcohol groups had above average number of Group C, Parent-related, registrations and the Psychiatric group had an above average proportion of Professional Anxiety registrations. The combined Marital and Psychiatric problem group contained the highest proportion of Emotional Abuse. The low level of Physical Abuse in the Alcohol group is perhaps surprising, but it was shown earlier that most of this group was registered in Category III so one would expect to find a high level of concern about parents rather than actual identified abuse.

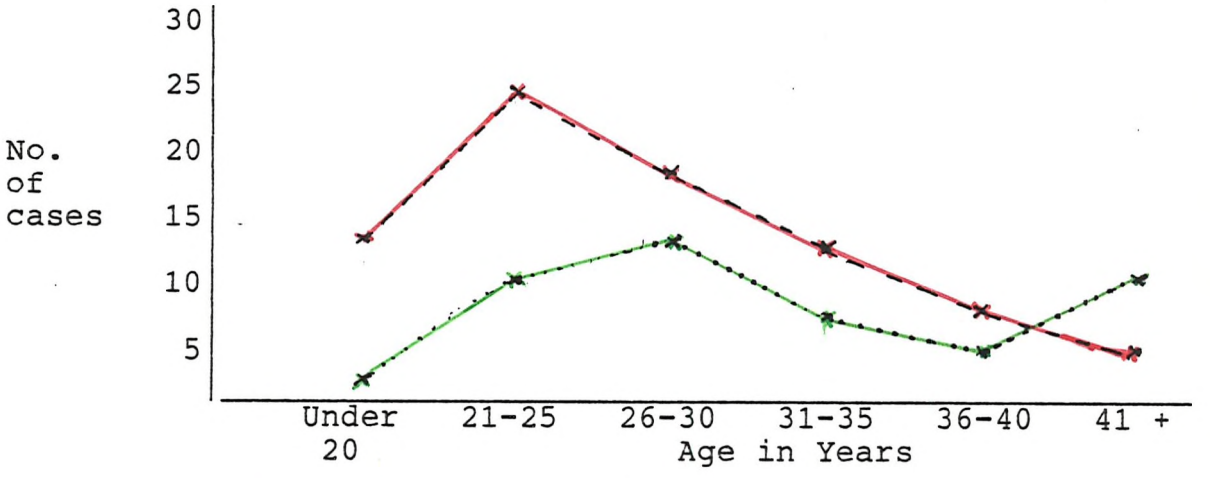
Summary

To sum up the parental problems analysis, then, it would seem that the most significant problems were marital tension, and psychiatric problems alone or combined with marital problems. Marital problems and Physical Abuse were more likely to go together than the average figures would suggest. However, although marital problems accounted for almost a third of the more serious registrations (Categories I + II), the situation with regard to these cases involved a wider and more varied range of problems than the Category III cases and provides a warning against a stereotyped view of abusing parents.

c. Age of Parents

Like much of the other information which was supposed to be recorded on the Register, the age of parents was often conspicuous by its absence. However, by cross-checking with the Central Index, it was possible to establish the age - at the time of Registration - of 87 of the mothers and 55 of the fathers (for this part of the study only, "fathers" include stepfathers and cohabitees) in the first 100 families on the register. The average age of these mothers was 27.76, that of the fathers 31.44 years. (This compares with NSPCC figures - based on detailed returns from social workers - of 25.95 for women and 30 for men (NSPCC, 1984,11). Strathclyde does not give details of parental age but the Lambeth study (based on information about 40 mothers and 16 fathers) produced an average age for mothers of 23.96 and for fathers of 27.44 years (Lambeth 1982, 15). The parents were grouped into 6 age brackets - under 20, over 41 and in 5 year spans between. (The results are shown for both men and women in Table 26). As one would expect from the lower average age of the mothers, they also had a lower peak age than the fathers'. Both sexes showed a decrease in their 30s, but fathers had a sharp rise over 41 years.

Table 26 Age of Parents at Time of Registration
(N=87 Women
55 Men)



Key Women ——— Men .....

The NSPCC does not give a detailed breakdown by age group but the Lambeth study, small though it was, provides some point of comparison. In Merton, 55% of mothers and 74% of the fathers were over 26 years of age, but in Lambeth the figures were 35% and 50% respectively i.e. the Lambeth parents appear to have been appreciably younger (Lambeth, 1982,15). It is not possible to determine why this should be so, except to note that it was earlier apparent that the Lambeth study contained a higher proportion of single parents. In Merton, the 14 single mothers among the women whose ages were available, all fell into the younger age brackets: 5 were under 20 years and only 4 were over 26, with none over 30. If Lambeth single mothers were similar in their age structure, their lower average age might be explicable, for women at least.

In order to discover whether the age of the parents had any bearing on the severity of abuse, the categories of registration were examined in relation to parental age. So far as fathers were concerned, the pattern was remarkably similar for all categories. Mothers, on the other hand, were more likely to have their children registered in Category I or II if they themselves were aged between 21-25 or 36-40. At either end of the age scale, for women, there was no difference between the categories, but between 26-30 years, the children were more likely to be registered in Category III.

The small numbers involved made analysis of any relationship between parental age and reason for registration difficult. However, the Physical and Emotional Abuse groups were large enough to show that physically abusing families had younger parents - the mothers were most likely to be aged from 21-25 (accounting for all but 9 of the 25 cases in this age group of mothers); fathers too were likely to be younger, but in their case were between 21-30 years. Emotionally abusing families had, on the other hand, older parents: there were no mothers under 20 or fathers under 25 in the Emotional abuse group, although one should perhaps note that Emotional Abuse may not be apparent until a child itself is older.

The mean age of the parents for each reason for registration group was also calculated and this largely confirmed the findings with regard to Physical and Emotional Abuse. The average age for fathers whose children were registered for Physical Abuse was 27.9, more than 3 years younger than the overall average. The average age of the mothers in physically abusing families was very close to the norm, despite the large numbers of young mothers. However, the average for mothers was two and a half years below the overall average in regard to Group C, Parent-related concerns. The very small numbers involved made the analysis with regard to Sexual Abuse particularly tentative but, nevertheless, the average age of parents with children registered for either Sexual or Emotional Abuse was markedly above the norm: in the case of women by 6 years for Emotional Abuse and 5 years for Sexual Abuse and, in regard to the fathers, by 5 years for Emotional Abuse and four and a half years for Sexual Abuse. Although the small numbers involved, particularly in the Sexual Abuse group have to be kept in mind, the findings in this respect are corroborated by the NSPCC study, which had the mean age of mothers of sexually abused children as 34.5, eight and a half years above average, and for father at 37.3, 7 years above the mean, although as Sue Creighton rightly points out sexually abused children themselves tend to be older and one would expect their parents to be older too (NSPCC, 1983,11).

Summary

Such conclusions as one can draw from this section must be tentative, but it did appear that the fathers of children who were registered were, on average, 3.7 years older than the mothers and that both were older than might have been expected from other studies. Generally speaking, both men and women were more likely to have children registered, particularly for Physical Abuse, when they themselves were in their twenties, and women when they were in their early twenties. The children of older women seemed increasingly less likely to be registered, but there was an increase in the number of fathers over 41 years. The parents of children who were registered for Emotional or Sexual Abuse were likely to be considerably older than the average although it is possible that this was, at least in part, because these children were themselves older.

7. Abusers

In just over a quarter of the families (95 or 28.9%) an adult was identified as responsible for the abuse. As one would expect, a greater proportion of these (61 out of the 95) were identified in regard to children registered in Category I or II. (With regard to the Category III cases, the person identified was the person thought to be the source of risk.) The vast majority (85%) of these identified abusers were one or other of the child's natural parents. 40 fathers, 38 mothers and 7 married couples were identified, together with 7 stepfathers or mother's boyfriends and 4 others (a grandmother, a neighbour, a sibling and another relative). No stepmothers were identified - possibly because in any case stepmothers were present in only 2.1% of the families.

Natural fathers therefore made up 42.1% of the identified abusers, with natural mothers making up another 40%. (This latter group, it should be remembered, included the 8 mothers whose children were registered because of "mother's own anxiety" that she might abuse but who had not necessarily actually abused their children.) The NSPCC

study, identified the abuser in 77.7% of cases and found that fathers were identified in 35.4% of cases and mothers 34.6%; "parent substitutes" (i.e. stepparents, cohabitees etc.) accounted for 20.75% of the NSPCC's identified abusers (NSPCC,1984,13-14), but it will be remembered that they also had a higher rate of remarriage than Merton did and therefore had more stepparents in the study. Moreover, as will be seen in a moment, most of the abusers identified were responsible for Physical Abuse and the NSPCC, it will be remembered, registered a far higher percentage of Physical Abuse cases than Merton did.

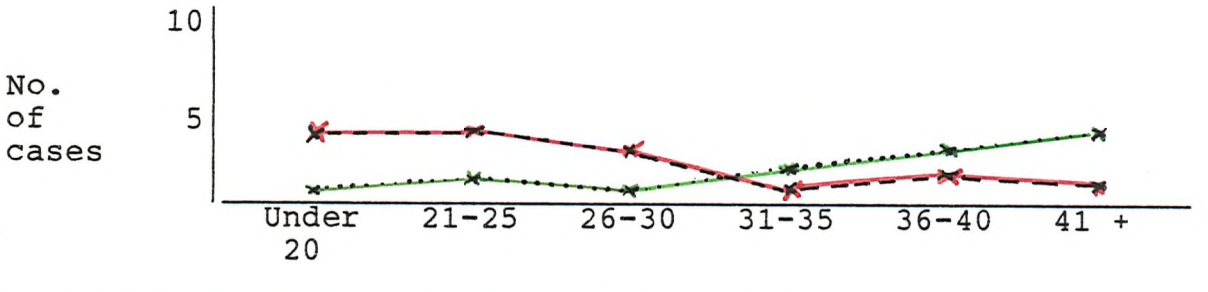
The near parity of the numbers of natural fathers and mothers identified as abusers might suggest that children are equally at risk from either of their parents. But, as the NSPCC study also points out, mothers are responsible for a much higher proportion of child-rearing than fathers and are normally with their children for more of the time than fathers are (NSPCC,1984,14). This would suggest that children are, in fact, more at risk when with their fathers than their mothers, on an hour to hour basis.

Three other variables were looked at in relation to abusers - their ages (but only with regard to the 15 women and 14 men who were identified as abusers within the group of parents whose ages were checked), their marital state and the type of abuse they were responsible for.

The ages of the abusers are shown in Table 27.

Table 27 Age of Parents identified as Abusers

(N = 15 Women
14 Men)



From Table 27 it can be seen that women under 30 outnumbered younger men, but men over 30 outnumbered the older women. In fact the average age of the male abusers was exactly the same as for the fathers generally, but the average age of mother-abusers was 26.5, a year below the average age for mothers of 27.76 years.

The analysis of the marital state of the abusers showed that 61% of known abusers were married to the child's natural parent. It is probable that, in the Merton situation, abusers were more likely to be identified in a situation in which there was another resident parent to spill the beans - the possible loyalty to the spouse being offset by the prevalence of marital problems. (The difference between the Merton and NSPCC studies was that the abusers in Merton were identified by the initial Case Conference, whereas in the NSPCC study, social workers who had been working with the family for a longer period, identified the abuser.) Moreover, as was seen earlier, 56.2% of the parents of registered children were married, so that the percentage of parents identified as abusers was only 5% higher than that.

However, the male abusers were more likely to be in a marital situation than the female abusers (since a larger number of unmarried parents were women). 85% of the fathers identified as abusers were married but only 52.6% of the mothers were. Conversely 23.7% of mothers identified as perpetrators were divorced or separated but only 5% of the fathers were.

Turning to the reason for Registration: as always, the Group A, Physical Abuse, cases dominated the figures. 62, or 65.3%, of the known abusers were responsible for, or suspected of causing, physical injury to a child. Of these 29 were fathers, 21 mothers and 3 were couples. In fact, 72.5% of the fathers named as abusers were the fathers of children registered for Physical Abuse, as against 68.4% of the mothers. Stepfathers and boyfriends were also predominantly in Group A, with 6 out of 7 in this group. Only 2 abusers, both mothers, were identified in the Neglect group - not surprising in view of the nature of this

involving "abuse by omission rather than commission" (NSPCC, 1984,13). In the Parent-related Group C, 11 out of the 13 suspected abusers were mothers (again not surprising since it involved all the families where the registration was a result of the mother's anxiety). The three single mothers identified as abusers were all in this group. Fathers, on the other hand, were more likely to be the focus of Professional Anxiety than mothers (5 fathers identified and only 1 mother). Both parents were identified in the two cases of Emotional Abuse where an abuser was identified and, finally, in the Sexual Abuse group, the abuser was identified as the father twice, the stepfather once and the mother once.

Summary

In less than one third of the cases was it clear who, the Case Conference considered, was responsible for abusing a child or was potentially a danger to that child. The group identified as abusers were mostly those who had already harmed a child - hence their children were registered in Category I or II, but they also included a group of mothers who had asked for help because they themselves feared they might harm their child. (This latter group included all the single mothers identified as possible abusers.) The vast majority (85%) of these identified abusers were the child's natural parents and were composed almost equally of fathers and mothers, despite the fact that, generally speaking, mothers have a far greater responsibility for caring for children and a greater exposure to them, particularly to the young children who formed the bulk of the registrations. There was little difference in age between abusing parents and other parents. Abusing fathers were most likely to be married, whereas a quarter of the mothers were divorced or separated. Most of the abusers were identified as responsible for causing physical injury and men were more likely to be identified for this reason than women.

8. After the Registration - Court Action and Removal from Home

All the children whose names were placed on the Register were the focus of official, professional concern. All were believed to be the victims, in one form or another, of abuse or to be at risk of such abuse and consequently to need protection. In order to discover what form this protection took (were hundreds of children snatched away from their families or subjected to draconian Court action as the popular press would occasionally seem to suggest?) the study attempted to discover how many of the children either became the subject of legal proceedings or were removed from home at some stage, and if they were, for how long.

Information about court action proved the hardest to discover from the cards in the Register - such information as was given was sketchy and often clearly inaccurate. It was therefore necessary to crosscheck each case with the Central Index and, as this was very timeconsuming, the data was collected for the first 100 cases only. The information about removal from home was available on the cards, although it still proved necessary to crosscheck a minority of cases. However, it was reasonably easy to gather the information for the full 328 cases and this was done. None of the other studies considered fully comparable situations. The NSPCC gives some figures about court proceedings or receptions into care but these are for the period immediately following Registration. What was looked at in this study was whether, at any point during the period of Registration, children had been the subject of legal proceedings or removed from home.

a. Court Action

In only 32 out of the 100 cases were there any legal proceedings at all. (In a further 12 cases, children were received into care voluntarily under what is now Section 2 of the 1980 Child Care Act, (formerly Section 1 of the 1948 Children Act) and it is possible that some of these receptions were arranged to avert the need for legal action, either because the parents were anxious to avoid the need to

go to court or because the professionals felt they did not have sufficient evidence of abuse to stand up to the Court's scrutiny.) The legal action which was taken was in one of three different court settings - Care Proceedings in the Juvenile Court, Wardship Proceedings in the High Court or intervention in hearings involving the custody of children in the Divorce Courts. In addition, in a few cases, where social workers (or others) obtained a Place of Safety Order from a single magistrate authorising the removal of a child to a place of safety that Order was not followed up by Court Proceedings - i.e. the chid was either received into care voluntarily or allowed to return home - in either event the Order lapsed.

The most common form of Court action was Care Proceedings, which were taken in 20 of the 100 cases, resulting in a Care Order, or occasionally a Supervision Order. The majority of the Care Proceedings followed a Place of Safety Order, but in a few cases - particularly where the intention from the start was to seek a Supervision Order, rather than the removal of the child, there was no prior Place of Safety Order.

Four of the 32 cases involved the Wardship jurisdiction of the High Court and, in 5 cases, matters were decided in the Divorce Court. (The latter situation would have arisen in one of two ways. In some cases, the parents sought a divorce and the judge, after considering welfare reports, felt it necessary to make a Supervision or Care Order - i.e. the local authority did not initiate action, but became involved by the court. In other cases, divorce proceedings were already in train when concern about possible or actual abuse led to the consideration of court action and the local authority achieved this by applied to "intervene" in the divorce hearing.)

The reason for registration, indicating the type of abuse from which a child was thought to have suffered or to be likely to suffer, was clearly likely to be relevant to any decision to get involved with legal proceedings and this was studied carefully. As might have been expected Group A,

Physical Abuse, was the most frequent type of abuse. While less than a third of the 100 families in this part of the study were involved in any type of legal proceeding, 38% of those registered for Physical Abuse were the subject of some legal action. Most of these were, not surprisingly from Category I or II, although in practice, a higher proportion of the Category III children registered for Physical Abuse became the subject of legal proceedings.

In fact, this applies across the whole spectrum. Of the 100 cases, 63 were from Category I or II, 37 from Category III, the so-called low risk category. But proportionately more of the Category III cases were received into care (13.5%) or the subject of court proceedings (32.4%) than the Category I + II cases (11.1% and 31.7% respectively). This greater liability of Category III to be the focus of action is particularly noticeable in relation to Group C, the Parent-related group, cases. There were 17 of these in the 100 cases - 4 from Category I or II, 13 from Category II. None of the Category I or II cases were the subject of legal proceedings or received into voluntary care - 8 of the Category III cases were (5 court cases, one in the High Court, one Place of Safety Order which was allowed to lapse and two voluntary receptions into care).

There were only 2 Sexual Abuse cases, one of which was received into voluntary care and the other became the subject of Care Proceedings in the Juvenile Court. Finally, the difficulty of proving that children have been emotionally abused may account for the fact that no child registered for that reason was the subject of legal action, although three (out of 7) were received into care voluntarily - the highest proportion of any group to be dealt with in this way.

Summary

Less than a third of the cases were brought to the attention of the courts, or even of a single magistrate, but those cases which were in the low risk category appeared to have a slightly higher chance of ending up in court than the

supposedly more serious cases. They were also more likely to be taken into care on a voluntary basis. Physically abused children were the most likely to be the focus of legal proceedings.

b. Removal from home

The cases where a child had been removed from home, for any length of time, long or short, were also studied to ascertain their overall numbers, to see if certain register groups were more likely to feature than others and to see what proportions of those removed were away from home long term or even permanently. (This information was available for all 328 families.) The first factor which stood out was that, as with the legal action, the percentage of families where a child was removed, voluntarily or compulsorily, for even a temporary period was 29.3% - less than one third of the total i.e. two thirds of the families registered were not affected by a removal from home. Indeed the percentage of children removed would be lower - the figures refer to families and not every child within a family would be removed. However, unlike the Court action written about above, families whose children were registered in Category I or II were more likely to be affected by a removal than those in Category III - 39.1% of the former against 19.8% of the latter, a considerable difference.

The 96 families where a child was removed were studied in more detail. 63 were in Category I + II, 33 in Category III. The length of time for which the children were removed was divided into temporary (less than 3 months), long term (more than 3 months but not indefinitely), permanent (where there was no intention the child should ever return home and, lastly, spasmodic (where children were removed more than once but for short periods or where there were deliberately arranged respite care arrangements, including planned boarding school placements). Seventy of the children were removed from home for longer than 3 months and just under half of these (34) were removed permanently. That is, 10.4% of all the families registered had a child permanently removed from home. The long term group was

larger and, although there was a clear intention to try to return some of these children or, to put it more cynically, the decision to remove permanently had not been openly made, it seems likely that at least some of the children in this group were unlikely ever to return home.

As expected, the largest number of those removed (60 out of 96) and particularly of those removed long term (26 out of 36) came from Group A, the Physical Abuse group - although a lower percentage of those permanently removed were from Group A, 62% against the long term 72%. Whereas overall 29.3% of families had a child removed, for Group A as a whole the percentage was 33.7%, just over one third. (However this only applied to Group A families registered in Category I or II; Category III Group A families were less likely to be affected by the removal of a child from home than Category III families as a whole - 17.4% against an overall figure of 19.8%.)

Not surprisingly, perhaps, in view of its nature, Group F, the Sexual Abuse group, had the highest proportion of its cases removed: four out of five and all either long term or permanently. The other groups with significant numbers of removals were C, the Parent-related group and H, the No Reason given, group. In Group C, the removals, apart from one, were all in Category III and 6 out of the 9 were long term or permanent. That is, Group C had a higher rate of permanent removals than Group A, particularly in Category III cases, where the permanent removal rate was 12.5% against Group A's (for Category III) 4.3%. Group H contained 12 children who were removed from home, half from Category I or II, the other half from Category III. Five of the Category III cases were removed long term or permanently, while only 2 of the Category I + II cases were. At the very least, this suggests some confusion surrounding the original registrations, although it may have been this very confusion which led to the eventual removal of the children. In the literature about child abuse, stress is frequently put on the importance of full assessments (e.g. Kempe and Kempe, 1978; Jones 1982; DoH 1988). However Corby states "while, in much of social work literature, assessment

is considered to a crucial stage in intervention, in practice ... many assessments are not very elaborate or painstakingly constructed" (Corby, 1987,86). Corby found that "this was true with regard to the child abuse cases" in his study (Ibid, 86) and it may well be that a study of the case files for these Group C and H cases would reveal a similar picture and confirm a hypothesis that, because the problems were never clearly identified, work with the family was not sufficiently focussed to prevent the removal of the children.

Summary

Whilst it is easy to be concerned and puzzled by the number of removals from theoretically low risk situations and particularly when no reason has been recorded for the original anxiety, it is necessary to remember that the great majority of children were not removed from their families, either voluntarily or compulsorily. Less than 30% of families were affected by the removal of a child at any stage and for only 21% of all the families on the Register was such a removal for longer than 3 months. It may, of course, be felt that the long term removal of a child in one out of every five cases is still a serious matter, particularly as more than half the long term removals appeared to be permanent or likely to become so. Nevertheless, it is necessary to remember that some of the cases involved children who had been seriously injured or sexually assaulted by their parents and even if the reasons for some of the other removals were less clear, a figure of between 10% and 20% does not support the view of wholesale removals of children propagated by some writers (see, for example, Geach and Szwed, 1983 Chapter 4).

Only in the Sexual Abuse group, did the numbers of children removed exceed those who were left at home. Indeed, for the rest, only in the Physical and Emotional Abuse group were the numbers of children removed even half as high as those who remained. If the Child Abuse Register was, as it was intended, recording "grave professional concern" about certain children and families, there was still a greater

emphasis on keeping families together than on removing the children.

9. Conclusions

The previous chapter looked at the Register itself and the incidence and types of child abuse reflected by that Register as a record of professional concern.

This chapter has been concerned with the actual data contained on the Register and attempted to draw from that data some sort of profile of the families and children, who were the objects of that professional concern. While the conclusions were often tentative, a picture of the families did emerge. A third of them lived in their own homes, suggesting that, in Merton, the registration of child abuse was not completely confined to the lower social classes. Families who lived on large council estates were more likely than other council tenants to become the focus of professional attention, particularly from social workers and health visitors, although the estates which attracted most attention changed over time.

Less than two thirds of the families had been known to Social Services before the incident which led to the Registration, but the families who were known longer were less likely to be registered as at serious risk.

While the average size of families with children on the Register was slightly higher than the national average, just under four families out of every ten contained only one child. Only children are also the first child of a family and the number of only children, coupled with the number of eldest children who were identified as the Key children in larger families, suggested that first born children run the greatest risk of being registered. Boys were registered more frequently than girls, although the latter appeared to be most at risk during their first year or in their teens. Children under five were generally more likely to be considered at risk than older children.

More than half the children lived with both parents and three-quarters lived in a household with two adults. The commonest parental problems were marital and psychiatric, alone or combined they accounted for 65% of the parental problems identified, suggesting that the professionals should be concentrating all available therapeutic help on resolving marital tension or promoting better mental health. Marital problems alone were mentioned in a third of the Category I + II registrations.

The overwhelming majority of identified abusers were the child's own parents, but in less than a third of cases were there any legal proceedings and in only just over a fifth of the families was a child removed for longer than three months, although half of these were removed permanently.

The overall picture then was of families, not very different from the general run of families and suffering from problems familiar to many. Because, as has been constantly stressed, the Register must be seen as a record of professional concern not as an authoritative record of the actual incidence of abuse and because, as it became clear in the last chapter, professional concern itself is influenced by external events and can be inconsistent and fluctuating, the most important questions that are raised by the profile of the families may not be the most obvious ones. Thus it would seem that professionals should be asking not "Why are younger children so at risk?" - important though that question may be - but "Why are more older children not considered at risk - are they really less likely to be abused, or do we, the professionals, not perceive when they are at risk?" Similar questions must be raised by the findings related to the families living on the big estates - are families who live on big estates really more likely to abuse their children or are they more likely to be <u>thought</u> to do so because of where they live, and if the answer to the first question is that they <u>are</u> more likely to abuse their children, is this because of a housing policy which has led to the more vulnerable families being placed on such an estate in the first place?

The collection of data from the Register and the early analysis of it was being done at the same time as the Guidelines were being written and the findings had a great influence on the contents of the Guidelines. Some particular instances have already been mentioned, but on a more general level the high proportion of cases which were registered because of Physical Abuse led to a greater emphasis on the signs and symptoms of Physical Abuse than on the signs of other forms of abuse. The inconsistencies and vagueness of many of the registrations led to considerable stress on clarity and clear assessments. In fact, it was these inconsistencies that made the production of the Guidelines even more important in the hope that they would lead to better standards of practice. It is with the production and content of the Guidelines that the next two chapters are concerned.

CHAPTER IV THE PRODUCTION OF THE GUIDELINES

(Note: A copy of the completed guidelines is to be found in a pocket at the back of the thesis. While a detailed reading of the booklet is not necessary at this stage, it may be helpful to take it out of the pocket and have it to hand for ease of reference.)

1. Introduction

The background to the decision to produce written guidelines has already been descibed. To recap briefly, in 1974, the DHSS had charged Area Review Committees with approving written instructions for all professionals (DHSS 1974b) and, over the years, it is clear the Merton Borough Review Committee was aware that this was a task that needed to be tackled, although it is equally clear that no one really thought through how it should be undertaken or who could realistically be expected to do it.

On 24th September, 1979, in a renewed attempt to get matters moving, the Committee agreed that the Chairman (i.e. the Deputy Director of Social Services), should raise the question of joint guidelines with the Area Steering Committee and that the Area Specialist in Community Medicine should be asked to undertake the task (BRC minutes, 24.9.79, Item 9). Two factors may have influenced the continuing failure to act in the following months. The Chairman was unable to attend the meeting of the Steering Committee and the Area Specialist had not been present at the meeting which nominated her as producer. Moreover, the Review Committee did not meet again for a year (on 22nd September, 1980), so it was not until then that the Chairman's failure to attend the Steering Committee meeting was known and it seems clear from the fact that he still "agreed it (i.e. the subject of the guidelines) would be raised" that somehow that was seen as a first step (BRC minutes, 22.9.80, Item 3). By the time the Borough Review committee met the next time (2nd March, 1981), the Steering Committee had been wound up, with the changing of Area Health Authority boundaries, and it was then that the Chairman commented that it would not be quite so easy to produce guidelines "as when

we had a committee managing the whole thing." (BRC minutes, 2.3.81, Item 3.b)

While one cannot but question the wisdom of asking such busy and senior people to undertake the project, Merton's failure to put intention into effect is harder to understand when one realises that both the other boroughs who were part of the same Area Health Authority, and members of the same Steering Committee, had produced guidelines by this time. At least six members of Merton's Review Committee were also members of the Steering Committee or of Wandsworth's or Sutton's Review Committees and must have had knowledge and experience of how they had managed to achieve this.

2. The Working Party

The appointment of the Working Party has also been described earlier, together with the way that its brief was subtly changed. It met on two occasions - 27th April 1981 and 6th July, 1981. Seven people were present on each occasion: two doctors (the Principal Physician Child Health and a Consultant Paediatrician), an NSPCC inspector, a senior policeman (on the first occasion an Inspector, on the second a Chief Inspector), the Divisional Nursing Officer and two representatives of the Social Services Department - an Area Manager and myself, a part-time Level Three Social Worker, specialising in Child Abuse. The first six members had been nominated by the Borough Review Committee. The Area Manager suggested that I attend as I had recently returned from a four month post qualifying course with the NSPCC School of Social Work. The other members of the working party agreed to co-opt me (BRC Working Party minutes, 27.4.81).

a) Preparing the Ground

The first meeting discussed the Working Party's remit - and has been pointed out - subtly altered it. (Ibid, Paragraph 1). The discussion then turned to considering guidelines available in other areas and one or two available specimens were handed round. The Area Manager and I "undertook to prepare a draft to be considered by the next meeting" (Ibid, Paragraph 2).

Between that meeting and the next, five procedural handbooks were examined. These were:

1) Child Abuse: Procedures relating to non-accidental injury to children, produced by the Lambeth, Southwark and Lewisham Area Review Committee (1981).

2) Child Abuse Procedures: City of Manchester Guidelines (No date given).

3) Draft Guidelines, circulated by the Hounslow Borough Review Committee for comment circulated (1981).

4) Child Abuse - Procedures and Guidelines, issued by Essex County Council Social Services department, plus "Most Bumps and Bruises are Accidents - A Few are Not So Easy to Explain - Guidelines on what to do about it", issued by the Essex Area Review Committee as joint guidelines for different professions (No date given).

5) Non-Accidental Injury to Children - Procedures for Nursing Staff, issued by the Merton Sutton and Wandsworth Area Health Authority (the AHA). (These were produced just as the working party met for the first time.)

These examples were chosen, because they were all that, at that point, appeared to be available. It subsequently transpired that several other Area Review Committees had sent copies of their guidelines when they produced them, but that these had been filed away unread. (As the study proceded these came to light, as did copies from other areas when my interest became known - by the end of the study I had a collection of over 20). In addition to the five mentioned above, the Area Manager and I read the excerpts from Coventry's guidelines printed in the Open University reader "Child Abuse" (Lee 1978, Appendix III) and received a full copy of their new, fourth, edition as soon as it was circulated in September 1981. (Coventry Area Review Committee). (One of the chastening facts we discovered was that Coventry was not the only area to be issuing a fourth edition as Merton embarked on its first.)

b) Analysis of other Guidelines

Looking at the collected guidelines, considerable variations in size, length, content and format were immediately obvious, even when one made allowance for the fact that one

was only intended for nursing staff (the AHA's Procedures) and one for social workers (Essex, although in this case there was a multi-disciplinary book as well). In length, they varied between 14 pages (Lambeth) to 29 (Essex - not counting the 11 pages in their separate multi-disciplinary booklet). Manchester also had 29 pages, the AHA 26 and Hounslow 21 (although this included no less than 3 pages of addresses).

The size and presentation were equally varied. Lambeth used a clear print on colour-coded pages for easy reference, but the booklet was 11.5 by 8.5 inches, which made it difficult to consult discreetly or even to carry around unobtrusively. Essex's internal procedures were badly photocopied in a small format, so despite the quality of their contents, they were difficult to read and unattractive in appearance. Their multi-disciplinary booklet was more appealing, being well printed and clearly set out, although the tone was unfortunately a shade patronising. Manchester's procedures were well laid out in a 8 by 6 inches booklet, which fitted into the standard social work diary. There was a picture of children playing on the cover and a use of 2 colours in the printing, which marked out the sections clearly. The AHA's Procedures for Nursing Staff were presented in a neat no-nonsense format, slightly smaller than Manchester's, with different colour pages bound together by a slide fastener. (Hounslow's were in draft form and there was no indication as to future format.) Coventry's booklet, when it arrived, was initially attractive (and the contents clear and helpful), but the typeface used was small and some people found it difficult to read. (Our later collection showed the same variety, ranging from larger than Lambeth's - and considerably heavier in weight - to pocket-sized, with a variety of bindings: some of which were obviously designed to accommodate subsequent additions, but which tended to fall apart after only a moderate amount of handling.)

A total of 29 topics were identified and these were analysed to show which appeared where (see Appendix C). No one booklet covered the full list. The score ranged from 7 (the Area Health Authority) to 24 (Essex) with Lambeth covering

16, Hounslow 14 and Manchester 13. Even where the same topics were covered, the depth and emphasis varied greatly. For example, Lambeth gave a comprehensive list of the types of injury which might be found, many couched in medical language (e.g. petechial haemorrhages, hypernatraemic dehydration, avulsion of provisional zone of calcification) only some of which were also explained in lay terms (Lambeth 1981,2). Essex spoke of the importance of medical opinion and referred briefly to unexplained cuts, bruises and lacerations (Essex undated b,1). The AHA gave a lucid description of suspicious injuries such as certain types of bruises, burns, black eyes, bite marks and mouth injuries (AHA undated 4). Hounslow gave no specific description of injuries but spoke of the need to seek medical advice and the procedure when a child was taken to the Casualty department of a hospital (Hounslow 1981, Section 3).

These observations about the diversity are confirmed by a brief survey of six sets of guidelines (only one of which was in our batch), which subsequently appeared in Community Care and which spoke of the variations in "presentation...in the weight and importance given to different subjects" and of "a marked variation in approach and emphasis", which was "inconsistent and confusing" (Community Care 12.5.83, 41).

Before the Working Party meeting on 6th July, 1981, the 29 different topics were consolidated into 20, by grouping together similar or related matters. These were as follows:

1. General Background
2. Medical symptoms
3. Situational symptoms
4. Social Background
5. Procedures
6. Police
7. Case Conferences
8. Duties of Case Conferences
9. Keyworker
10. The Register
11. Deregistration
12. Reviews
13. Transfers
14. Missing families
15. Diplomatic families
16. Services families
17. Area/Borough Review Committees
18. Address list
19. Flowchart/checklist
20. Monitoring forms

A brief summary of what appeared to be emerging as the salient points to be covered within each topic was also prepared. This was combined in a chart showing which of the guidelines actually said what about each issue (See Appendix D). It was put up in the form of a wall chart for the meeting and the Working Party, in fact, spent most of the time looking at it and discussing its implications. The object of this exercise was to agree on the basic minimum that Merton's guidelines should contain and to get other people's (and other disciplines') view on the approach to be adopted. As well as the analysis of what other guidelines did contain, we pointed out the absence of sections dealing with sexual or emotional abuse and neglect and asked for suggestions of other areas which needed to be covered.

This discussion on 6th July was concerned with both format and topics. The minutes of the meeting record "It was agreed that any booklet should be small enough to fit into a pocket or handbag and that colour coding of pages was helpful" (BRC Working Party minutes, 6.7.81, 1). (The latter subsequently had to be abandoned on the grounds of cost).

So far as the topics were concerned, it was agreed that two could be jettisoned. It was not felt necessary to include details of Review Committee membership (Topic 17) nor to include copies of specimen forms (Topic 20). Clear definitions of the different types of abuse were felt to be important and it was agreed that these should include sexual and emotional abuse. The Principal Physician produced copies of "skin maps" (outline pictures of a child's body) used by the Health Department for recording bruises and other marks on children they examined and it was felt that all professionals would find these helpful and that they would draw attention to the need for clear, factual recording of observations (Ibid).

c) The purpose of Guidelines

There was no real discussion about the underlying purpose of guidelines. It appears to have been assumed that they were needed and that they should be multi-disciplinary. Several

of the ones we had looked at contained detailed advice for different professionals (i.e. health visitors, school nurses, midwives, dentists, clinical medical officers and clinic nurses each had their own section) - although the advice contained was often almost indistinguishable from the other sections. It was agreed that we should concentrate on common action and leave individual agencies to produce any additional instructions for their own staff on an internal basis (Ibid).

Apart from the multi-disciplinary ethos, there was no consideration of the philosophy which lies behind the production of handbooks of procedural guidance. Bacon and Farquhar have said that "child abuse procedures have been designed to produce a politically defensible system of case management rather than a basis for therapeutic activity" (quoted in Dingwall, Eekelaar and Murray 1983, 256). Hallett and Stevenson refer to the criticism that "with their focus on administrative procedures, they serve to protect the agency rather than the interests of the child and family", although they comment that "it seems more appropriate to view the procedures as an understandable response (author's emphasis) to the public and professional anxiety which preceded them and contributed to their development" (Hallett and Stevenson 1980, 13-14). Glastonbury and Cooper speak of a "bureaucratic response" and "a major preoccupation with devising rules". (Glastonbury, Cooper and Hawkins, 1980, 98-9) But David Jones, who also lays down some admirably clear ground rules about what such guidelines should contain, advises that they should be "practical, agreeable to all agencies and acceptable to practioners, sufficiently detailed to give meaningful guidance yet sufficiently concise to be clear and memorable". He concludes "Clear procedures and a predictable response from colleagues release energy which is devoted to forming a relationship with the family and assessing the risks" (Jones 1982, 100-1).

None of this was discussed, although some of it may have been assumed. My own determination, knowing that many

practising social workers agreed with the criticism cited by Hallett and Stevenson above, that guidelines are produced to protect management (hence such items as lists of Area Review Committee members), was to produce practice guidelines, designed to help the individual practioner who, in Glastonbury and Cooper's words has to "knock on a strange door with an unknown world beyond, screwing up courage to suggest to parents that they have ill-treated a child" (Glastonbury, Cooper and Hawkins, 1980, 97). Clear procedures would help the practioner - they would also protect the rights of children and parents, who may well have suffered at times from the effects of ill-defined anxiety or an over-zealous faith in the power of Child Abuse Registers. At the same time a clear framework for departmental or agency responsibilities would be helpful for everyone.

To return to the deliberations of the Working Party meeting: in brief, it was decided to include the 18 topics left from the original list, add something about forms of abuse other than physical injury, include the skin maps and devise a format which would be attractive and convenient. At this stage, it seemed that the best way to tackle the actual writing would be to adapt what was already available (none of which was subject to copyright and much of which had clearly been adapted from other common sources, e.g. lists of medical symptoms). The minutes record "The Area Manager and the Social Worker hope to produce a first draft as soon as posible" (BRC Working Party minutes 6, 7.81, 1) and indeed some sections were ready for discussion by the next meeting of the Borough Review Committee meeting on 14th September, 1981 (BRC Working Party minutes 14.9.81, 4.ii). The Working Party did not meet again.

3. Drafting and Negotiating

a) Discussions with the Borough Review Committee

By the time of the September Borough Review Committee meeting, the Deputy Director of Social Services had retired early because of ill-health and the Area Director had taken his place (albeit with the title of Assistant, not Deputy,

Director) being also elected Chairman of the Review Committee at the meeting (Ibid, 14.9.81). Consequently he no longer had the time for the detailed work of drafting and writing, although he continued to take a very active and close interest in the project, discussing each section before it was negotiated through other bodies, helping with those negotiations and organising the funds needed to print the final product. So the great bulk of the writing was done by myself.

Starting from the list of agreed topics, sections were drafted - in no particular order, but often in response to a particular event or request. For example, the sections on minor injuries and interviewing the parents were originally developed for a teaching session with day care staff and field social workers, but appeared to have relevance for all concerned with child abuse so were re-written into a suitable form a few days later and tabled at the next Borough Review Committee (BRC minutes 14.9.81). The section on the Keyworker was one of the first to be written, being originally drafted in December 1981 at the request of the Divisional Nursing Officer, following discussion with her.

Some sections were re-drafted several times and figured prominently in several meetings of the Borough Review Committee. The Keyworker section was one of them. It was discussed (and altered) at two meetings in 1982 (BRC minutes 1.2.82, Item 5 and 6.9.82, Item 4.1). It had also been discussed at an earlier meeting (Ibid, 14.9.81, Item 3c) before the draft was produced. The Divisional Nursing Officer was involved in discussions not only with myself, but separately with the Assistant Director between meetings. Then, in December 1982, following discussions between the British Association of Social Workers and the Health Visitors' Association, a joint statement was issued about the role of Health Visitors in child abuse cases. It was suggested that only social workers could fulfil all the functions of a Keyworker, but that Health Visitors could take a prime role and fulfil some of the key tasks, given suitable Social Services back-up in the form of a nominated Case Co-ordinator (BASW-HVA 1982). As a result of this

statement, the section on the Keyworker was rewritten yet again. The revised draft was tabled at the next meeting of the Borough Review Committee and agreed without comment (BRC minutes 11.7.83, Item 5).

The content of the drafted sections was a mixture of what was current practice in the Merton area (e.g. the practice was that Case Conferences were chaired by Social Services - in hospital represented by a Principal Hospital Social Worker, in the areas by an Area Manager or Team Leader) and what was hoped would improve that practice and ensure that child abuse was handled in the best possible way (e.g. when Case Conferences were chaired by a Team Leader, it should not be a Team Leader with line management responsibility, but another able to take a more detached view and bring a fresh perspective). This was clearly understood and accepted by all members of the Borough Review Committee. The aim was to improve practice. The arguments which took place during the negotiations were about the best way to achieve that and, sometimes, what was the best practice. (For example, the involvement of the police in cases of sexual abuse was seen by some people - notably the paediatricians - as likely to increase the trauma to the child. The police saw it as essential if perpetrators were to be caught and further abuse avoided.)

Because the Guidelines were to be published under the auspices of the Borough Review Committee, all drafts were submitted to their meetings, having been first discussed with the former Area Manager, by then Assistant Director of Social Services. Between September 1981 and July 1983 when the final draft was sent to the printers, the Borough Review Committee met five times and the Guidelines were discussed at each meeting. On 14th September 1981, the discussions were about the medical examination of children at school, the family background of abusing families, Case Conference membership including police participation and the minutes of Case Conferences. The Keyworker issue was raised for the first time and placed on the agenda for the next meeting (BRC minutes, Items 3c and 4ii). The meeting on 1st February 1982 discussed the draft section on the keyworker's role,

which the Divisional Nursing Officer emphasised was only a draft and asked for further discussion about. This meeting also decided to use the term "child abuse" in preference to the previous "non-accidental injury" both in its own title and with reference to its own activities and in the guidelines - the idea being to emphasise that the problem was not just a case of physical injuries but also to fall in line with the terminology used in the 1980 DHSS circular (DHSS 1980). This meeting also considered the draft on the transfer procedures for families with children on the Register, who moved to other areas (BRC minutes 1.2.92, Item 4, 5 and 6).

The next meeting considered at length what was by then a virtually complete draft. The minutes describe it as "substantially different, both in content and layout and incorporating many previously suggested amendments" (BRC minutes 6.9.82, Item 4.1). (It was over 40 pages long - the final draft sent to the printers was 53 pages.) There was a very full discussion and the meeting went through the document page by page and line by line. Twenty-six amendments were requested of which 14 involved either corrections of titles (e.g. District Health Authority rather than Area Health Authority) or minor alterations to phraseology. The detailed discussion centred on (a) the definition of sexual abuse and the appropriate action to be taken, (b) the most appropriate place to seek medical help when a child was injured, (c) situations in which an immediate referral to the police was important and which section of the police should first be contacted and, finally (d) the role of the Keyworker (Ibid, Items 4.1 a-e). Of these items, only the second caused any real problems - which were to recur at later meetings. The Paediatrician present was adamantly opposed to any mention of an Accident and Emergency department and held that all injured children should be taken directly to a paediatrician. The police and the representatives of the NSPCC and Social Services felt that, firstly, this is not always practicable, (particularly in emergencies or at night), secondly, that it is often easier to persuade parents to allow a child to be taken to a casualty department (and to come along themselves) and that

there is a positive benefit to keeping the parents involved in the action. It was eventually accepted that the guidelines should just refer to a hospital and stress the availability of consultant paediatricians and their willingness to see children on a direct referral. The Assistant Director undertook to draft an amendment to this effect and circulate it with the minutes, which he did (Ibid, addendum).

The meeting also discussed the possible format and the number of copies which would be required and was told that an application was being made for funding (Ibid, Items 4.2-4.3).

The next meeting took place on 17th January, 1983. The Paediatrician present was a colleague of the one present in September but the amendment was apparently acceptable and was not discussed in any detail. Instead the section written by a local general practitioner was agreed with minor amendments and a revised introduction and a revised section on Service Families were considered and approved. Finally, a draft checklist and flowchart were agreed and the meeting expressed enthusiasm for the proposed format which they were shown in a mock-up (BRC minutes 17.1.82, Items 5.1-5.5).

The actual contents of the guidelines were discussed for the final time on 11th July, 1983. By then, as will be described below, the neighbouring borough of Sutton had indicated that they wished to join forces with Merton and issue the guidelines as common procedures and the draft had already been discussed at a meeting of Sutton's Borough Review Committee. Several minor amendments had been suggested, which appeared readily acceptable and the Merton meeting agreed them without dissent. There was one problem connected with de-registration, since Sutton did not have an inactive section on their Register, but it seemed simple (and acceptable) to insert a short statement to the effect that this provision applied only in Merton. The other problem, which the Merton Review Committee had been specifically asked by Sutton Review Committee to discuss -

at the instigation of the Paediatrician who had been present at the Merton meeting on 17th January, 1983 and who was a member of both Borough Review Committees (being present in Merton at the present meeting also) - was again the question of which department of a hospital an injured child should be taken to. The paediatrician wished it to be specifically stated that a child should not be taken to a casualty department, but only to a paediatrician. After a discussion, which became somewhat "lively", she accepted that a child could be taken to an Emergency department, provided that it was stated that the paediatrician was informed beforehand or immediately on arrival (BRC minutes 11.7.83, Item 5).

b) Other Negotiations

While the Borough Review Committee clearly bore the responsibility and had the final say about the detailed contents of the guidelines, there were also other bodies which had to be consulted or negotiated with at different levels and about different matters. There were discussions with interested parties (such as the Navy and the Royal Air Force). There were negotiations with those who had departmental responsibilities. The drafts were discussed with the Area Managers' group and it was clear from comments made by other members of the Borough Review Committee that similar discussions took place within their agencies. The Assistant Director negotiated the finance for the printing costs through the Joint Care Planning Team (a body composed of Social Service and Health Authority representatives responsible for the allocation of "joint funding" money to be spent on projects likely to be of benefit to both services). It was also necessary to gain the approval of the Merton Borough Social Services Committee before a formal application could be put to the Area Health Authority for such joint finance (LBM Social Services Committee minutes 23.11.82). Finally, there were negotiations with colleagues, particularly in my own team in the Wimbledon Area Office who were among those who would be putting the procedures into practice.

i) Interested parties

A local General Practioner, known to be concerned about the cases of child abuse he came across and the professional dilemmas these posed, was approached, through a colleague who was attached to his surgery, shown the part of Hertfordshire's guidelines which had been written by a local doctor and agreed to provide something similar. He discussed this with the other members of his practice and together they produced a draft. I visited him to discuss this on 13th January, 1983 and we agreed some slight changes of emphasis to stress even more clearly the necessity to regard the child as a patient in his own right.

Negotiations with the Services were conducted initially through SSAFA (Soldiers', Sailors' and Airmen's Families Association), but then, in regard to the Air Force, by telephone and with the Navy by letter. The contact with the RAF proved time-consuming and, initially, worrying. After two days spent trying to track down the right person to contact within the Ministry of Defence, I was eventually given a direct telephone number. This was answered by an officer who explained that he was not the person I wished to speak to but happened to be passing the telephone; however, he informed me that he knew that child abuse was not a problem in the RAF since they "would get rid of any chap who did something like that or, if it was his wife, get rid of him because they didn't want chaps who could not control their wives" (Personal note of a conversation dated 19.1.83). The next day I received a telephone call from the correct officer, very anxious to assure me that the RAF did have a problem, that they recognised it and were extremely anxious to co-operate with Social Services and that the attitude expressed to me the previous day was neither correct nor the norm. He explained their procedures and together we agreed on the wording of the section to be included (Personal note, 20.1.83).

The RAF wished their contact point to be identified by a post number P.4(a) - rather than by the title of the job or an individual postholder's name. My first telephone

conversation had apparently been with P.4(b) who dealt with housing.

Having had some previous contact with the Naval Personal and Family Service, I communicated with them by post and received a long letter in October, 1982, enclosing copies of their procedures and welcoming our interest since 50% of their families lived in their own homes scattered throughout the U.K. (Letter from the Chief Staff Officer dated 13.10.82). (The Navy sustained their interest and enthusiasm and eventually ordered enough copies of the Guidelines to equip all their social workers.)

Negotiations with other outside bodies were confined to confirming telephone numbers and referral points for the address list from neighbouring boroughs and from the Foreign and Commonwealth office.

ii) Area Managers

The drafts were also submitted to the regular meetings of the Area Managers' group for comment and observation. Area Managers are responsible for chairing Case Conferences. Consequently, they have considerable knowledge of individual cases, but are not as involved in the day to day problems as the Social Workers and Team Leaders. They therefore represented a perspective mid-way between that of the majority of the Borough Review Committee members, who had little direct involvement and that of the social workers, who were dealing with the situation constantly. It had become apparent from my study of the Register that the incidence of identified child abuse varied considerably between the four areas and so did the manner in which it was handled, but from the start all four Area Managers welcomed the project and made constructive suggestions. I was invited to three of their meetings on 3rd June, 1982, 25th August, 1982 and 1st June, 1983. The drafts were discussed with considerable attention to detail and they were anxious that it should be clear not only what should be done, but how. For example, they agreed totally with the principle that a Case Conference should not be chaired, in the absence of the Area Manager, by a Team Leader with line management

responsibility, but they were concerned about how, at times, that was to be arranged. (The solution embodied in the internal Social Services Procedure Order, which was issued at the same time as the Guidelines (see Procedure Order 5 Appendix 4), was to authorise the invitation of a suitable chairman from one of the other Area Teams.)

One Area Manager was responsible for the first draft of the checklist, based on one he had devised for internal use in his own area (which was the one carrying the largest percentage of registered cases). Another, who had recently chaired a particularly difficult Case Conference, suggested that there should be more detailed guidance on the duties of Chairmen and Case Conferences and took a close interest in this section when it was drafted.

iii) Colleagues

Discussions with my colleagues took a variety of forms. If the guidelines were to be primarily of assistance to practitioners, as I was determined, then their support and help was vital. In February 1982 a copy of the current draft was sent to each of the Area Managers with a request that they bring it to the attention of their social workers and invite their comments. Whether the social workers in the other three areas ever discussed them in any detail is not clear. At any rate there was no direct feedback. In my own Area Team, copies were certainly circulated and a group meeting was held to discuss them - three social workers, who were unable to attend, sending written comments (Personal notes dated 24.2.82 and March 1982).

I had, at that stage, been concerned that the guidelines might be perceived as limiting initiative and as aimed at protecting the agency rather than the child. I also asked people if they found them too bureaucratic or too complicated or whether they saw them as management's procedures rather than practitioners'. The group were firm that they found them helpful and supportive and thought that they would help relieve anxiety, setting workers free to act. Their suggestions were similarly constructive. They wanted guidance on situations which they had met in their

work; for example, the problem that arose when a man, known to have abused a child in the past, and whose own child's name had been removed from the Register, moved in with a new family. (The problem would be that, because of the removal of the family name from the Register when the child was deregistered - probably for the perfectly proper reason that there was no contact between the child and his father - someone becoming suspicious of the situation in the new family, would not be helped by an inquiry to the Register.) The solution we adopted was to propose a list of known abusers, who might move into other families, should be kept on the Register for a period of 10 years, after the removal of the family name through the normal deregistration process (Guidelines, Section 6.49).

Colleagues provided on-going criticism in other ways. They would consult me about a case or, in my absence, knowing that a copy of the most recent draft would be in my desk drawer, they would look up something and tell me later if they found it helpful.

iv) Piloting

Colleagues were also useful for piloting. A section would be drafted and discussed with the Borough Review Committee, but I would simultaneously give a copy to colleagues working on the Duty Desk (and therefore likely to be the first people to receive an allegation of suspected abuse). They would be asked, when the next case came up, to follow the suggested procedure and subsequently to comment on its clarity, helpfulness and comprehensiveness. Their reports back were only given orally but were invariably helpful and positive and they were far more likely than members of the Borough Review Committee to spot omissions in a sequence of required actions.

In particular, they proved helpful in the piloting of the Flowchart to be found on the back cover of the Guidelines. This caused many problems and went through at least six different drafts. Each was tried out on a group of four colleagues - one of whom claimed to be incapable of understanding any flowchart! The version which finally

appeared was, he said, the first he had ever understood or found helpful and he became one of its most fervent supporters.

Other groups used for piloting were nursery nurses, child-minders and officers-in-charge of nurseries, plus a group of Physical Education teachers. In the course of training sessions, they asked for specific advice on the type of bruises to watch out for and the section on minor injuries (Section 3.3 of the Guidelines) was produced and revised in the light of their comments. Their enthusiasm for what was originally a rough sketch of common sites of accidental and non-accidental injuries led to it being further developed and included in the final version (see page 6 of the Guidelines). Most of this part of the piloting was therefore done in training sessions and discussions - as the work progressed I was increasingly frequently asked to speak to groups about problems connected with child abuse - but following such a session, I would circulate a revised draft to the group concerned and ask for their report back on its effectiveness. It was in the course of one such report back that a down-to-earth Officer in Charge of a day nursery pointed out that a child with genital or anal bruising could be learning to ride a bicycle!

Because of the delays, which all the negotiations and discussions caused, together with the subsequent delays in the production of the printed version, there was never any attempt to pilot a completed version in, for example, one Area Team and revise the complete document in the light of that experience. The reasons for not doing a full pilot scheme were that first, Merton is a small borough and, although social workers stick closely to Area Office boundaries, many of the other professionals - and particularly medical or health staff - operate across the whole district. Thus there could well have been practical problems in implementing a pilot scheme in some of the cases with which they dealt and not all. Secondly, the design of the guidelines was quite deliberately intended to make revision easy - the internal booklet could be detached and

replaced - and it was always envisaged that any reprinting would also be an opportunity to revise the contents in the light of the experience of working with the guidelines over a matter of five years or so. (In fact, as will be seen, this is exactly what happened: five years after the circulation of the version which form the basis of this study, a revised - and considerably expanded - edition is being prepared for the printer.)

c) The London Borough of Sutton

The guidelines, as they were finally issued, were done so jointly by the Merton and Sutton District Review Committee, which came into being on 22nd September, 1983. It will be remembered that it was the reorganisation of health district boundaries which had led to the dissolution of the Wandsworth Merton and Sutton Steering Committee in 1981. The new District Health Authority boundaries were co-terminous with the boundaries of two boroughs, Merton and Sutton. As early as February 1982, the possibility of combining review committees was mentioned at the Merton Borough Review Committee (BRC minutes 1.2.82, Item 7) and subsequent informal contacts indicated that Sutton were considering revising their guidelines and were interested in combining in that project as well. On 7th October, 1982 a meeting was held, attended by two representatives from each Social Services department, two from the District Health Authority and one from the Police. They discussed both an amalgamation of the two Borough Review Committees (which it was decided to recommend to both those bodies) and the possibility of having joint procedures, in the form of common Guidelines. Sutton were given copies of Merton's latest draft, plus mock-up of the proposed format and, while they indicated considerable interest, they asked for time to consider them and consult their sub-committee, which was planning their fresh draft. (Minutes of a meeting held on 7.10.82).

While preparations for amalgamating the two Review Committees went ahead, nothing was head about the Guidelines for some months. At the January 1983 meeting of the Merton Borough Review Committee, one of the paediatricians, who was

a member of both Borough Review Committees showed enthusiasm for a joint issue and undertook to raise the matter again with Sutton (BRC minutes 17.1.83, Item 5.5). It subsequently transpired that Sutton had mislaid the copies they had been given so six replacements were sent to them. As the planned schedule was to have the draft finalised for the printers by June, they were asked to make a decision as soon as possible (Letter from Assistant Director, Merton dated 9.3.83). On 28th April, 1983 a letter was received agreeing to joint guidelines in principle but asking for consideration of various possible amendments. One list was attached, another received a month later on 26th May, 1983. The amendments proposed were largely minor textual matters: there were only two issues involving any policy differences. Firstly, Sutton did not, officially, have an inactive section on its Register and felt strongly against introducing one. (The word "officially" is used deliberately, since it subsequently transpired that the Register was kept on computer and that no name was ever actually deleted, but was simply removed from the monthly print out and made inaccessible to anyone without the necessary password (Personal communication).) This problem was accommodated quite simply by noting that that part of the guidelines which dealt with the inactive section referred only to Merton. (See Section 6.2.3 of the Guidelines). The second problem has already been discussed in the description of the Borough Review Committee negotiations and referred to the issue of whether a child should ever be taken to the Accident and Emergency department of a hospital. Sutton's previous procedures had indicated that this should never be done intentionally, although they actually sent a monthly list of the names of registered children to the Accident and Emergency department of their local hospital, in case there was a query about a child. This issue was finally resolved in a telephone call on 12th July, 1983 following the meeting of the Merton Review Committee and the draft delivered to the Department of Teaching Media at Southampton University (who were to do the artwork and layout) the following day.

4. The Format

It will be remembered that the importance of getting the format of the Guidelines right had been stressed from the beginning and the second meeting of the Working Party had made some suggestions about the advantage of a format which enabled the guidelines to be kept in a pocket or handbag (BRC Working Party minutes 6.7.81). Too many of the other guidelines looked at seemed unattractive (Essex), difficult to read because of the size or type of print (Coventry), too large to carry about easily or unobtrusively (Lambeth), too gimmicky (Kingston - which had different sized and coloured pages for each topic, an initially attractive idea, but the pages were hard to turn over because of their different sizes). The binding of some made them difficult to handle. For example, Greenwich had produced a large format which fastened at the top, necessitating the use of both hands to turn over a page. Essex's revised version, which was received after Merton's own format had been finalised, was held together by a ring binder from which the pages slipped in a matter of hours.

The Guidelines would, it was hoped, raise the standard of practice. If this hope was to be realised, it was important to have a format which encouraged people to use them. It was not enough to produce a booklet which people read once and put on one side. Moreover it needed to be produced in a form which could be used by someone, possibly meeting a case of child abuse for the first time, who was very nervous and might even be trying to consult the booklet surreptitiously or in a bad light. It was hoped that staff would carry it around. Therefore, while it should be clear to the professional what it was about, the format should not arouse too much parental anxiety or suspicion.

What was needed, in short, was a format which was small enough to enable the guidelines to be carried around - preferably in a diary, handbag or jacket pocket - and which did not have the words "child abuse" or "injury" on its cover. Internally, it should have a typeface that was easy to read and should be arranged in such a way that people could find their way round it without difficulty.

Geoff Poulton, then a Lecturer in the Department of Social Work Studies at Southampton University and, at that stage, one of my supervisors, suggested a folding cover, with the booklet inserted separately and produced a prototype at a meeting at the University on 24th September, 1982, which was attended by the Assistant Director of Merton Social Services and myself. The possibilities of the design were immediately apparent. It had a front pocket into which an address list, blank skin map, check list and any other material, which might need regular updating, could be inserted. There could be a flow chart on the inside of the back cover and, since the cover itself should last a long time, being of stronger material, it might even be possible to revise the booklet without renewing the cover.

The next step was to consult the Department of Teaching Media, also at Southampton University. This department specialises in the production of teaching materials, including written material, in a format aimed to enhance and promote the message of that material. They agreed to do all the artwork and to prepare the Guidelines for the printer. They produced the cover design, suggesting the reversed colour scheme for the internal booklet, redrew the skin maps and laid out the flowchart more clearly. The final size of print used was smaller than had been hoped for, being governed by the size of the whole design, but it was a clear type and its disadvantages were, it was considered, outweighed by the advantages of the rest of the format.

The Department of Teaching Media took longer to prepare and complete the artwork than had originally been hoped, largely because the staff member handling the task had a period of prolonged sickness. In the end, there was a thirteen month delay between delivering the final draft to the Department of Teaching Media and collecting the finished product from the printers.

5. Publication

In March 1983, as the final draft was nearing completion, the District Health Authority agreed to make £2,000

available for the publication of the Guidelines. (This money was allocated out of "joint funding" - that is money set aside for combined health and social service projects.)

Merton Council's own printing section was approached but felt unable to handle the project because of the complication of the proposed cover. At their suggestion, two other local printers were approached but neither were able to match the estimates of Culverlands Press, a Southampton printer recommended by the Department of Teaching Media who used this firm regularly. Culverlands Press saw no problems in handling the proposed format and produced an initial estimate of 800 copies for the available £2,000.

At this stage, the Department of Social Work Studies at Southampton University expressed interest in a joint venture, believing there was a market for the booklet among Social Studies students and other social work bodies. As a result of a much larger print order producing economies of scale, Merton and Sutton eventually received 2,000 copies for its money and the University had a further 1,000 copies, which, in fact, sold well and stocks were soon exhausted.

Merton and Sutton had originally estimated that 800 copies would be more than adequate. In practice, the 2,000 copies were all distributed within four years and it was necessary to produce a photocopied version while awaiting the completion of the revised edition.

6. Conclusions

This chapter has looked at the way the Guidelines came to be written, how the topics for inclusion were selected, how successive drafts were prepared and negotiated with a number of different bodies, how certain parts were piloted and finally how the particular format was devised and the Guidelines finally published. The next chapter will look at the actual content in detail and also consider what lessons may be learnt from the problems which were encountered during the process of production.

Reference was made during this chapter to the ease of revision being one of the factors which influenced the format of the Guidelines. During the years which followed their publication, it became increasingly clear that not only would it be necessary to reprint much sooner than had been anticipated because of the constant demand for copies, but that it would also be essential to revise the contents. This need for revision stemmed from the importance of keeping abreast, if not ahead, of ideas about good practice, of being responsive to the actual situation within Merton and to the needs of local practitioners and of taking heed of the lessons learnt in working with the Guidelines. In addition, the second half of the Eighties was once again a time when Child Abuse became front page news and Inquiry Reports and Government directions constantly stressed the need for comprehensive procedures. These issues will be dealt with in more detail in the final chapter.

CHAPTER V THE CONTENT OF THE GUIDELINES AND THE LESSONS TO BE LEARNT FROM THEIR PRODUCTION

(Note: This chapter looks at the specific content of the published version of the Guidelines, referring to individual sections. It will therefore be helpful to have the copy provided in the back pocket of the thesis to hand, while reading what follows.)

1. Introduction

It will be remembered that 18 topics for inclusion in the projected Guidelines were agreed at the second, and last, meeting of the Working Party on 6th July, 1981. All these were in fact included, although some are in a modified form. As time went on, other topics were added. Some of these formed complete sections in their own right (e.g. Relevant Legislation, which became an appendix to the Guidelines - see Section 10). Others were not totally fresh topics so much as a considerable expansion of the original expectation. For example, only two of the Guidelines from other areas which we had looked at mentioned Service families: Hounslow gave details for dealing with Army families only (Hounslow, Para. 7.5) and the Area Health Authority suggested that all service contacts should be channelled through SSAFA (the Soldiers', Sailors' and Airmen's Families Association). During the drafting of the Guidelines, it was increasingly felt to be important to include specific advice on each of the three services and this was done as part of the section on Special Cases (see Section 7.3). Additional material was incorporated and existing material expanded, during the drafting in different ways and for a variety of reasons, which may be summarised as follows:

a) It arose from popular demand, in the sense that as I became increasingly involved in training sessions and discussions about child abuse, the same questions came up time and again, revealing a need for more explicit coverage of a particular matter: for example, people constantly asked for help in deciding if small or minor injuries were suspicious. From this, as has been described, "the layman's

guide to more common minor injuries" (section 3.3) was developed.

b) At least two inquiries reported while the guidelines were being written: Jason Caesar (Cambridge 1982) and Pinder/Frankland (Bradford 1981). Suggestions for improving procedures made in those reports were incorporated. The definition of "abusing adult" in the Introduction (Section 1) was widened to include "foster parents" and the procedure for inviting people to a Case Conference was altered to include a provision for contacting other agencies who might have had contact with a family (Section 5.1.2.) as a direct result of these inquiries.

c) As copies of other people's guidelines were received, my attention was drawn to ideas which I thought were good and adapted for our own use. For example, Hertfordshire's guidelines (Hertfordshire 1979), which were sent to me in 1982, included a section written by a local General Practitioner (Ibid, 19) - an idea which we copied (Section 8.2.).

d) Particular events influenced the contents. One Case Conference, held in the Wimbledon area office in the summer of 1982, caused considerable anxiety to some of the participants, because of what was seen as its lack of structure and confusion about its purpose. It appears to have illustrated both Jones's comment that a Case Conference "may come to mirror the family conflicts and tensions" (Jones, ed. 1982, 163) and Hallett and Stevenson's that "not only may conferences have more than one purpose but that their purposes may be differently perceived or emphasised by those who attend" (Hallett and Stevenson 1980, 65). Following that, and drawing heavily on Hallett and Stevenson's book, the section on Case Conferences was considerably expanded.

e) The simultaneous analysis of the Register highlighted problem areas. For example, the section on diplomatic immunity was far more detailed than had originally been intended, but Merton is an area which is popular with

families working for foreign embassies and the need for clear advice became apparent from the study of cases on the Register, where diplomatic immunity had been claimed. It also became apparent, as the chapters on the Register earlier in this study have shown, that there was considerable confusion about the purposes of registration (one family was registered for one day only), the information on some families was extremely sketchy, deregistrations took place because of "lack of co-operation", etc. Inevitably these findings from the Register study were reflected in the contents of the Guidelines in an attempt to improve practice.

f) My own experience as a practising social worker had a constant influence on both the topics covered and the emphasis that was given. Throughout the time that the guidelines were being drafted, I was carrying a caseload of child abuse cases. My own need for information led to the section on relevant legislation (Section 10.1); my own attempts to assess possible injuries (and the questions of nursery nurses in training sessions I was conducting) drove me to research the information which lies behind the layman's guide to minor injuries (Section 3.3). In effect, the contents were constantly influenced by everyday practical working experience and tested out against that as well.

2. The Final Version

The contents, as they were finally printed, are arranged in 10 sections, each of which (apart from the first introductory one) has subsections and most of which have subdivisions to the subsections. For ease of reference, each paragraph is numbered according to its section, subsection and subdivision (i.e. paragraph 3.3.5 is the fifth paragraph in the third subsection of Section 3).

Section 1, the Introduction, explains the purpose of the Guidelines, their limitations and the problems involved in dealing with child abuse. Two points were stressed - that the welfare of the child must be the first consideration and that abusing adults are not always the child's parents but

may be other care-takers. This latter point was quite deliberately placed at the beginning (and in a different type face) to catch attention.

The definitions of Child Abuse which follow in Section 2 were based on those contained in the DHSS circular (DHSS 1980, 2.2), but amplified to include sexual abuse and to stress the possibility of physical abuse arising through acts of omission as well as commission. They also include the suggestion that children can be emotionally abused by an over-protective parent as well as by a cold or hostile one.

The third section deals with Assessment. The medical symptoms given were based on those in Lambeth's guidelines (Lambeth, 1981, 2), but prefaced by the comment that the list was intended to help doctors examining a child and that other information on injuries for people without specialised medical knowledge would follow. That information is accompanied by a skin map which indicates in two colours the common sites for accidental and non-accidental injury. (A blank skin map for workers to mark is in the front pocket of the Guidelines). This skin map was based on one in an American book (Faller 1981, 256), but adapted for a British lay practitioner. The chapter also includes advice on the importance of asking for an explanation of observed injuries and mentions some worrying parental attitudes, which are covered in more detail later.

The fourth section on Action distinguishes between emergencies and less urgent situations and includes a reminder about the importance of confirming referrals in writing. A discussion about the initial interview with a family is intended to convey several messages:

a) the importance of explaining to parents what is happening and giving them a chance to explain their version of events.
b) the importance of not making quick judgments on the basis of their emotional reactions but of offering the family appropriate help both with the present crisis and with other problems that may come to light in the interview.

c) the importance of not giving pledges of confidentiality (which may not be able to be honoured), while respecting the parents' right to as much privacy as is possible.
d) the importance of accurate recording.

The fifth section, which is the longest, deals with matters relating to Case Conferences. If child abuse is to be handled successfully by multi-disciplinary co-operation (and there appears to be general agreement with Kempe's dictum "No one group or discipline can carry the load alone.....collectively there is some hope for success; individually the struggle goes on" (Kempe and Helfer 1980, 274), then the Case Conference is the corner-stone of this co-operation. Individual members of the Case Conference may have to work closely together between conferences, but unless the Case Conference has already set the scene (or the people concerned have already established a close working relationship in other cases), their task will be much harder. Therefore this chapter attempted to provide a clear framework to facilitate co-operation. (This was not the time or place to be questioning the value of Case Conferences or to theorise about what could be learnt from a study of group dynamics. The Borough Review Committee, acting in accordance with the DHSS advice, had adopted the Case Conference as a tool in the management of child abuse and the Guidelines clearly needed to lay down some simple ground rules.)

Membership was the first issue. Most practitioners, who have been involved with child abuse, have attended conferences where 20 or 30 other people have been involved. In that situation, vital contributions may go unheard or unsaid - as is noted in the Karen Spencer inquiry, when a Health Visitor was not heard when she tried to correct wrong dates given by a paediatrician (Derbyshire 1978, 8). The DHSS advise "persons having statutory responsibilities ...persons concerned with the provision of services...and persons with information regarding the child and his family" should normally be included and detail 12 different professionals under these headings, with 6 others who may be invited "when appropriate" <u>plus</u> representatives of any

voluntary organisations working with the family (DHSS 1974 b, 16). (It is easy to see how - particularly if a family has moved recently or, for example, attends a hospital across borough or health district boundaries, the numbers would soon mount up.) Hall, in a paper on the Team Approach, lists 14 people likely to be present at "an average-sized conference" (in Carver ed 1978, 196) and adds "It is clear, therefore, that any decision-making process among such a large number of people, many with a differing professional outlook, cannot be easy and might well fail...." (Ibid). David Jones, who with McClean and Vobe had written an account of how some of the problems associated with Case Conferences were tackled in Nottinghamshire (Jones 1979), advised in the book "Understanding Child Abuse": "In practice, the conference should comprise 7 or 8 members, except in unusual circumstances" (Jones, 1982, 165). The likelihood of being able to put such advice into practice is somewhat undermined by the list of agencies to be invited which follows (Ibid). It is also clear that Social Services, if not other agencies, are expected to be represented by staff who have control of resources as well as those who know the case or are present to fulfill a role such as chairing or taking minutes. It would seem likely that the number advised would inevitably be exceeded on most occasions.

Merton attempted a compromise and started by repeating the advice of the Select Committee on Violence in the Family: "The conference should consist of the smallest number of people conducive to good management" (House of Commons 1977, xxxi) in the hope that that would at least remind people that a smaller group might be a better decision-making forum. The Guidelines then gave the type of people that the DHSS had suggested, but not the individual professions and suggested an additional check with agencies not invited to ensure that they had not had relevant or recent contact. (This last precaution was in response to the Jason Caesar inquiry's expressed concern that the Probation Service had not been invited to a case conference when they were in fact actively involved with a family (Cambridgeshire 1982, 13).) The intention was to try to maintain flexibility while

making clear the sort of people who were likely to have a relevant contribution to make.

The literature stesses that a great deal of responsibility for the success or failure of a case conference rests on the Chairman (Jones 1982, 168;, Hallett & Stevenson 1980, 91). Consequently it was stressed that the Chairman should have no other role to play and should not have line management responsibility. (Previously in Merton, Senior Social Workers had sometimes chaired cases being dealt with by their own social workers, in the absence of the Area Manager.) The duties of the Chairman were given a whole subsection (Section 5.4) and those of the Case Conference itself were also detailed at some length (Section 5.2) together with the basic information needed about any child whose name was to be placed on the Register. This was done in an attempt to ensure that the minimum standards expected were clearly articulated. The same principle lay behind the detailed instructions about the role of Keyworkers and Prime Workers (Section 5.5). By the time this was finalised, as was detailed in the last chapter, BASW and the Health Visitors' Association had agreed that Health Visitors could, in certain circumstances, undertake the "prime" role, provided that they had a designated "case-co-ordinator" from the Social Services Department to act in support (BASW - MVA 1982). (Prior to this, very few Health Visitors had been prepared to take on this responsibility even if they were the only person who was successfully gaining entry and the problem was one such as neglect, for which their skills were particularly suited - those Health Visitors who would act as Keyworker, often did so with the disapproval of their colleagues.) The joint statement helped to clarify the issues and the section on the Keyworker was based on this, although it went further by requiring that the division of responsibilities be spelled out and recorded in writing (Section 5.5.4). The responsibility of other members of the conference to support Keyworkers or Prime Workers (Section 5.5.5) was mentioned as a result of my own personal experience, on more than one occasion, of being told, by departing members of a Case Conference, which had just appointed me Keyworker - "Thank goodness, its all your

responsibility now and I can stop worrying/relax/get on with other things". Another area which had caused problems in the past and which was dealt with in this section was the issue of the Minutes and confidentiality. There had been occasions, (which, from discussions with colleagues from other areas, I knew were not unique to our local experience,) when Case Conference minutes had been passed on to other people or agencies, without any reference to members of the original members of the Conference. (For example, in one of my own cases a General Practitioner sent a full set of minutes to a Psychiatrist to whom she was referring a mother, who, on the G.P.'s own advice, had not been told her child's name was on the Register - the Psychiatrist openly referred to the contents of the minutes in the mother's presence and many months of patient work were undone.) If minutes are to be sent out, it is impossible to guard totally against such a situation, but, by the decision to circulate only a list of decisions with a summary of the full proceedings, plus constant reminders of confidentiality, it was hoped to try to minimise the danger.

The sixth section deals with the Register, its purpose, the categories of registration and the active and inactive sections. As was explained earlier, up until this time in Merton there had been 3 categories (and before 1976, there had been 4). To recap briefly these had been:

1) where there is certainty or near certainty that non-accidental injury had occurred;
2) where injury had occurred and there is reason to suspect it may be non-accidental;
3) where there is no evidence of injury but certain of the circumstances in which non-accidental injury is likely to occur have been identified.

It was clear, from my study of the Register, that these distinctions were not understood in practice. Children, whose parents had been convicted of assault on them, were registered in Category 3; some, for whom no evidence of injury could be produced were registered Category 1. It was in an attempt to prevent this sort of confusion, that it was agreed that the categories should be reduced to two and the

division should be between those who were known to have suffered from child abuse and those about whom there was concern for various defined reasons (Sections 6.2.1 and 6.2.2). Deregistration was deliberately emphasised as an aim, but a balance still had to be struck between discouraging Case Conferences from "playing safe" by keeping a child's name on the Register indefinitely (as had clearly happened at times in the past) and ensuring that a child was still adequately protected. This is why it is suggested (in Section 6.5.1.d.) that some children might be so disturbed by their experiences that their names should be kept on the Register, even when they had been removed from home permanently. (The children I had in mind were those familiar to any experienced foster parent or residential social worker, who continue to try to provoke the abusive reactions they have previously received). But while Deregistration had to be encouraged, it also had to be done for the right reasons. As was mentioned in the chapters on the register, there was a small, statistically insignificant, but worrying group, who were deregistered because their families refused contact. Challenged about this, Area Managers denied that it would ever happen in their areas; just in case, a reminder that this was not an adequate reason for deregistration was inserted (Section 6.4.5).

The seventh section deals with Special Cases - families who have gone missing, claim diplomatic immunity or are particularly likely to move around, because the fathers are in the Armed Forces. There was some scepticism that it was necessary to include Naval or Air Force families in a booklet designed for a London Borough - though not on the part of the service personnel contacted, who, as was said earlier, were quite clear about both the relevance and importance.

Following on the Special Cases is Special Agencies (Section 8). While the aim of the Guidelines was to concentrate on a common multi-disciplinary approach and not to single out individual agencies, an exception was made in two instances - the Police and General Practitioners. This was done, in

the case of the Police, because of what was perceived as a widespread ignorance about their role in child abuse cases and a reluctance to involve them. The purpose of a separate section on General Practitioners was to try to persuade the G.Ps themselves to play a more active role in the management of these cases and in particular to attend Case Conferences. (Over a 12 month period in Merton, General Practitioners, who often have vital information and close continuing contact with a family, had attended only 26 out of 111 Case Conferences). We hoped that having the section written by a local doctor would also help . This aim was defeated by the fact that few, if any, General Practitioners received a copy of the Guidelines, although enough copies were made available to the Family Practitioner Committee. (This problem of distribution will be discussed in more detail shortly.)

The ninth section is headed Lessons from Research and gathers together some common factors, which have been shown to have significance in studies of the aetiology of child abuse. Many of these factors appear in other guidelines - the additional ones are based on the work of Kempe (particularly in Kempe and Helfer 1980 and Kempe and Kempe 1978, Chapters 2 and 3) and on studies by Smith, Hanson and Noble (Smith et al 1973, Smith et al 1974). Even if the child has not been abused, the presence of several factors would certainly indicate a family under stress and likely to be in need of help and it was hoped to draw attention to this, while warning that the presence of even a large number of factors does not "prove" abuse. Because emotional and sexual abuse, although detailed in the initial definitions in Chapter II, were not at this time such familiar concepts to many people (some of whom still appeared to equate child abuse with "non-accidental injury") they were dealt with again at this stage. (At the time, there was a certain feeling that it was "progressive" to say so much about sexual abuse: rewriting the Guidelines five years later, in the wake of the Cleveland inquiry, it seemed almost incredible that there was so little reference and detail.)

Finally the Appendix deals with legal issues, in particular the grounds for taking action and going to court. It is not intended as a substitute for professional legal advice, but, like the earlier layman's guide to minor injuries, to provide enough information for the non-legally qualified to understand more clearly what action is possible, in the hope that they may both seek legal advice more appropriately and understand it when it is given. It contains the unequivocal statement that any person may apply to a magistrate for a Place of Safety Order (provided, of course, they have grounds to do so). This is the correct legal position, although several Nursing Officers have refused to believe me! The section closes with advice about the position in respect to the consent for a medical examination of an injured child in its parents' absence. This was specifically requested by three Matrons of Day Nurseries, who had been in the position of having to make decisions about this without time to seek legal advice.

This concludes the contents of the internal booklet (which can be removed from the external cover, if required - or if it were wished to revise the booklet without revising the cover). The cover itself contains a front pocket in which are placed a blank skin map (for recording bruises or injuries), an address list and a spare copy of the Checklist of actions to be taken. The Checklist also appears, in more permanent form, on the cover. Some agencies have used the front pocket for including copies of their own internal procedure orders, which would seem an eminently sensible thing to do.

At the present time of writing the Guidelines are still in circulation and use, although, as has been indicated, a revised version is nearing completion. The version, which is the subject of this study, arose out of the circumstances and needs of the time and five years later the needs, while not fundamentally different, have changed considerably in extent and emphasis. Little of the present version is being jettisoned but several portions, especially those dealing with sexual abuse, are being expanded.

3. The Lessons Learnt

a) Problems

From inception to completion, the guidelines took almost three years to produce. Apart from the delay, caused partly by sickness, which took place during the year between the finalisation of the text and the delivery of the copies from the printer (which was not Merton's responsibility), it is hard to know how the time could have been shortened. The very nature of multi-disciplinary production involves time-consuming consultation, discussion, drafting and redrafting, if the result is to be acceptable to all those involved. Had the design been less ambitious or the selection of topics less wide-ranging, something slighter might have been produced more quickly. If the person doing the bulk of the writing (myself) had actually been seconded to the task, or given some time in which to do it, the writing might have been quicker, although the negotiations would not have been. As it was, the writing was largely done in my own free time and competed with the analysis of the Register for that time.

Such delay was, in the circumstances, probably not excessive. The only reference to the completion, as opposed to discussion, of procedural guidelines, which I have been able to find, is in an article entitled "Case Conferences on Child Abuse: the Nottinghamshire approach" in which the authors state: "The inauguration of the procedures manual followed 18 months of work by an ARC (Area Review Committee) sub-committee (half-day per fortnight)" (Jones, McClean and Vobe 1976, 7). It will be remembered too that the Merton Borough Review Committee discussed the possibility of producing guidelines for seven years before matters started to move - a situation similar to that recorded by Dingwall, Eekelaar and Murray who found that, in the Area they studied, discussions had begun "early in 1975" and that at the end of the study "it was merely hoped it would appear in the course of 1981" (Dingwall, Eekelaar and Murray, 1983, 134, 142). So the delays in Merton would not seem to have been unique or unusual. Nevertheless, there were some delays which were clearly caused by inter-disciplinary,

hierarchical or communication problems. In addition, both during the drafting period and later after the Guidelines were published, there were distribution problems.

i) Inter-disciplinary problems

Child abuse is an emotive subject and the management of the problem causes anxiety and tension at many different levels. The effect of media publicity has been to increase what has been described as "the high level of professional anxiety" (Hallett and Stevenson 1980, 15).

While Social Services Departments bear the statutory responsibility, the other professionals involved - in particular, the medical professionals - are not only regularly involved with child abuse but rightly feel that they have particular knowledge and skills which are relevant to its management. The part played by the medical profession in drawing attention to child abuse in the sixties and seventies was described earlier. Child abuse is still most frequently defined on a medical model - the terminology used is of symptoms, diagnosis and treatment plans. In view of these factors, it would be surprising if there were not sometimes differences in the way the different disciplines feel matters should be managed and that this should effect the production of guidelines or procedures. In this case, the differences surfaced particularly over the question of who could or could not be expected to undertake responsibility for the Keyworker role and whether or not it was proper to take a child to a Casualty department. The different professionals had genuinely different views and reconciling them was very time consuming.

It is possible that, had the Working Party continued to meet and had that been the group responsible for over-seeing the draft, that the same impetus that enabled it to cover so much ground in the two meetings it did have, would have carried the project through more quickly. Moreover, it would have been considerably easier to negotiate multi-disciplinarily in a smaller group which met regularly than it was in the large committee (average attendance of which

ranged from 12 to 20), meeting only two or three times a year, whose members did not always attend every meeting.

ii) Hierarchical problems

During the period when the guidelines were being drafted, I was employed as a part time field social worker. Apart from consultation with my colleagues, all the negotiations had to be conducted with more senior people, often considerably more senior. Moreover, I was a practitioner and not a manager, which meant that I was inclined to see things from a different perspective. The argument over the correct place to take an injured child was clearly prolonged by the difference in view between senior consultants who were concerned that a child should be seen by the person with the most skill and experience and the practitioners (principally myself and the NSPCC representative) who were concerned with what, in practice, it was feasible to do and knew, at first hand, the difficulty of actually getting hold of a busy paediatrician.

iii) Communication problems

There were several kinds of communication problems. One was the amount of time that contacting the right person could take. For example, as detailed above, identifying and speaking to the correct RAF officer took two complete days. Another problem was changes of personnel, which often involved re-running previous discussions and returning to subjects which had already been supposedly dealt with. This particularly happened with the two Paediatricians from the same hospital group who tended to alternate at meetings. A new police representative on the Borough Review Committee insisted that every reference to contacting the police should be altered to designate the Chief Inspector, Juvenile Bureau (BRC minutes 1.2.82). Following the reorganisation of health service boundaries, there were many changes of personnel and people, who had been deeply involved in a complex negotiation over a particular matter, would no longer be around. (This was occasionally helpful. The Divisional Nursing Officer, who had been so very concerned about the role of the Keyworker and the problems of Health Visitors in this respect, was not in post when the section

based on the BASW-Health Visitors Association statement was tabled, and it went through without demur.) Finally, there were occasional difficulties caused by people taking up a rigid position or sticking to a particular view in the face of all reasonable argument or irrefutable fact. For example, one senior nursing representative tried hard to have the reference to Section 28(1) of the 1969 Children and Young Persons Act removed from Section 10 of the Guidelines on the grounds that it was not correct to say that "any person" could apply for a Place of Safety Order (although those are the exact words in the statute), because a Health Visitor, in her view, could not. (This was a view that surfaced again from another senior health service officer, after the Guidelines were printed, during a seminar I was leading to introduce them - the person concerned was a magistrate as well as a health service employee and said firmly that she would not grant a Place of Safety Order to anyone other than a representative of Social Services of the Police, because no one else was "allowed" to apply.)

iv) Distribution Problems

Some time was lost by the failure of other agencies to attach as urgent a priority to the discussions as was hoped for. In the case of the Borough of Sutton, who eventually joined with Merton to issue the Guidelines jointly, time was lost because they mislaid the drafts they had been given and this did not come to light for almost 5 months. When they received replacements, they inevitably wanted to suggest amendments, some of them matters which had already been discussed at length in the Merton Review Committee.

There were subsequent distribution problems after the Guidelines were printed and sent out. Education Departments in the two boroughs received enough copies for at least two to be sent to each school, but in the years which ensued, schools regularly claimed never to have seen copies. (At a Training session in July 1989 for "designated teachers" - i.e. the member of a school's staff who has been given special responsibility for child protection - three out of the twenty teachers present had never see nor heard of the Guidelines (Personal Note dated 30.6.89).)

More disturbing was the failure to get copies to General Practitioners. It will be remembered that one of the reasons why a local General Practitioner was asked to write a section for the Guidelines was because there was concern in Merton, as elsewhere (Jones, McClean and Vobe 1979, 6) about their failure to attend Case Conferences and communicate with other agencies. The Family Practitioner Committee was sent sufficient copies for every local General Practitioner to have one. The copies were delivered personally to the Family Practitioner Committee by the Principal Physician (Child Health). A chance enquiry to my own GP six months later led to the discovery that no one in his practice had seen a copy. Further enquiries revealed that no local practice appeared to have received a copy. The Principal Physician made enquiries and was told, firstly, that the Family Practitioner Committee (which was after all represented on the Borough Review Committee, although its representative did not often attend meetings) would decide whether to circulate the Guidelines or not and, secondly, that they would be circulated when they could be found (Personal note dated March 1985). Three years later, they had still not been circulated. At this stage, a letter was received, by the Director of Social Services in Merton, from a senior manager of the Wandsworth, Merton and Sutton District Health Authority. He explained that he had recently arranged for the distribution of Wandsworth's Guidelines to General Practitioners and would be happy to distribute Merton's - "if you have any". Since by this stage, the original print run was nearly exhausted, he was asked to try to find the copies delivered three years earlier and either distribute them or return them (correspondence between the District Manager and the Director of Social Services, Oct -Nov, 1987). So far as can be discovered, they were never found.

b) Solutions

Nevertheless, despite all the delays and the problems, the reality is that the Guidelines were written and produced, that the copies taken by Southampton University were all sold out and that Merton and Sutton's own order, more than

twice the number which it was originally anticipated would be needed, was exhausted within four years and people were still asking for copies of the original, even when plans for its successor were well advanced. Clearly the Guidelines, which arose out of need in a particular place at a particular time met that need and were seen as a multi-disciplinary production.

Both Inquiry Reports and DHSS memoranda have constantly stressed the importance of inter-disciplinary co-operation in handling cases of child abuse (DHSS 1982, passim, and DHSS 1988b, which particularly emphasises the point in its title - "Working Together"). Area Review Committees were specifically intended to be multi-disciplinary bodies set up to enable such co-operation. Nevertheless, there are acknowledged difficulties about multi-disciplinary working, caused by such factors as the different priorities and decision making structures within different professions, as well as ignorance about other professions' structures. These problems are discussed by Webb and Hobdell in an article in "Teamwork in the Personal Social Services and Health Care" (Lonsdale, Webb and Briggs 1980) and many of the problems, and solutions, which they discuss were paralleled in Merton during the production of the guidelines.

i) When the theory of action-research was being discussed in the last chapter, the first point made was that there needs to be a cause if action is to bear fruit. Olive Stevenson, in an article in the same book, speaks of "an interest by one team member" appearing to lead to action (Lonsdale, Webb and Briggs. 1980, 19) and the discussion in the book about Webb's article quoted above concludes "teams must have specific goals" (Ibid, 153). However, teamwork, even when there are shared goals, cannot be imposed and the important point would seem to be that made by Olive Stevenson that at least one person's interest and commitment will be vital if momentum is to be sustained to see the task through to completion. In this instance, many people had a commitment to the cause of child abuse and to better

practice in handling it and their commitment was an encouragement to me to see my original interest through.

ii) A smaller team with a specific goal appears to find it easier to achieve more than a larger team or group. This was shown in the achievement of two meetings of the Working Party by comparison with many of the larger Borough Review Committee meetings. Briggs refers to "the superiority of brief, task-oriented services not requiring a strong relationship" (Ibid, 85) and it would seem that that was exactly what got the Working Party moving so quickly and so well, since the specific nature of the task and the brevity of the timespan involved appeared to overcome any difficulty in the inter-disciplinary relationships involved.

iii) The difficulties, as well as the importance, of multi-disciplinary working were referred to above and arise partly from the different priorities and decision making processes in different agencies (Webb and Hobdell in Lonsdale, Webb and Briggs, 1980, 104). In particular, as Dingwall points out in an article in the same book, nursing and medical social work have both developed "in a dependency relationship with medicine, taking on subordinate and routine tasks" (Ibid, 120). In addition, as has been pointed out already, the theory of child abuse was, in the early stages, evolved largely by doctors on a medical model of cause, symptom and effect. Given these factors, it is hardly surprising, perhaps, that at times in the negotiations over the Guidelines, the doctors sought to impose their own view and seemed to expect to be deferred to. (This surfaced particularly in the argument over the correct medical venue to take an injured child to referred to several times.)

However, these difficulties were overcome and this would seem to have been because <u>all</u> the professionals shared a basic aim to improve services to children and this triumphed over inter-disciplinary difficulties, possibly aided by the fact that individual consultants were not always regular in their attendance at meetings and tended to alternate with colleagues.

iv) Dingwall and colleagues have also written about the attempts of Area Review Committees to work together (Dingwall, Eekelaar and Murray, 1983) and they found that co-operation was more successful in some areas than others. It appeared that it was those Review Committees which were prepared to delegate to sub committees, composed of members who were more likely to know each other and be used to working together, which were able to "pool their authority" and get things done within their own agencies (Ibid, 143). It seems also that these were nearer to the "coal face" and that that can be a powerful factor in achieving co-operation and action. Certainly in Merton, the pressure to persevere and complete the Guidelines came from the actual practitioners and this in its turn put pressure on senior management to be seen to deliver the goods.

v) A further factor which would seem to have had a significant part in ensuring that the project was completed successfully was that it was rooted in a knowledge of the local situation and local needs. The study of the Register may have seemed at times, or to some people, to be totally divorced from the Guidelines. In fact, it provided much of the theoretical base on which they were grounded.

4. Conclusions

This chapter has looked at the contents of the Guidelines as published and discussed the lessons learnt from the problems encountered during their production.

Five years later, when the Guidelines came to be revised, some of these lessons were to prove invaluable as will be seen in the final chapter.

The publication of the Guidelines was not the end of the story. In fact, in one sense it was the beginning. Once they were collected from the printer they had to be presented to the professional who would have to put them into practice. They had to be "taught in" both within Social Services and all the agencies working locally in the field of child abuse. How this was done and how events,

both locally and nationally, affected the subsequent revision that was nearing completion as this study too was being finished will be dealt with in the concluding chapter.

CHAPTER VI THE CONCLUSIONS OF THE STUDY

1. Introduction

This study was started in 1981, a year in which, it seemed reasonable to believe at the time, a period of intense interest in, and activity concerned with, child abuse was drawing to a close and it could be helpful to reflect on how one outer London Borough had reacted during that period and how it had tried to manage its response to the problem. Although at least five inquiry reports appeared during 1981 - Malcolm Page (Essex 1981), Richard Fraser (Lambeth 1981), Lucy Gates (Bexley 1981), Emma Hughes (Calderdale 1981), Christopher Pinder/Daniel Frankland (Bradford 1981) - these were all Local, rather than Central, Government inquiries. The DHSS had issued a memorandum on Central Register systems (DHSS 1980) and much of the attention in 1981 and 1982 concentrated on the form future inquiries should take (BASW 1982). In 1982, the DHSS published a study of 18 inquiry reports (DHSS 1982) and Norman Fowler, the then Secretary of State for Social Services, wrote in the foreword of the analysis helping agencies "make their work even more effective" and helping "to prevent other children sharing the same fate" (DHSS, 1982, iv). The scene seemed set for a period of reflection and consolidation of the lessons learned.

It seemed an appropriate time to start a study of one particular Register and the writing of the same area's guidelines and as the data was being collected and the Guidelines written, there did appear to be a lull of sorts. The five reports published in 1981 had made that the most prolific year for inquiries, but also could be seen, or so many practitioners hoped, as a final blood-letting. In fact, the next three years only saw a further two reports: Jason Caesar in 1982 (Cambridgeshire 1982) and Shirley Woodcock (Hammersmith and Fulham 1984) and neither of these attracted the national publicity of some of the earlier reports. (1983 was the first year since 1973 in which no report was published.)

The data on the Register was collected up till March 1983 and the Guidelines were delivered by the printer in July 1984. As will be shown later in this chapter, the circulation of the Guidelines led to an intense demand for training and "teaching-in" sessions. Both parts of the study had been very closely allied with practice - the study of the Register was a study of what had happened in practice and the Guidelines were an attempt to articulate a framework for practice - and it had always been anticipated that there would be a period of explanation, discussion and dissemination. What had not been anticipated was that there would be such an explosion of demand for teaching and consultancy nor that this would be both succeeded and prolonged by a resurgence of national interest and a further wave of reports. There were three in 1985: Jasmine Beckford (Brent 1985), Reuben Carthy (Nottingham 1985) and Heidi Koseda (Hillingdon 1985). The first of these was both highly publicised in the media with the sort of attention paid to the social workers involved that had been first seen in the Maria Colwell case (Parton 1985, Chapter 4) and was the subject of a lengthy and also much publicised report. Many Area Review Committees, including Merton's (by now joined with Sutton) felt the need to consider the findings of the report in relation to their own local procedures and practice and such considerations were barely completed when further child deaths led to the appointment of yet more committees of inquiry. The Tyra Henry (Lambeth 1987) and Kimberley Carlile (Greenwich 1987) reports appeared as the Secretary of State announced that Lord Justice Butler-Sloss would chair an Inquiry into Child Abuse in Cleveland and shortly after Esther Rantzen started Childline on television. Such was the background against which the study was written up. Inevitably the pressure which resulted distracted from the academic study. It is a pressure which many researchers have to face: how can one take to think and reflect when there is urgent action to be taken? Theoretically it is clear that thought and reflection may lead to an improvement of services and, in this case, a better deal for future children at risk of abuse. In practice, it is the children who are at risk now who seem in more need of help and, at times of high media attention, it

can almost seem that one moment of inattention to them may have horrendous consequences for both child and professional alike.

This chapter will recap on the original aims of the study, consider what lessons were learnt and what happened as a result, how the work involved in the study coupled with external events led, not only to delays in writing the study up, but to changes in the Borough's approach to the management of child abuse and to demands for further guidance and training. It will consider too whether the study achieved its original aims and try to point to areas where further research is needed or where the lessons learnt from the study still have to be applied.

2. The Aims of the Study Revisited

The aims, as stated at the beginning, were to look at the procedures developed by management, through a multi-disciplinary Review Committee, to analyse the information contained on the Register and to observe, describe and detail how the Guidelines came to be written and what they contained. It was hoped that, ultimately, the study would contribute to the improvement of professional practice and procedures, by providing professionals with better information on which to base decisions and with better tools, in the form of clearer guidance, with which to work. This, in its turn, it was hoped, would lead to a better service for both children at risk and their families. There was already an awareness of the problem, but that awareness, it was hoped, would be both increased and better informed and it would be an awareness not only of the problem but of ways of dealing with it. The analysis of the Register would, it was hoped, reveal underlying trends and patterns, which might have significance for the provision of resources, for on-going work with the family or even for preventive work to save future children from possible abuse. Professionals, it was pointed out, were operating in a climate of anxiety and appeared to lack an overall vision or frame of reference and it was possible that the study could help to provide this.

The study aimed to do these things in two very different ways. Firstly, by looking at the Register, which already existed, to see whether it could be used not just reactively to keep track of numbers of children and to provide a point of reference, but proactively to discover what lessons could be learnt from its contents, which could be applied to other children or situations or to help develop better procedures. Secondly, the study chronicled the creation of something, which did not exist at all at the beginning, but which was being created, somewhat late in the day, as guidance for professionals working in the field of child abuse.

So far as was possible, the study attempted to relate the findings to other available research and to make comparisons. Unfortunately, there were no national statistics available until the study was nearing completion, when the Department of Health issued a report based on Register returns for the whole of England for the year ended March 1988 (DoH, 1989). None of the other studies had covered exactly the same ground, so it is not possible to be sure how generally applicable the findings about the Register are. So far as the Guidelines are concerned, no other such detailed study has been identified, although there is evidence that the time taken to produce them was not unusual.

Before considering how far the aims of the study were achieved, it is necessary to consider what was learnt, and what happened as a result of what was learnt in relation to the Register, the Guidelines and local practice generally, as well as considering in more detail what happened both nationally and locally during the intervening years, which both affected the findings of the study and delayed its completion.

3. The Lessons of the Study and the Developments which followed

a. The Register

The analysis of the Register yielded two types of statistics. The first concerned the numbers of families and children registered, totals on the Register each year, information about the reasons children were registered or deregistered, trends in referral rates and variations between years, Area Offices, the length of time spent on the Register and the types of cases referred by different professional groups. This part of the study was concerned with the overall lessons to be learnt from the Register. The second use of the statistics was to try to build up a profile of the families and the children who were the object of all this professional concern, where they lived, the size of the families, the age and gender of the children, the parents' marital status and problems and, lastly, how often the professional intervention resulted in court proceedings or children being removed from home.

So far as the Register itself was concerned, the statistics showed a pattern of fluctuations and adjustments as well as steady and predictable trends. The numbers of Referrals varied from year to year, often, it seemed influenced by external events. The actual totals on the Register, however, remained pretty steady, a high number of Registrations one year being followed by a higher than average number of Deregistrations the next year. Throughout the years studied, Physical Abuse was by far the most common reason for placing a child's name on the Register and over half the families registered were registered because children were believed to have been physically injured or were considered to be at risk of possible injury. Physical Abuse was seen as the most common type of abuse: it was also considered the most serious form of abuse and particularly dominated the more serious categories. (There are some signs that this situation is beginning to change - while Physical Abuse is still the most common reason for placing children's names on the Register in Merton, in March

1989, for the first time ever it accounted for less than half the total number of registrations (43.6%) and Sexual Abuse, which had accounted for only 1.5% of the cases registered up to 1983, was given as a reason for 15% of cases.)

Physical Abuse was also likely to be the reason for registration for those cases which stayed longest on the Register. While it was heartening to discover that the most commonly given reason for deregistration was that a family had made progress, it was less encouraging to realise that the average time spent on the Register was longer for the families which made progress than for those who were deregistered for other reasons. Perhaps the lesson to be drawn from that is that working with abusing families is very time-consuming and may take a long time.

While the large numbers of children held to be at risk of physical abuse formed a steady core of the numbers on the Register, the fluctuations were contributed largely by the cases where the reasons were vaguer or even not given at all - the Professional Anxiety and No Reason given groups fluctuated the most and tended to be particularly high in years of enhanced media attention or public concern. This confirmed the hypothesis that the Register was a record of professional concern rather than of actual abuse, a distinction which it is important to keep constantly in mind while considering the figures.

Comparing the time spent on the Register by those cases which had been deregistered with the cases which were still in the Open section, confirmed that there was a definite tendency for cases to drift and, if they were not deregistered within the first two years, they became increasingly likely to remain on the Register for several years or, in some cases, almost indefinitely.

Reference was made, when describing the way that concern over child abuse was articulated and described in the 1960s and 1970s, to the lead given by the medical profession in drawing attention to the problem and this is reflected in

the large number of referrals, and particularly those in the early years of Merton's Register, which came from medical professionals. That was not surprising, nor the fact that the Medics were also responsible for referring most of the families, who seemed, because they lived in their own homes, to be more likely to be middle class. What was more surprising, at first sight, was that the medical professions, like Social Services, referred a higher proportion of the less serious cases, but this may have been because these two groups were more alert to the problem of child abuse generally, and were more prepared to refer the less serious cases. Other agencies, on the other hand, may have hesitated to refer families where the abuse was less readily obvious or where they felt families should be given the benefit of the doubt or another chance. While that could account for the high proportion of Social Services' referrals which were registered in Category III, the number of Social Services cases, which were registered without a reason being clearly articulated, remained concerning.

The large number of Medical referrals was not surprising, but the small number of cases referred by some other agencies was. The study covered 13 years and in that period only 4 cases were referred by the Police and only 2 by the NSPCC. It was pointed out that the situation with Police referrals would almost certainly be different if an analysis of current cases on the Register were considered, since cooperation with the Police and the latter's awareness of, and sensitivity in handling, cases of child abuse has greatly increased in recent years, culminating in the Metropolitan Police area with the launching of Child Protection Teams of specially trained officers. (Merton and Sutton's Child Protection Team was operational from the end of May 1989 and joint training of police and social workers began two weeks later.) The two NSPCC referrals were more surprising since during this period, there was a NSPCC Inspector with particular responsibility for Merton and a small, but constant, flow of publicity in the local media about their work and presence as well as accounts of fund-raising events.

While it appeared that concern about child abuse varied from year to year - and even according to the time of year or the part of the borough - and that much of what was being registered was professional anxiety, rather than clearly assessed abuse, there could be no doubt about the amount of professional time and effort that had been invested in the cases. The study made no attempt to quantify the amount of time spent working with a family but only considered the time and cost of meetings about the family. The cost of the meetings involved would seem likely to have been in the region of £3,000 per family - at 1980 prices - and the time involved in meetings was a minimum of 24 hours per family, even if one supposed that each meeting was only attended by 6 people and lasted a maximum of an hour. In reality the figure was likely to be much higher.

The profile of the families themselves showed that they seemed not untypical of many families. There was a tendency to have slightly larger families than the national average, but that was matched by the number of single child families which was the same as the national average. Most of the children lived with two adults and over half of them lived with both natural parents. True single parents made up less than 10% of the study and appeared less likely than other parents to physically abuse their children, although they were seen as more likely to neglect them or to put them at risk because of their own problems. A third of the families lived in their own homes - a lower proportion than in Merton as a whole, but still a sufficiently high number to confirm that it was not only families from the lower social classes who found their children's names on the Register. The families who lived in their own homes, however, were, like the single parents, more likely to be registered in a lower category, although there were some signs that this was changing in relation to the Own Homes group. Families, who lived on large estates were more likely than other council tenants to be registered and in a more serious category, but the distribution on the actual estates varied over the years and the present cases on the Register show a considerable difference from the earlier years. Over a third of the families had not been known to Social Services before the

referral which led to the Registration and those families which had been known longest were more likely to be seen as low risk.

More boys were registered than girls, although the latter were more at risk in the first year of their lives and in their teens. This had been seen as a typical finding and confirmed the NSPCC studies, but the recent Department of Health statistics have shown that nationally, in 1988, girls accounted for 52.3% of children registered and boys only 47.7% (DoH, 1989,5). This was very different from this study's finding of 54.9% boys and 45.1% girls, but the situation in Merton itself has also changed and, in the year ended March 1988, 25 girls and 26 boys were added to the register - a proportion nearer to the recent national figures. Why the situation should have changed is not totally clear and would need to be specifically researched, but two possible reasons suggest themselves. Firstly, a far larger number of children are now registered for sexual abuse than in previous years (9% of Merton's register in 1988, 15% in 1989) and more girls than boys are registered for sexual abuse (DoH, 1989,6). Secondly, fewer girls than boys have been the subject of inquiries into child abuse tragedies over the years (Blom-Cooper gives a list of 33 inquiries held between 1973-87, 19 of which related to boys and only 14 to girls (Greenwich, 1987, App 8)). However, since 1981, 10 out of the last 16 inquiries have been concerned with girls. Moreover, these include the cases which attracted the most media attention and public concern - Jasmine Beckford, Tyra Henry and Kimberley Carlile. In view of the fact that it appeared from the analysis of the register that figures went up at times of public concern, it might also be that the proportions of girls registered could have been influenced by these external events.

Young children were more likely to be registered than older children, although they were also more likely to be seen as at less risk than older children and consequently more likely to be registered in Category III. Nearly 38% of the families contained only one child and this, coupled with the 45 Key children who were the eldest in their family, made it

appear that the first born child in a family is most likely to be considered at risk of abuse. Abusers, where identified, were most likely to be members of the child's immediate family, but showed otherwise no characteristics which differentiated them from the general run of parents. Fathers appeared, as one might expect, to be older than mothers and, whereas mothers seemed less likely to have children registered as they got older, there was some evidence that older fathers were more likely to find the family's name on the Register. The analysis of the parents' problems indicated that the professionals at least perceived these to be most likely to be marital tensions or psychiatric problems, or a combination of them both, and stress factors such as poor housing or unemployment were not often mentioned.

Although some children were removed from their families, legal proceedings resulted in less than one third of the cases and the proportion of long term removals was even lower.

These were the trends and patterns which emerged from the study of the Register. Up to the time of this study, the only use that had been made of this material was to answer the occasional query about whether a particular child was registered or not and to extract the quarterly statistics for the Review Committee meetings. The DHSS's advice that Registers could be used "to provide material for training and research" (DHSS, 1980,1.2) was heeded only when this study came into existence. Moreover, although quarterly statistics had been extracted, there had been no attempt to look at the picture over a longer period or to consider whether the trends and patterns had relevance for either the day to day management of the problem or for the planning of resources.

The overall impression given by the Register at the beginning of the research was of confusion - confusion over its format and use, confusion over the criteria which led to Registration or Deregistration and confusion over its purpose. The numbers fluctuated, the information contained

on the cards varied, the reasons for registering were often not given and the reasons for deregistering sometimes seemed illogical, to put it mildly. It was clear that such procedures as existed were not being followed in every case and it was clear that there were variations in practice between different parts of the borough, even when one made allowance for the possibility of different population trends.

All this contributed to the belief that the Register was a record of professional concern about certain families and that it could not be seen as a definite record of the incidence of child abuse in Merton. It was also apparent that there had been, and still was, a great deal of activity. That some of that activity was somewhat unfocussed did not mean that a lot of energy had not been expended and what it was clearly necessary to do was to harness the energy and channel it into handling cases of abuse as well as possible. If the study of the Register could be used to increase awareness and improve identification of the children at risk, it was possible that the numbers on the Register might escalate but it was also possible that the Register might come closer to being a record of the actual incidence of abuse rather than of professional concern about abuse.

This is not to suggest that the Register contained many children's names, where the professional concern was misplaced (although it has been pointed out that there was a worrying number of wrong registrations and of cards referring to families whose children had never been registered). In the vast majority of cases, there was clearly reason for concern and even though the study revealed no dramatic cases of the type likely to hit the headlines (the only known death had occurred to a child whose family had not previously been known and whose siblings were only registered at a later date) it did reveal constant accounts of bruises, fractures, burns or deprivation to an extent that professionals were quite properly anxious about a child's welfare.

In practice, some of the lessons learnt from the study of the Register led to considerable changes in the management of the Register and in the use that was made of it. Within two years of the date at which the collection of the material it contained ended, I had been appointed as Custodian of the Register with a brief to monitor adherence to procedures, to draw attention to situations or events which might have significance, to ensure that all cases were reviewed regularly and properly (referring back to the Case Conference if necessary) and to be available to advise workers about chid abuse or to attend Case Conferences in a consultative capacity, as well as to be available to help with training. Since the previous Custodian had, in theory, been the Assistant Director it might appear that my appointment downgraded the importance attached to the Register, but the reverse was true. No Assistant Director had the time to read the minutes of all Case Conferences or to attend them if invited. No Assistant Director could do more than glance at the statistics prepared by his secretary in preparation for the next Review Committee and, in practice, as we have seen, the main burden for maintaining the Register had previously fallen on the Assistant Director's secretaries, who had no specialised knowledge or experience. One of the first steps I took was to improve the security of the Register and, until it was computerised, another two years later, everything was kept under lock and key and carefully put away out of sight. Moreover, the system, while it remained a manual one, was so organised that queries could be answered in a matter of minutes at the most. When the question of computerisation was first explored, the emphasis from the first was on a system to which only myself and my administrative assistant should have access. The computerisation obviously also allowed us to monitor the statistics in a much more sophisticated manner. In fact, what is now being monitored is not just the quarterly statistics but the content of Case Conferences' discussions and the type and complexity of cases on the Register as well as how the reasons for registration vary from year to year. Any future study will have far more material already to hand and will not have to collect so much of the data manually.

The fact that the Custodian became a named professional with a particular brief to do the job, led to an increase, not only of inquiries to the Register although that happened, but of calls for advice or, often from other professionals, to discuss a case in theory before deciding whether to make a referral or not. As will be shown in a moment, the years since the data collection finished have been years of considerable concern and activity in the professional field of child abuse and of a constant stream of reports, documents, government advice or questionnaires and all these could be digested and dealt with far more satisfactorily because of the increased availability of the information contained on the Register.

The accompanying publication of the Guidelines specified very clearly the criteria for Registration and this factor, allied to my own delegated authority to refer matters back to the Chairperson of the Case Conference, has led to much greater clarity about the reasons for registering particular cases. There is now no case on Merton's Register where the reason for registration is not known or is not in one of the defined groups of Physical Abuse, Emotional Abuse, Neglect, Failure To Thrive or Sexual Abuse. There are still children who are considered at risk, rather than as actually having suffered abuse, and the risk may arise from their parents' drug problem or inadequacy but the type of abuse of which they are at risk must now be clearly spelt out. (A parent's drug problem does not necessarily put a child at risk, if that parent ensures that the child is well cared for and not exposed to dirty needles or the possibility of an accidental overdose.)

The regular monitoring also means that questions are asked if a case has not been reviewed for a long time and a future study would hopefully show that fewer cases had lingered on the Register for years without regular consideration about whether registration was still justified.

All the activity has made the Register more accessible and has perhaps helped to explode some of the mystique or any

lingering feeling that simply placing a name on the Register afforded protection to a child. The emphasis on monitoring has helped to focus on Registration as being a beginning of a process, not an end in itself and the constant emphasis on the work that needs to be done as a consequence has led to other developments, which will be dealt with in more detail shortly, such as the formulation of Child Protection Plans.

Above all, the information on the Register is now, hopefully, accurate and complete. Following the issue of the Guidelines, I devised a form (see Appendix E) which has to be filled in for each case registered and which, if it appears to be incorrectly or inadequately completed, is queried again and again until it is accurate.

The information which was gained in the study of the data on the Register has also proved useful in training sessions. Before the study started, very little training had been done locally or in a multi-disciplinary setting. Workers had attended courses run by outside agencies and one or two special sessions had been mounted for a particular group, such as the Chairpersons of Case Conferences. As will be seen shortly, the publication of the Guidelines led to an explosion of training sessions to ensure that they were put into practice clearly and consistently. That training could only be done by someone familiar with their contents and so all those sessions were locally organised and from that came an increasing demand to teach and train not just on the Guidelines but on the topic of child abuse generally. Previously such sessions might have tended to be based on other people's research or theory, but following the study of the Register, it was possible to link theory to local practice and to give it a new relevance.

b. <u>The Guidelines</u>

The chapters on the Guidelines described how they came, after many delays, to be written and produced, the negotiations which were involved in this and the considerations which influenced their content and format. The Guidelines arose from the situation and needs of the

time. No agreed multi-disciplinary procedures existed and the members of the then Borough Review Committee were conscious that the Department of Health and Social Security had charged them with producing some as far back as 1974 (DHSS 1974b,3). When they were first circulated in 1984 they were more detailed and comprehensive than any of the individual agencies' previous internal procedural guidance and, so it appeared from a comparison with other areas' handbooks, from that available elsewhere. Yet the second half of the Eighties saw such an avalanche of amplified instructions and advice from both Central Government and Inquiry reports (DHSS 1986a and b, DHSS 1988a,b,c,d and e, DoE 1988 and Home Office 1988) that the revised edition of the Guidelines which is being completed as this study is written up, has been completely rewritten and will be about twice the length of the original.

The main lesson to be learnt from the account of how they came to be written must be that the production of multi-disciplinary procedures is a time-consuming and difficult task. A tremendous amount of work is involved in getting the material together and casting it into a form that is acceptable to people with very different professional perspectives. Such work requires time to be spent in discussing, negotiating, drafting and redrafting. From the start it was determined that the Guidelines should be multi-disciplinary and this sometimes involved refusing to include material, which applied only to the internal workings of one agency, while making sure that matters such as Case Conferences, and what they were expected to achieve, were clear to people of all professions, whether they were frequently involved in them or not.

It was little wonder that the Guidelines had not previously been written. It would have been very difficult for professionals of the seniority of those involved in the Borough Review Committee to find the time to write them, particularly as most of them were too far removed from practice to be readily familiar with the practical difficulties and procedures involved.

The study of how the Guidelines eventually came to be written confirms both theories about action-research and the theories on teamwork to be found in Lonsdale, Webb and Briggs' work. They make it clear that teams need specific goals (Lonsdale, Webb and Briggs, 1980,153) and it will be remembered that it was when the task of writing the Guidelines was delegated to a small working party that they really began to get off the ground. Stevenson, in the same book, commented that "an interest expressed by one member seemed to lead to action" (Ibid, 19) and it seems, looking back on the writing of the Guidelines that it was largely the interest expressed through the Working Party and the work that I was personally able to put in which enabled the whole Review Committee to cooperate in seeing the project through. Inevitably there were problems and it still took a long time, but, despite the unexpected hitches in both production and distribution, the Guidelines were eventually produced and proved to be in such demand that not only had Southampton University sold out its 1,000 copies within a couple of years but Merton and Sutton had gone through more than twice the number of copies they had anticipated using and, five years later, have run out of a further photocopied run of another thousand copies. The research that went into the format clearly paid off. Locally, they have been known as "the Red Book" and the eye-catching design did just that - catch people's eyes and consequently their attention. They also appear to have been seen from the start as a multi-disciplinary production and not as belonging principally to Social Services. Other professions used them equally - and, on occasion, to tell Social Services what they were supposed to be doing!

Inevitably over the years, some gaps became apparent or some parts proved unpopular. For example, there were constant complaints from schools that no one had been charged with telling them when a child on the Register started a new school. The decision not to circulate full minutes to all Case Conference participants, although agreed in the full Review Committee by all the agencies, proved extremely unpopular with some professionals, particularly Health

Visitors, and when the time came to rewrite, they lobbied hard to get this changed.

The Guidelines provided, for the first time, agreed procedures to be followed by all the agencies in membership of the Review Committee. Previously multi-disciplinary cooperation had been largely dependent on the good will of individuals and on unwritten, and sometimes unspoken, understandings or expectations. Now it was much easier to be clear what the expectations were and to ensure that certain basic requirements were met. The results were both better informed workers from all professions and a clearer understanding of what management might expect to be common practice. It is believed this meant that practice in fact improved although a further study would be needed to measure that objectively.

The immediate effect of the publication of the Guidelines was, as has been said, an explosion of teaching and training sessions, both to internal Social Services groups and to multi-disciplinary groups, composed of all the agencies involved. Within Merton, in the weeks which followed the circulation of the copies, I conducted training sessions in each of the Area Offices, explaining what was new or different in the Guidelines, what the expectations were and how it was hoped they would work in practice. This not only helped to introduce the Guidelines to individual workers but also introduced me to people in the other areas and, when I took up the job of Custodian 6 months later, people were already prepared to accept me as someone involved with child abuse and committed to improving practice and were therefore quick to take advantage of my role as a consultant.

I was also asked to undertake training and teaching sessions in Sutton, which had joined Merton in issuing the Guidelines, had shared in the final stages of production and were committed, through their membership of the joint District Review Committee, to implementing them at the same time. Sutton did not appoint a specialist social worker as Custodian of their Register until two or more years after Merton and were still, at this time, running their Register

much as Merton had previously managed theirs. So it was agreed that I should help with their training sessions also, although on a freelance basis. In addition, there were other sessions for staff within Merton who were unable to attend the sessions in the area offices as well as sessions for health service personnel, childminders, etc. The Guidelines appeared to meet a need, but they also appeared to spark off further needs for discussion, teaching and consultation about what to do in individual instances. Nor were these training sessions one-off occasions. The constant turnover of staff in any London Borough means there is a continual need for a rolling programme of induction and training and by 1986 a quarterly programme of introductory days aimed at staff, newly qualified or new to the area, and catering for social workers, teachers, police, education welfare officers and other interested professionals was established. I was not personally responsible for all the teaching on these days, but even when there was only one session to teach there was still planning and preparation to fit in.

The basic training met one need, but there was also a continuing demand for more advanced training and, particularly during the last three years, for training about child sexual abuse both for field staff and their managers.

In the description of the contents of the Guidelines, it was said that, at the time of their original production, it seemed "progressive" not only to include sexual abuse as one of the forms of abuse, which should be considered a reason for Registration but also to amplify the definition further later in the booklet (Section 9.3 of the Guidelines). It will be remembered that, at this stage, the DHSS were still on record as considering sexual abuse should not be "included as a separate category" of abuse and that dealing with it under the child abuse procedures raised "complex issues" (DHSS, 1980,1). However, it was also pointed out in the last chapter that, revising the Guidelines, five years later, in the wake of the Cleveland Inquiry (DHSS, 1988a) it seemed incredible that we had offered so little advice on how to deal with sexual abuse. The DHSS had by then not

only recognised that it should be included as a category of abuse in its own right, but had also devoted a whole chapter of the latest guidance to discussing it (DHSS, 1988b, Chapter 6). Before the Cleveland affair had become front page news, before the Inquiry had been appointed and at about the time that the DHSS was feeling its way to more explicit guidance on the handling of sexual abuse, by issuing a draft guide (DHSS, 1986a) which stated that "Cases of sexual abuse should be brought into the system of inter-agency cooperation" (Ibid, 24), Merton and Sutton were becoming aware of a pressing need to produce their own local guidance. It was also clear that this could not wait for the full revision of the Guidelines which was already being mooted and, in 1987, a 12 page, photocopied document was issued headed "Guidelines for the Initial Management of Child Sexual Abuse in Merton and Sutton". Like the original Guidelines this was aimed at a multi-disciplinary audience and it was always envisaged that it would ultimately form part of the revised version of those Guidelines. While much of the impetus for the writing of the Sexual Abuse Guidelines came from two Child Psychiatrists based at Queen Mary's Hospital for Children, the manner in which they were produced and the format in which they were written was a logical extension of the production of the original.

Similarly the lessons learned in the writing of the original Guidelines proved of benefit when it came to the re-writing. This time, the District Review Committee (the joint Merton and Sutton committee) shortly to become, as decreed by the latest DHSS advice (DHSS,1988b,38), the Area Child Protection Committee - delegated the task to its Standing Sub-Committee, a group of 6 professionals from the two Boroughs' Social Service and Education departments and 2 representatives from the Community Health services - a senior Clinical Medical Officer and an Assistant Director of Nursing Services. This group, chaired by the Director of Social Services from Sutton, determined what the contents should be, thrashed out the policy issues and discussed the drafts as they were produced. The actual writing was largely, but not exclusively, done by myself and the final version appears likely to be twice the length of the

original. The lessons, which had been learned, were the value of a small working party, in touch with current practice and the avoidance of large committees arguing over details. The final draft was sent out to each agency for comment, but the consultation period was deliberately kept short, so that matters could not drift.

Other people had also clearly learned from the previous experience. Those with particular axes to grind, such as the Health Visitors mentioned above, got in early and lobbied hard. Others, in particular the Police, clearly felt confident that the result would be acceptable and made little comment, other than encouragement.

The delays, this time round, came from other directions. The actual re-writing was easier, because the original Guidelines formed a base from which to start. The delays came from the constantly promised, but long delayed, guidance from the DHSS, which clearly needed to be incorporated in any revision, but which was held up, so we were informed, by the need to await the outcome firstly of the inquiry reports into the deaths of Jasmine Beckford and Kimberley Carlile and then the inquiry into events in Cleveland. The guidance was eventually issued in July 1988.

c. Practice and Management

Many of the effects of the study and the developments which came out of it have already been referred to above. The Register was upgraded and made more secure as well as more accurate. The Guidelines hopefully improved practice and certainly led to an explosion of demands for training, advice and consultation and ultimately to an expanded edition. The Guidelines seemed to focus attention on the local situation and the training sessions which followed also brought the different professionals into closer contact and encouraged joint consideration of wider issues than might be raised in the individual cases over which they usually met. During these training sessions, it became apparent that people appreciated clearly formulated policies and procedures which gave a clear, firm base from which to

work. The Guidelines had been very largely geared towards the assessment of abuse. This had appeared to be the need at the time: to help people to investigate alleged incidents and work together to deal with this. However, the assessment was only the beginning of the story in most cases and from there there needed to be consideration of the principles involved in on-going work - for example, the involvement of parents in Case Conferences or the need to make plans to protect children from further harm. These, and other issues, needed to be tackled and led to the production of written material, such as model Case Conference agendas, a format for Child Protection Plans and advice for those preparing to attend Case Conferences. While it may seem that there could be a danger that the proliferation of material and its commendation by management might tie professionals too tightly to procedures and undermine professional discretion, the aim continued to be to give a framework from which professional practice could develop and improve.

Management at a higher level also changed. Meetings of the District Review Committee were always held regularly each quarter after 1983 and, although this was partly a result of external events, there never again seemed to be an uncertainty about its role or a lack of topics to discuss. The Review Committee wrote itself a constitution and also delegated much work to sub-committees - by 1987 there were three: the Standing Sub-Committee which considered questions of policy, prepared papers for discussion at full meetings of the Committee in response to the most recent inquiry report or DHSS memorandum, as well as reviewing actual cases and being prepared to mount an immediate case review in the event of a local tragedy, the Training Sub-Committee, charged with co-ordinating multi-disciplinary training and the Sexual Abuse Working Party, whose brief was self-evident from its title. Obviously, this did not all result solely from the current study and, as has already been mentioned and will be detailed further in a moment, there were many external events which concentrated attention on the management of child abuse and the response that Review Committees should make. Nevertheless, it seems

reasonable to suggest that the writing of the Guidelines had helped to prepare the way by showing that multi-disciplinary co-operation could produce results and that such results could be well achieved through smaller working groups.

4. Other Events which influenced developments

Reference has already been made to the many inquiry reports and government circulars and guides which appeared in the years following the collection of the Register data and the publication of the Guidelines and during the time in which the study was supposed to be being written. What seemed in the early Eighties to be a period of recovery after the storm, turned out to be only a lull before an even bigger one.

The Inquiry reports of the Eighties turned out to be much longer and more wide-ranging than those of the Seventies. The Maria Colwell report had a bare 120 pages and concerned itself mainly with the events in East Sussex (DHSS 1974a). The Jasmine Beckford report had 305 pages with 140 pages of appendices (Brent 1985), the Kimberley Carlile report 292 (Greenwich 1987) and the Cleveland Inquiry 320 (DHSS 1988a). In addition all made recommendations which were intended to be relevant to other authorities than the ones where the events had taken place. All received widespread attention and, in Merton, were the subject of much discussion as well as reports to be prepared for the Review Committee on their significance for the local situation. While such reports were submitted to the Review Committee through the Standing Sub-Committee, inevitably much, though not all, of the responsibility for producing Merton's share of them (as well as drafting comments for the Borough's Councillors) fell on myself.

There were other reports to be considered and evaluated - the Metropolitan Police produced "The Force Response to Child Abuse" early in 1988 (referred to by one local Inspector as "Our New Bible") and were busy seeking co-operation in the establishment of their local Child

Protection Teams, which were to handle the police investigation of any alleged abuse.

The Inquiry reports had, as was said earlier, generated a great deal of media attention, much of it hostile to professionals working in the field of child abuse. Events in Cleveland, in particular, aroused unprecedented criticism and incredulity that abuse could conceivably happen on that scale. There was a widespread belief that many of the diagnoses made by the Cleveland doctors must be wrong. However, set against this was another trend, which had arisen partly from the publicity given to cases of child abuse by Esther Rantzen's television programmes and the founding, in October 1986, of Child Line, a free and confidential telephone service for children who wished to talk about the abuse they were suffering. Child Line received (and still continues to receive) a flood of calls and, while the refusal of the majority of the children to identify themselves has meant the expected deluge of referrals to local Social Services departments never materialised, it did have a powerful effect convincing many people in daily contact with children, that abuse was more widespread than had been previously realised and led to an increase in referrals from other sources.

These contradictory trends were echoed within Social Services by the differing attitudes one encountered during these years. While most social workers, faced with the criticism of yet another of their number in the press or latest inquiry report, tend to echo Olive Stevenson's comment in the Maria Colwell report "There but for the Grace of God went I" (DHSS, 1974a,8), some, in my observation, are so determined not to be panicked by the latest report, that they become more ready to take risks. "Just because Jasmine Beckford died, it does not mean every child is at risk" a social worker said to me the week after that report was published. No one would suggest it did, but neither is it an excuse not to investigate each allegation as thoroughly as one can.

As early as 1983, when Geach and Szwed's book "Providing Civil Justice for Children" (Geach and Szwed, 1983) was published, there were signs that families, and particularly parents, were not prepared to let the professionals manage the problem of child abuse in their own way without criticism and during the Eighties, the work of the Family Rights Group and of the pressure group PAIN (Parents Against Injustice) has ensured that those concerned with the management of child abuse should be reminded of all the issues involved in placing children's names on Registers and have undoubtedly had an effect in making some authorities more circumspect. In Merton itself, two parents, leading members of PAIN, started proceedings for a judicial review of a Case Conference decision to keep their child's name on the Register and sparked off a heated debate about the ownership of Case Conference decisions, which resulted in an appeals procedure being devised for inclusion in the revised Guidelines.

The growing emphasis on the rights of parents came largely from outside but, in the way of many of these developments, coincided with ideas which had been tentatively flagged in the Guidelines. Just as the "progressiveness" of discussing sexual abuse in the Guidelines, however inadequately, prepared the ground for developing procedures to deal with the handling of sexual abuse allegations in advance of government directives to do so, so the original Guidelines, going in advance of what was common practice in Merton at that stage, suggested "Consideration may be given to inviting the parents and/or the child to attend the case conference, or part of it, subject to the agreement of the participants" (Section, 5.1.11).

The implementation of the 1980 Children Act led to Guardians ad litem being appointed in almost every case of Care Proceedings in the Juvenile Court, with a consequent increase in the length and complexity of such cases. Legal issues generally have become of much more importance in the management of child abuse. Blom-Cooper drew attention (in the Kimberley Carlile report) to the lack of legal authority for a local authority to consent to a medical examination

for a child on a Place of Safety Order (Greenwich 1987,144) causing much concern and highlighting the need for scrupulous observation of legal technicalities. At the time of writing, the progress of the Children Bill through Parliament is both a source of interest and a reminder of the need to plan future training courses in preparation for its implementation.

The effect of all these other events was not only to increase one's workload and to delay the completion of the study, but to heighten awareness of the issues which had arisen in the study and to draw attention to the need to revise, adapt and adjust procedures to meet changing needs, as well as taking account of yet further needs for training. In this connection, the legacy of some of the outside influences and events was particularly marked. Unlike the Seventies, when the emphasis had been on the physical abuse of children and the "battered baby syndrome", in the Eighties, the focus increasingly changed to the sexual abuse of children and this required both different procedures and different training techniques to help professionals to deal with an emotive, and hitherto largely taboo, area.

5. Evaluation of the Study

When considering whether the study achieved its aims, it is comparatively easy to conclude that the primary aims of examining the Register and the development of the Guidelines were achieved in that the data was collected and the writing of the Guidelines was observed and described. To decide whether the lessons were learned and have been applied, whether practice has been improved, whether awareness has been increased and resources are better planned is not so easy.

In the years immediately after the collection of the Register data was finished and the Guidelines were issued, the numbers on Merton's Register fell. In 1984, there were only 44 families on the Register, the lowest number since 1973. Looking at the cases which were deregistered that year, it is clear that there was a tightening up of criteria

and a closer scrutiny of the need to keep families on the Register. Among the deregistrations which contributed to the fall (from 58 families in 1983) were several, where children had been removed from home some years previously and who had remained on the Register for no obvious reason. The numbers subsequently rose again, as one would expect, as the inquiry reports heightened awareness of the problems and in March 1989 the number of families on the Register stood at 77, higher even than in 1975. Because of the lessons learned from the Register study, it was possible to watch the rise and to chart its progress, being reasonably confident that the tide would eventually turn and there are now, in June 1989, some signs that it has done so, with a drop becoming apparent. It seems likely, however, that the rise in the number of registered sexual abuse cases (now forming 15% of the total) is having much the effect that the stress on physical abuse had in the Seventies and it may well be that the numbers on the Register will never fall quite so low again.

There is an impression, shared by those who regularly attend Case Conferences, that the cases dealt with are becoming more complex. This may be because of the external factors, such as the impetus given to more thorough assessment by the knowledge that work may be scrutinised (and perhaps criticised) by a Guardian ad litem and more thorough assessment frequently leads to cases appearing more complex than a briefer investigation had revealed. It may too be the result of the greater number of cases of sexual abuse coming to light, since some of these are of exceptional complexity. It may be that the study of the Register opened more eyes to the fact that middle class families may also be involved in abuse and that more of these cases are being registered. (While a more detailed study would be needed to validate the hypothesis, the impression gained from the constant study of Case Conference minutes and attendance at Case Conferences is that, in middle class families, abuse often does not come to light so soon as in working class families and the situation has, as a result, become more complicated). It may be a combination of all these factors but it may also be that the Guidelines did achieve their aim

of increasing awareness and improving practice and that we are seeing the results of that.

Some of the findings of the study of the Register have undoubtedly not yet been used to the full. For example, the realisation that marital problems were the most commonly cited problem for parents has not been used either to divert resources into marital counselling or to mount training sessions in working with marital stress.

Whether the study helped to reduce anxiety and provide a frame of reference for professionals is also difficult to evaluate, since there were so many other events which served to increase anxiety. Some professionals made full and frequent use of the opportunities to consult and ask for advice - others did not. The Guidelines certainly provided a common frame of reference for all professions and, as such, probably contributed to improved multi-disciplinary working. Certainly, it became harder for anyone to plead ignorance of what was expected of them or what was the extent of the problems facing them. That must help to improve practice.

6. The Way Forward

a. The Application of the Knowledge Gained

It is possible, following studies of this type, to use the knowledge gained to point to mistakes that have been made in th past and to tighten up systems and procedures so that the same mistakes are not made again. Obviously that is important and necessary, but it is hoped that the findings of this study can be used not just to audit past and current practice, but to look at ways future practice might develop. Thus it seems to me to be important to ensure that the Register becomes the best possible tool in the management of the problem of child abuse and to note the large numbers of young children who appear to be at risk and to consider what services are needed to reduce that risk. But it is also important to consider whether the smaller numbers of older children registered means that older children are genuinely at less risk or whether that risk is less likely to be

noticed and it is consequently necessary to consider trying to raise awareness of possible abuse among professionals who come in contact with older children. Increasing awareness may well lead to a larger number of referrals (as has certainly happened with cases of child sexual abuse). Nevertheless, it seems to me that, if one accepts that the Register is largely a record of professional concern, the absence of such concern about older children does not necessarily mean they are not being abused.

There is a need therefore for the findings of the study to be applied to the planning of services and resources and for such planning to include consideration of what the study did not reveal as well as what it did. It may be too that some of the results will need to be considered in relation to the policies of other departments such as Housing. For example, why were there so many families on the Estates? Is there a danger that abusive families may be placed together or do certain areas give their inhabitants a bad reputation? Such questions need more research before they can be answered and that will be dealt with in a moment.

b. Preventive Work

The original brief to the Working Party, it may be remembered, contained a charge to consider how preventive work might be carried out (BRC, March 1981). That was the one part of the brief that was completely forgotten and never dealt with, unless one can consider the writing of the Guidelines to have been preventive.

The findings of the study certainly reveal areas in which preventive work might help to save future children from abuse. Preparation for parenthood is often mentioned in this connection and certainly the number of young children and only children who were considered at risk (or who were actually abused) suggests that some parents are ill-prepared for the demands that young children make. However, the findings about the number of parents who were reporting marital problems leads one to feel that Preparation for Marriage courses may be equally helpful in protecting children. The numbers of parents with psychiatric problems

also suggests that work may need to be done in anticipating the risk caused to children by what may at first appear to be just a health problem for their parents.

c. Future Research

This study has presented certain findings, in relation to the management of Child Abuse in Merton, between 1970 and 1983, with some reference to what has happened since. While the study has described what happened and analysed the data which was found on the Register, further research would be needed to determine how typical the findings are and whether they are still true of the situation in Merton, as well as determining how typical they are of other areas, either with a similar population structure or with more obvious problems of deprivation.

Future research should look at whether the situation has changed as a result of the writing of the Guidelines and the tightening up of Registration procedures. It has been shown that there are certainly some differences - for example, there are no longer any cases on the Register where no reason for Registration has been identified. Only further research could show, by a detailed study of the cases concerned, whether the difference is largely semantic or whether the insistence on identifying a form of abuse has actually meant that the situation has bee more thoroughly assessed and the decision to register is therefore a considered and reasoned one, rather than an expression of generalised anxiety.

If such research showed that the situation had changed and improved, it would also be important to look at the numbers on the Register in the years following this study's data collection and, to study their fluctuations in some detail, considering not only how the numbers varied but how the different types of abuse changed. No direct comparison with the present finding would be possible if the tightening up of the criteria has really worked, since there should no longer be a group, for example, which could be designated Professional Anxiety. Nevertheless, it would be possible to compare the finding in relation to the seriousness of the

concern. (Following the publication of the Guidelines, the old Categories I and II were amalgamated and since 1984, there have been only two categories but they correspond to the division that has been observed throughout the study and it could prove instructive to study the referral pattern of these categories.)

Future research should also look at the professional referral patterns to see whether they changed or whether the bulk of referrals - and particularly of the less serious referrals - continued to come from the medical profession or from Social Services. It has been suggested several times during this study, that a future study might show a different pattern of police referrals. It would be important to look both at the number and type of such referrals as well as seeing whether Education, with the appointment of designated teachers in each school to act as liaison staff for child abuse referrals (as directed by the Department of Education in 1988 (DoE, 1988,1)) has referred more children where there is concern as opposed to actual observed abuse.

Future research could also help to throw light on the geographical variations that were noticed in this study. These variations were both in the areas covered by the three District offices and within the types of council tenancies. Any study of the latter would need to look in detail at housing policies as well as at changing demographic trends.

It would be interesting too to look again at the time families spend on the Register and to see both whether the average time spent has changed and whether the reasons for Deregistration have changed. The Guidelines laid down that, only in exceptional cases, should a child be deregistered in less than a year, so in theory one might expect the average time spent on the Register to have increased. However, one would hope that the increased attention that has been paid to regular monitoring would have lessened the amount of drift on the Register and consequently decreased the average time.

Any future study would have the great advantage of having national statistics against which to measure the situation in Merton, since the Department of Health have indicated that the national survey is to be an annual one (DoH,1989.4). However, this would necessitate a slight change in the way the data on Merton's register was collected, by comparison with this study, since the Dept. of Health has elected to collect the number of children, as opposed to families, who are registered.

It would be very useful if any future study which was mounted had both the time and the facility to look at case work files (both Social Services'and other agencies') to examine the process of referral and the reasons for registration in greater depth. A study of files could almost certainly illuminate many of the unanswered questions from this study, particularly about those cases where there was no reason given for the registration or deregistration or where the category in which the case was registered seemed at odds with the criteria. It would be particularly interesting to look for indications of parental attitude and whether a parental admission (of having already abused a child or of fear of abusing a child) made it more or less likely that the case was registered in a serious category than happened when a parent categorically denied the professionals' suspicions.

Any future study would certainly, in view of the increasing numbers of cases of sexual abuse which are being registered, want to look at these cases in particular detail to see what lessons could be learned and whether any trends emerged which could be of assistance to those trying to help such families.

A more detailed study could helpfully compare those cases which are registered with those which are not, as well as looking at cases which are investigated but which never get as far as a Case Conference, so that registration is not considered. Dingwall, Eekelaar and Murray wrote of the Rule of Optimism which they found operating in the assessment of allegations of abuse (Dingwall, Eekelaar and Murray, 1983,

Chapter 4) and which they describe as giving the benefit of the doubt to parents in preference to labelling injuries non-accidental. This study has shown how the number on the Register fluctuated, apparently in relation to outside events which influenced the level of anxiety among professionals. If one compared the number of referrals, the number of registrations and the number of decisions not to register over a period of some years, it might be possible to ascertain whether the Rule of Optimism is more likely to operate in times when concern about child abuse is less acute. Such research would also, as was suggested in Chapter III, help to show whether the apparent variations in numbers on the Register in the different Areas was influenced by variations of professional approach.

Ideally a study needs to be devised which can compare the numbers of children who are registered with the numbers who actually suffer abuse, but this would be extremely difficult to do, both because of the difficulties of definition but even more because of the difficulty of arriving at any estimation of how many children are abused without the professionals knowing about it. With regard to sexual abuse, retrospective research asking adults to report, generally anonymously, on their own early experiences has produced results suggesting as many as 35% of girls and 30% of boys may have had a sexually abusive experience (Finkelhor, 1986,20 which also gives details of studies reporting lower prevalence rates.) To my knowledge, no study has tried asking for reports of other types of abusive experience and it might be worth doing so, provided the problems of definition were recognised and dealt with. Such research, however incomplete or emotive, might give some yardstick of comparison from which to try to evaluate actual rates of abuse in the community as a whole. Until one can discover how much abuse actually exists, one has no method of telling how nearly Registers reflect the true incidence of abuse.

Finally, it was pointed out earlier that the original edition of the Guidelines concentrated on the assessment of allegations of child abuse and that in the years after they

were issued, it became clear that there was a need to move on and to deal with the work which has to be done if the process of registration is going to truly protect the child. The revised edition of the Guidelines is having to take cognizance of this and a future study too might devise a way of looking at the work that is done during the time that a child's name remains on the Child Protection Register, and in what ways that work affects the time spent on the Register.

7. Postscript - A Summary of the Lessons Learned

The study both of the Register and of the writing of the Guidelines share one important moral. In the management of problems such as child abuse, nothing is static. Situations fluctuate and change and the responses needed change too. There is a lot of energy there which can be harnessed and focussed to meet the needs, but not only do the needs change, but the very meeting of the needs may reveal further needs. The Guidelines, in particular, arose from the needs of the time, but are, in themselves, no longer topical. Fresh Guidelines are needed and the relevance of the previous ones lies in the lessons that can be learned about how to produce them. One is reminded of T.S. Eliot's description of writing poetry:

> Trying to learn to use words, and every attempt
> Is a wholly new start, and a different kind of failure
> Because one has only learned to get the better of words
> For the thing one no longer has to say, or the way in which
> One is no longer disposed to say it.....
> There is only the fight to recover what has been lost
> And found and lost again and again: and now, under conditions
> That seem unpropitious. But perhaps neither gain nor loss.
> For us, there is only the trying. The rest is not our business.
>
> (T.S. Eliot, Four Quartets, East Coker, V,lines 3-7, 15-18)

APPENDIX A Questionnaire used for Register Data

1. Code number	
2. Date of original referral to Social Services	
3. Date of Registration	
4. Category of Registration	
5. Reason for Registration	
6. Date of Deregistration	
7. Reason for Deregistration	
8. Sex/Age of child first registered	
9. Number of children in the family	
10. Number of children on the Register	
11. Sex of children in the family	
12. Sex of children on the Register	
13. Sex of children born during registration	
14. Sex/age of children added to Register	
15. Referred by	
16. Parents' marital status	
17. Mother's age	
18. Father's age	
19. Housing tenure	
20. Parental problem	
21. Key child ?	
22. Court proceedings	
23. Removal from home	
24. Abuser	
25. Number of Case Conferences	
26. Number of Paper Reviews	

APPENDIX B Merton Procedure Orders

(Note: These are reproductions of copies which were themselves often of poor quality.)

1. Earliest extant procedure order - issued Nov.1974

PROCEDURAL ORDER NO. 25
(Revised Nov.74)

LONDON BOROUGH OF MERTON

SOCIAL SERVICES DEPARTMENT

CHILD ABUSE IN ACCIDENTAL INJURY

1. (1) This paper is intended to set out for the guidance of social workers and information of those concerned with non-accidental injury to children, the action which should be taken when they become aware of a child who is exposed to the risk of abuse or in fact, abused.

1. (2) Families at risk can be divided into four categories :-

(a) Where there is certainty that non-accidental injury has occurred.

(b) Where there is near certainty that non-accidental injury has occurred.

(c) Where injury has occurred and there is reason to suspect that it may be non-accidental.

(d) Where there is no evidence of injury but certain of the factors associated with the "battered baby syndrome" have been clearly identified.

FIRST STEPS

2. (1) It is essential that whenever a social worker becomes aware of a child at risk in any of the foregoing categories the basic facts be recorded in detail. (see P.O.No.1)

2. (2) The record should include, if possible, the maiden name of the mother, the name of the doctor and health visitor concerned, name of the person reporting the facts; whenever possible the telephone numbers of such persons should be included. The Department's indices should be checked for relevant information concerning the family.

2. (3) The facts must be discussed with a senior officer forthwith and must be communicated (and confirmed in writing on Form SS.2), to the Deputy Director, the Principal Physician Child Health, the G.P., the Council's Solicitor, the NSPCC, the Education Department, Welfare/Special Services Section, and any other agencies known to be involved. The procedure outlined must be implemented promptly and instructions given to the named worker responsible for the action to be taken.

2. (4) No steps should be taken by the social worker alone to obtain hospital admission except in cases of extreme urgency. Where there is reasonable suspicion of non-accidental injury, action should be taken to safeguard a child against further injury and to ensure that a differential diagnosis is made and any treatment needed given without delay. This may be by :-

(a) Admitting the child to hospital.
Paediatricians prefer that the child be admitted directly to the Ward for "social reasons" and this obviates parents waiting in casualty department and perhaps being assessed by inexperienced junior hospital doctors. This may be done by the family Doctor, the Principal Physician in Child Health, or if neither available, the Social Worker may contact the Paediatrician or Deputy, directly.

(b) removing the child to a place of safety under an order of the Justices; this may, in certain circumstances, be a hospital.

(c) arranging examination by the family doctor or principal physician in child health, who may then decide to refer to a hospital.

2. (5) Details of the circumstances concerning the child should be entered on the "At risk" register (kept by the Deputy Director) from information supplied by the Area Co-ordinator on form SS.2.

2. (6) In cases where professional workers suspect that non-accidental injury has occurred but do not feel that the evidence in their possession is sufficient to enable them to initiate admission to hospital, they should, in addition to consulting the family doctor, discuss the case with at least one colleague, either a senior colleague in the same department, or a colleague in an allied profession who is working in the same area. This discussion should take place on the same day that suspicion is aroused, or at latest, the next day. It should cover all aspects of the case, and particularly whether or not admission to hospital is required and if an immediate case conference should be called.

2. (7) It would be important to seek information from the pupils' Headteacher/nursery school, the Education Department Welfare Special Services Sections, the appropriate Child Guidance Clinic, the general practitioner/health visitor, and the N.S.P.C.C. inspector. Because the evidence may be inconclusive it should be made clear to those persons approached that the enquiry is of a confidential nature and that (unless specifically agreed that action should be taken as a result of the enquiry) direct intervention is not proposed. The possibility of a case conference should be mentioned.

Clearly, those consulted will need to be given a feed back and a Form SS2 is well suited to the purpose when a case conference seems inappropriate.

The Sutton Social Services Department have divided responsibility for convening case conferences between the Area Managers and the hospital Principal Social Worker. Because the arrangements in Merton are based firmly on the Area Manager, the hospital Principal Social Workers in St. Helier or Queen Mary's, Carshalton, may act independently, and there is a risk of conferences being convened in regard to children living in Morton, by the hospital.

In such circumstances it is important that the senior representative of Merton Social Services Department attending the conference ensures that notes are kept of the proceedings, and a report prepared.

The responsibility for action being taken lies with the Social Services Department, with particular attention to paragraphs 3(2) and 3(3).

If a child has been included on the "at risk" register the case should be treated as potentially one of non-accidental injury, until by agreement of a case conference properly recorded the decision is made for the child's name to be removed. The decision to remove the child must be made known to all the agencies concerned.

2. (8) In cases where admission to hospital has been arranged, steps should be taken to preserve the link between the parent and child and this may require the overnight stay of the parent at hospital, or involve prolonged daily visits. Every effort should be made to establish a professional relationship with the parents and to secure their understanding and co-operation. It is considered to be equally important, however, that they should be made aware of the legal situation and the possible implications of non-accidental injury to their child.

CASE CONFERENCES

3. (1) In all cases falling within categories (a) (b) (c) and (d) of paragraph 1. (2), a case conference should be arranged and in the majority of instances it would be highly undesirable that a case conference should be delayed because full membership cannot be convened.

The administrative responsibility for convening a conference and producing its report lies with the area social services manager and all who are potentially involved or who have information relevant to the conduct of the case should be invited to attend as a matter of absolute priority.

3. (2) The case conference needs to consider in particular :-

(a) whether the child needs to be admitted to hospital or removed to a place of safety.

(b) whether court proceedings should be recommended.

(c) whether information should be laid before the police.

(d) the identification of those supportive services which are thought to be necessary to safeguard the welfare of the child if parental care in the home is to continue.
The conference must be satisfied that such services are available and not merely desirable.

The report of the case conference should include an account of its deliberation on all the foregoing and other relevant factors, and the decisions taken regarding the next action and future conduct of the case. It should nominate a key worker for initiating the next action.

Copies of the report must be circulated to all members of the case conference and to the Director of Social Services.

3. (3) The conference must decide when its next meeting shall be called and in any event, a meeting should follow in three months with regular reviews thereafter at intervals not exceeding six months.

The Area Social Services manager will be responsible for convening these meetings.

4. (1) CO-OPERATION WITH THE POLICE

If the police are to be involved in an alleged offence they are greatly assisted if they are informed about this as soon as possible. When the decision of the police to begin inquiries is known it should be communicated to the Chairman of the case conference and to the key worker immediately; it is desirable this should happen before any such inquiries are undertaken.

ADDITIONAL NOTES OF GUIDANCE

There is now considerable literature on the subject and the appendix to this paper suggests worthwhile reading. The signs of any non-accidental injury are listed as a framework around which to describe the practical procedures to be followed and not intended to be taken as a complete account of the "battered baby syndrome".

The response of the public in general to "baby battering" tends to be of horror and condemnation, looking for action in terms of punishment rather than compassion. Social workers must bear in mind the need to educate the public in seeing the needs of parents in terms of help for those suffering from sickness of the mind.

It is vital that all concerned with infants and young children should be alert for the first signs of non-accidental injury. Older children are not immune.

The first signs which may be very slight are, in effect, major warnings. Typical examples are :-

(a) Minor injuries such as facial bruises, damage in the mouth region, or small burns.

(b) Bruising which could indicate that the child had been gripped tightly and possibly shaken, or

(c) an unexplained failure to thrive.

Other signs may be given by the abnormal patterns of parents' behaviour, including repeated demands for medical attention from the General Practitioners and Casualty Departments, delays in seeking advice, a plausible explanation of an injury which does not quite fit the case.

Once suspicion is aroused the behaviour of the parents is always a factor to consider and where possible, attention should be paid to the condition of any other children and to the general situation in the home. Older children and relatives sometimes support dubious statements made by parents or guardians, or may themselves invent false explanations.

W. HUTCHINSON

DIRECTOR OF SOCIAL SERVICES

RG/JMG
20th November, 1974

2. July 1976 revision

PROCEDURAL ORDER NO. 25
(Revised July 1976)

LONDON BOROUGH OF MERTON

SOCIAL SERVICES DEPARTMENT

CHILD ABUSE IN NON-ACCIDENTAL INJURY

1.(1) This paper is intended to set out for the guidance of social worker's and information of those concerned with non-accidental injury to children, the action which should be taken when they become aware of a child who is exposed to the risk of abuse or, in fact, abused.

The Department of Health & Social Security's guidance is that :-

"The safety of the child must in all circumstances be of paramount importance and must override all other considerations. It is nonetheless undeniable that there will be occasions when the need to protect a child will conflict with the wish to preserve a relationship of trust with another party, and that the problems posed by confidentiality admit of no easy solution although it is important to work towards solving them. Any decision about the release of information is normally one for professional judgment but the factors which ought to be taken into account in reaching such a decision are the "need to know" and the consequent restriction of information to those directly concerned with the family and who have the duty legitimately to perform a service on its behalf; and the importance of taking action in a child's best interests in the light of all relevant facts. It would be helpful if the passing of information between the caring professions were regarded and treated as analogous to that passed in confidence within a single discipline. Whenever possible however an adult's agreement should be sought to the sharing of information about him with professionals from a different discipline".

1.(2) Families at risk can be divided into three categories :-

(1) Where there is certainty or near certainty that non-accidental injury has occurred.

(2) Where injury has occurred and there is reason to suspect that it may be non-accidental.

(3) Where there is no evidence of injury but certain of the circumstances in which non-accidental injury is likely to occur have been identified or are suspected.

FIRST STEPS

2.(1) It is essential that whenever a report is made to the Department of a child at risk in any of the foregoing categories the basic facts be recorded in detail. Accurate and detailed information is clearly crucial in dealing with this problem, with reports dated and signed.

2.(2) The record should include, if possible, the maiden name of the mother, the name of the doctor and health visitor concerned, name of the person reporting the facts; whenever possible the telephone numbers of such persons should be included.

The Department's indices should be checked for relevant information concerning the family.

2.(3) The facts must be discussed with a senior officer forthwith and must be communicated (and confirmed in writing on Form SS.2) to the Deputy Director, the Principal Physician Child Health, the G.P., the Council's Solicitor, the NSPCC, the Education Department Welfare/Special Services Section, and any other agency with a professional interest known to be involved. The procedure outlined must be implemented promptly and instructions given to the named worker responsible for the action to be taken.

2.(4) No steps should be taken by the social worker alone to obtain a place of safety order or hospital admission except in cases of extreme urgency. Where there is reasonable suspicion of non-accidental injury, action should be taken to safeguard a child against further injury and to ensure that a differential diagnosis is made and any treatment needed given without delay. This may be by :-

(a) Admitting the child in <u>category 1 & 2</u> to hospital. Paediatricians ask that whenever a child's admission to hospital is contemplated the paediatrician should be asked to provide a bed. It is highly prejudicial to a satisfactory outcome for the case in hospital to be handled by anyone without the skills and insights of the paediatrician. The admission may be initiated by the family Doctor, the Principal Physician in Child Health, or if neither available, the social worker may contact the Paediatrician or Deputy, directly.

(b) Removing the child to a place of safety under an order of the Justices; this may, in certain circumstances, be a hospital.

(c) Arranging examination by the family doctor. If the general practitioner is not immediately available or if the client was other than at home, then the Community Health Department should be approached.

2.(5) Details of the circumstances concerning the child should be entered on the "At Risk" register.

<u>It is of the utmost importance to safeguard the confidentiality of the register. For this reason the register will be kept in conditions of the strictest security and maintained by the Deputy Director the designated officer of the London borough of Merton, who will receive referrals from information supplied by</u>

NOTE: Last line missing.

2.(6) In cases where professional workers suspect that non-accidental injury has occurred (category 2) but do not feel that the evidence in their possession is sufficient to enable them to initiate admission to hospital, they should, in addition to consulting the family doctor, discuss the case with at least one colleague, either a senior colleague in the same Department, or a colleague in an allied profession who is working in the same area. This discussion should take place on the same day that suspicion is aroused, or at latest, the next day. It should cover all aspects of the case, and particularly whether or not admission to hospital is required and if an immediate case conference should be called.

2.(7) It is important to seek information from the pupil's school, Education Department Welfare Special Services Section, the appropriate Child Guidance Clinic, general practitioner/health visitor, and the N.S.P.C.C. Inspector. Because the evidence may be inconclusive it should be made clear to those persons approached that the enquiry is of a confidential nature and that (unless specifically agreed that action should be taken as a result of the enquiry) direct intervention is not proposed.

2.(8) In cases where admission to hospital has been arranged, steps should be taken to preserve the link between the parent and child and this may require the overnight stay of the parent at hospital, or involve prolonged daily visits. Every effort should be made to establish a professional relationship with the parents and to secure their understanding and co-operation. It is considered to be equally important, however, that they should be made aware of the legal situation and the possible implications of non-accidental injury to their child.

CASE CONFERENCES

3.(1) In all cases falling within categories 1, 2 or 3 of paragraph 1(2), a case conference should be arranged as soon as possible after the child at risk has been identified. It is highly undesirable that a case conference should be delayed because full membership cannot be convened.

The administrative responsibility for convening a conference and producing its report lies with the Area Co-ordinator and all professionally who are involved should be invited to attend as a matter of absolute priority.

3.(2) The case conference needs to consider in particular:-

(a) whether the child needs to be admitted to hospital or removed to a place of safety.

(b) whether court proceedings should be recommended.

(c) whether information should be laid before the police.

Note: Reproduction faults on original.

(d) the identification of those supportive services which are thought to be necessary to safeguard the welfare of the child if parental care in the home is to continue.

The conference must be satisfied that such services are available and not merely desirable.

The report of the case conference should include an account of its deliberation on all the foregoing and other relevant factors, and the decisions taken regarding the next action and future conduct of the case. Copies of the report must be circulated to all Agencies concerned and to the Deputy Director of Social Services. It should nominate a key worker to have primary responsibility and who will be preferably the professional most closely concerned with the case.

The key worker is the focal point through whom all information is channelled and is primarily responsible for ensuring that it reaches all appropriate agencies.

3.(3) The conference must decide when its next meeting shall be called and in any event, a review should follow in three months and thereafter at intervals not exceeding six months.

Where circumstances have not changed, the nominated key worker could circulate by SS.2 and only convene a meeting if a member of the conference had a reason to press for action.

It is acknowledged that the decision of a case conference cannot be binding on the representatives of bodies with statutory powers and duties in relation to children and that when a consensus view cannot be reached, any participant may after consultation with senior officers find himself constrained to take action contrary to that recommended by other members of a case conference. Where this occurs the members must be notified of the proposed action and the reasons for it.

The Area Co-ordinator will be responsible for convening these meetings.

3.(4) The Sutton Social Services Department have divided responsibility for convening case conferences between the Area Managers and the hospital Principal Social Worke... Because the arrangements in Merton are based firmly on the Area Co-ordinator, the independent action by the hospital Principal Social Workers, e.g. in St. Helier ... Queen Mary's Carshalton, may result in the convening ... a case conference in respect of children living in ... by the hospital. In such circumstances it is impo... that a senior representative of Merton Social Serv... Department attends the conference to ensure that ... are kept of the proceedings, and a report prepar... ... to the guidance in paragraph 3.(2).

The responsibility for defining the action to ... with the Social Services Department, with partic... attention to paragraphs 3(2) and 3(3).

If a child has been included on the "At Risk" register the case should remain on the register (with the category of injury stated) until, by agreement of a case conference properly recorded, the decision is made for the child's name to be removed. To reduce the demands on professionals' time it may be sufficient for a SS.2 to be circulated giving reasons for the proposed removal of the case from the register, or re-classification of the case or change of key worker, or the agreed plan - and inviting comments.

4.(1) CO-OPERATION WITH THE POLICE

If the police are to be involved in an alleged offence they are greatly assisted if they are informed about this as soon as possible. When the decision of the police to begin inquiries is known it should be communicated to the Chairman of the case conference and to the key worker immediately; it is desirable this should happen before any such inquiries are undertaken.

SIMON RODWAY

DIRECTOR OF SOCIAL SERVICES

:G/J:G
23rd July 1976

3. July 1978 revision

(Note: Reproduction faults on original.)

PROCEDURAL ORDER NO 25

(Revised July 1978)

LONDON BOROUGH OF MERTON

SOCIAL SERVICES DEPARTMENT

CHILD ABUSE IN NON-ACCIDENTAL INJURY

1. (1) This paper is intended to set out for the guidance of social workers and information of those concerned with non-accidental injury to children, the action which should be taken when they become aware of a child who is exposed to the risk of abuse or, in fact, abused.

The Department of Health & Social Security's guidance is that :-

"The safety of the child must in all circumstances be of paramount importance and must override all other considerations. It is monetheless undeniable that there will be occasions when the need to protect a child will conflict with the wish to preserve a relationship of trust with another party, and that the problems posed by confidentiality admit of no easy solution although it is important to work towards solving them. Any decision about the release of information is normally one for professional judgment but the factors which ought to be taken into account in reaching such a decision are the "need to know" and the consequent restriction of information to those directly concerned with the family and who have the duty legitimately to perform a service on its behalf; and the importance of taking action in a child's best interests in the light of all relevant facts. It would be helpful if the passing of information between the caring professions were regarded and treated as analogous to that passed in confidence within a single discipline. Whenever possible however an adult's agreement should be sought to the sharing of information about him with professionals from a different discipline".

1. (2) Families at risk can be divided into three categories

(1). Where there is certainty or near certainty that non-accidental injury has occurred.

(2) Where injury has occurred and there is reason to suspect that it may be non-accidental

(3) Where there is no evidence of injury but certain of the circumstances in which non-accidental injury is likely to occur have been identified.

FIRST STEPS

2. (1) It is essential that whenever a report is made to the Department of a child at risk in any of the foregoing categories the basic facts be recorded in detail. Accurate and detailed information is clearly crucial in dealing with this problem, with reports dated and signed.

2. (2) The record should include, if possible, the maiden name of the mother, the name of the doctor and health visitor concerned, name of the person reporting the facts; whenever possible the telephone numbers of such persons should be included.

The Department's indices should be checked for relevant information concerning the family.

2. (3) The facts must be discussed with a senior officer forthwith and must be communicated (and confirmed in writing on Form SS.2)to the Deputy Director, the Principal Physician Child Health, the GP, the Council's Solicitor, the NSPCC, the Education Department Welfare/Special Services Section, and any other agency with a professional interest known to be involved. The procedure outlined must be implemented promptly and instructions given to the named worker responsible for the action to be taken.

2. (4) No steps should be taken by the social worker alone to obtain a place of safety order or hospital admission except in cases of extreme urgency. Where there is reasonable suspicion of non-accidental injury, action should be taken to safeguard a child against further injury and to ensure that a differential diagnosis is made and any treatment needed given without delay. This may be by :-

(a) Admitting the child in category 1 & 2 to hospital. Paediatricians ask that whenever a child's admission to hospital is contemplated the paediatrician should be asked to provide a bed. It is highly prejudicial to a satisfactory outcome for the case in hospital to be handled by anyone without the skills and insights of the paediatrician. The admission may be initiated by the family doctor, the Principal Physician in Child Health, or if neither available, the social worker may contact the Paediatrician or Deputy, directly.

(b) Removing the child to a place of safety under an order of the Justices; this may, in certain circumstances, be a hospital.

(c) Arranging examination by the family doctor. If the general practitioner is not immediately available or if the client was other than at home, then the Community Health Department should be approached.

2. (5) Details of the circumstances concerning the child should be entered on the "At Risk" register.

It is of the utmost importance to safeguard the confidentiality of the register. For this reason the register will be kept in conditions of the strictest security and maintained by the Deputy Director the designated officer of the London Borough of Merton, who will receive referrals from information supplied by the Area Coordinator (also known in other Departments as the Area Manager) on form SS.2 (see 2(5)).

2. (6) In cases where professional workers suspect that non-accidental injury has occurred (category 2) but do not feel that the evidence in their possession is sufficient to enable them to initiate admission to hospital, they should, in addition to consulting the family doctor, discuss the case with at least one colleague, either a senior colleague in the same Department, or a colleague in an allied profession who is working in the same area. This discussion should take place on the same day that suspicion is aroused, or at latest, the next day. It should cover all aspects of the case, and particularly whether or not admission to hospital is required and if an immediate case conference should be called.

2. (7) It is important to seek information from the pupil's school, Education Department Welfare Special Services Section, the appropriate Child Guidance Clinic, general practitioner/health visitor, and the NSPCC Inspector. Because the evidence may be inconclusive it should be made clear to those persons approached that the enquiry is of a confidential nature and that (unless specifically agreed that action should be taken as a result of the enquiry) direct intervention is not proposed.

2. (8) In cases where admission to hospital has been arranged, steps should be taken to preserve the link between the parent and child and this may require the overnight stay of the parent at hospital, or involve prolonged daily visits. Every effort should be made to establish a professional relationship with the parents and to secure their understanding and cooperation. It is considered to be equally important, however, that they should be made aware of the legal situation and the possible implications of non-accidental injury to their child.

CASE CONFERENCES

3. (1) In all cases falling within categories 1, 2 or 3 of paragraph 1 (2), a case conference should be arranged as soon as possible after the child at risk has been identified. It is highly undesirable that a case conference should be delayed because full membership cannot be convened.

The administrative responsibility for convening a conference and producing its report lies with the Area Coordinator and all professionally who are involved should be invited to attend as a matter of absolute priority.

3.(2) The case conference needs to consider in particular:-

(a) whether the child needs to be admitted to hospital or removed to a place of safety.

(b) whether court proceedings should be recommended.

(c) whether information should be laid before the police.

(d) the identification of those supportive services whichare thought to be necessary to safeguard the welfare of the child if parental care in the home is to continue.

The Conference must be satisfied that such services are available and not merely desirable.

The initial report of the case conference should include, on Form C/C/4, an account of its deliberation on all the foregoing and other relevant factors, and the decisions taken regarding the next action and future conduct of the case. Copies of the report must be circulated to all Agencies concerned and to the Deputy Director of Social Services. It should nominate a key worker to have primary responsibility and who will be preferably the professional most closely concerned with the case.

The key worker is the focal point through whom all information is channelled and is primarily responsible for ensuring that it reaches all appropriate agencies. Before a person is nominated to be a key worker they should be made aware of the notes on Guidance on the Role of the Key Worker, which is attached as Appendix 'A'.

3.(3) Case Conferences (Families moving from one local authority to another)

When it is known that a family with a child on the Non-Accidental Injury Register is moving to the area of another authority, it should be the responsibility of the new Authority to arrange a case conference as if the case was a new referral to their Register. If geographically possible, those involved from the previous authority should attend, but, as a minimum, copies of all the available written information should be supplied to the new authority. A summary letter is not sufficient. Where practicable consideration should be given to joint visiting. Precise information on the actual date when the child was last seen should be included in the information transferred between authorities.

3.(4) The conference must decide when its next meeting shall be called and in any event, a review should follow in three months and thereafter at intervals not exceeding six months.

Review conferences will be reported on Form C/C/3 except where circumstances have not changed significantly and the nominated key worker circulates on Form SS.2. a summary of the situation, and only convenes a meeting if a member of the case conference has a reason to press for the conference to be held.

It is acknowledged that the decision of a case conference cannot be binding on the representatives of bodies with statutory powers and duties in relation to children, and that when a consensus view cannot be reached, any participant may, after consultation with senior officers, find himself constrained to take action contrary to that recommended by other members of a case conference. Where this occurs the member must be notified of the proposed action and the reasons for it.

The Area Coordinator will be responsible for convening these meetings.

3.(5) The Sutton Social Services Department have divided responsibility for convening case conferences between the Area Managers and the hospital Principal Social Worker. Because the arrangements in Merton are based firmly on the Area Coordinator, the independent action by the hospital Principal Social Workers, eg in St Helier or Queen Mary's, Carshalton, may result in the convening of a case conference in respect of children living in Merton, by the hospital. In such circumstances it is important that a senior representative of Merton Social Services Department attends the conference to ensure that notes are kept of the proceedings and a report prepared, according to the guidance in paragraph 3.(2).

The responsibility for defining the action to be taken lies with the Social Services Department, with particular attention to paragraphs 3.(2) and 3.(4).

If a child has been included on the "At Risk" register the case should remain on the register (with category of injury stated) until, by agreement of a case conference properly recorded, the decision is made for the child's name to be removed. To reduce the demands on professionals' time it may be sufficient for an SS.2 to be circulated giving reasons for the proposed removal of the case from the register, or re-classification of the case or change of key worker, or the agreed plan - and inviting comments.

4. COOPERATION WITH THE POLICE

If the police are to be involved in an alleged offence they are greatly assisted if they are informed about this as soon as possible. When the decision of the police to begin inquiries is known it should be communicated to the Chairman of the case conference and to the key worker immediately; it is desirable this should happen before any such inquiries are undertaken.

SIMON RODWAY

DIRECTOR OF SOCIAL SERVICES

RG/MS

Attachment to
PROCEDURAL ORDER NO. 25

APPENDIX 'A'

MERTON SOCIAL SERVICES DEPARTMENT

GUIDANCE ON THE ROLE OF THE KEY WORKER

In accordance with the agreed procedure of the Department, the Case Conference is required to nominate a key worker when a child is identified as being at risk of N.A.I. The appointment should be on the basis of the key worker having the best opportunity for monitoring the situation in the home, communicating with the parents, and furthering the agreed plans of the Case Conference.

Key Workers are :-

1. responsible for taking a leading role in the management of the case as appropriate to his/her professional discipline, and as agreed by the Case Conference. Other professionals may also have defined tasks in promoting the agreed plans.

2. responsible for notifying the Area Coordinator of new information or changes in circumstances which might warrant Case Conferences being convened and/or relovant information being communicated to members of the Case Conferences.

3. expected to be able to provide adequate reports to the Case Conference on the work they have done as key workers. If a change of key worker is indicated, a written summary would be expected.

4. required, when circumstances necessitate, to give corroborative evidence in support of the Social Services Department's application for a Place of Safety Order. If care proceedings follow, the key worker's evidence will be required in court.

RG/MS
24th April 1978

C/N/1

4. November 1980 revision

PROCEDURAL ORDER NO 25
(Revised November 1980)
(See also LASSL 80(4))

LONDON BOROUGH OF MERTON
SOCIAL SERVICES DEPARTMENT

CHILD ABUSE IN NON-ACCIDENTAL INJURY

1. General Considerations

1. (1) This paper is intended to set out for the guidance of social workers and information of those concerned with non-accidental injury to children, the action which should be taken when they become aware of a child who is exposed to the risk of abuse or, in fact, abused.

1. (2) The registration of children on the NAI Register falls within the following criteria:-

a. Physical injury
All physically injured children under the age of 17 years where the nature of the injury is not consistent with the account of how it occurred or where there is definite knowledge, or a reasonable suspicion, that the injury was inflicted (or knowingly not prevented) by any person having custody, charge, or care of the child. This includes children to whom it is suspected poisonous substances have been administered. Diagnosis of child abuse will normally require both medical examination of the child and social assessment of the family background.

b. Physical neglect

Children under the age of 17 years who have been persistently or severely neglected physically, for example, by exposure to dangers of different kinds, including cold and starvation.

c. Failure to thrive and emotional abuse

Children under the age of 17 years

(i) who have been medically diagnosed as suffering from severe non-organic failure to thrive; or

(ii) whose behaviour and emotional development have been severely affected;

where medical and social assessments find evidence of either persistent or severe neglect or rejection

d. Children in the same household as a person previously involved in child abuse

Children under the age of 17 years who are in a household with or which is regularly visited by a parent or another person who has abused a child and are considered at risk of abuse.

1. (3) The DHSS's general guidance is that:-

"The safety of the child must in all circumstances be of paramount importance and must override all other considerations. It is nonetheless undeniable that there will be occasions when the need to protect a child will conflict with the wish to preserve a relationship of trust with another party, and that the problems posed by confidentiality admit of no easy solution although it is important to work towards solving them. Any decision about the

release of information is normally one for professional judgment but the factors which ought to be taken into account in reaching such a decision are the "need to know" and the consequent restriction of information to those directly concerned with the family and who have the duty legitimately to perform a service on its behalf; and the importance of taking action in a child's best interests in the light of all relevant facts. It would be helpful if the passing of information between the caring professions were regarded and treated as analogous to that passed in confidence within a single discipline. Whenever possible however an adult's agreement should be sought to the sharing of information about him with professionals from a different discipline".

1. (4) For the purposes of statistics families at risk can be divided into three categories -

a. Where there is certainty or near certainty that non-accidental injury has occurred

b. Where injury has occurred and there is reason to suspect that it may be non-accidental

c. Where there is no evidence of injury but certain of the circumstances in which non-accidental injury is likely to occur have been identified

2. <u>First Steps</u>

2. (1) It is essential that whenever a report is made to the Department of a child at risk in any of the foregoing categories the basic facts be recorded in detail. Accurate and detailed information is clearly crucial in dealing with this problem, with reports dated and signed.

2. (2) The initial information recorded by the social worker should include, if possible, the maiden name of the mother, the name of the doctor and health visitor concerned, name of the person reporting the facts; whenever possible the telephone numbers of such persons should be included. More detailed data is required for the NAI register - see paragraph 3 (2).

2. (3) The facts must be discussed with a senior officer forthwith and a decision made as to whether a case conference should be convened. The facts must also be communicated (and confirmed in writing on Form SS.2) to the Deputy Director, the Principal Physician Child Health, the GP, the NSPCC and where appropriate the Education Department Welfare/Special Services Section, and any other agency with a professional interest known to be involved. The procedure involved must be implemented promptly and instructions given to the named worker responsible for the action to be taken.

2. (4) No steps should be taken by the social worker alone to obtain a place of safety order or hospital admission except in cases of extreme urgency. Where there is reasonable suspicion of non-accidental injury, action should be taken to safeguard a child against further injury and to ensure that a differential dianosis is made and any treatment needed given without delay. This may be by :-

a. Admitting the child in Category 1 & 2 to hospital. Paediatricians ask that whenever a child's admission to hospital is contemplated the paediatrician should be asked to provide a bed. It is highly prejudicial to a satisfactory outcome for the case in hospital to be handled by anyone without the skills and insights of the paediatrician. The admission may be initiated by the family doctor, the Principal Physician in Child Health, or if neither available, the social worker may contact the paediatrician or Deputy, directly.

b. Removing the child to a place of safety under an order of the Justices; this may, in certain circumstances, be a hospital.

c. Arranging examination by the family doctor. If the general practitioner is not immediately available or if the client was other than at home, then the Community Health Department should be approached.

2. (5) It is important to seek information from the pupil's school, Education Department, the appropriate Child Guidance Clinic, general practitioner/health visitor and the NSPCC Inspector. Because the evidence may be inconclusive it should be made clear to those persons approached that the enquiry is of a confidential nature and that (unless specifically agreed that action should be taken as a result of the enquiry) direct intervention is not proposed.

2. (6) In the case of children in school who are reported to be at risk of NAI, the AHA advises that if a Head Teacher asks the Area Specialist in Community Medicine (Child Health) or her staff to examine a child with suspected non-accidental injury, the examination may be done without the parents' consent. The duty of the examining doctor is a straightforward duty owed to the child and not to the parent. The doctor need not fear an accusation of breach of confidentiality if as a result of examining a child suspected of suffering from non-accidental injury, information was given to a third party without parental consent. The Medical Defence Union are sure they could successfully defend a doctor in a situation where information has been disclosed in order to prevent reasonably foreseeable harm to an innocent person.

2. (7) In cases where admission to hospital has been arranged, steps should be taken to preserve the link between the parent and child and this may require the overnight stay of the parent at hospital, or involve prolonged daily visits. Every effort should be made to establish a professional relationship with the parents and to secure their understanding and cooperation. It is considered to be equally important, however, that they should be made aware of the legal situation and the possible implications of non-accidental injury to their child.

3. Case Conferences

3. (1) In all cases falling within categories 1, 2 or 3 of paragraph 1.(4), a case conference should be arranged as soon as possible after the child at risk has been identified. It is highly undesirable that a case conference should be delayed because full membership cannot be convened. The administrative responsibility for convening a conference and producing its report lies with the Area Coordinator, and all those who are professionally involved should be invited to attend as a matter of absolute priority.

3. (2) When a decision has to be made whether or not to inform parents (or those caring for the child) that the child's name has been entered on the register, the child's best interests should be the chief consideration. In most cases parents should be made aware in the course of their contacts with professional workers that it is considered or suspected that their child has been abused and it is recommended that, unless in an individual case there are exceptional reasons for not doing so, parents should be informed that it has been decided to place their child's name on the register and should be given the opportunity to discuss and question the decision. When and by whom they are informed should be decided at the case conference. If a decision is taken not to inform the parents, a full record of the reasons for the decision should be included in the case conference minutes, so that it will be available in the case records of each agency concerned. Parents who have been informed of the registration of their child should also be informed when their child's name is removed from the register.

(3) If the decision of the case conference is that the child's name should be added to the NAI register, then the following data will have to be included on the register -

a. child's full name, known aliases, known addresses, sex, date and place of birth

b. full names (including maiden name), known aliases, and addresses of parents or others caring for the child and the name and address of any other adult members of or regular visitors to the household, together with information on their relationship to the child

c. full names, dates of birth and sex of other children in the household

d. GP's name, address, telephone number

e. child's school, playgroup, nursery or child minder, if any

f. nature of injury and by whom inflicted, reason for referral, and whether child abuse has been substantiated

g. date of registration

h. name of the key worker and the agency to whom he belongs, including telephone number

i. agencies involved

j. date when case next due for monitoring

k. legal status of child, and location (if not at address noted under (a)

l. whether the parents or care givers have been informed of registration

Note: Last line illegible on original.

It is the Area Coordinators' responsibility to notify the Deputy Director of any changes in this information which come to attention, so that the register may be kept up to date.

It is of the utmost importance to safeguard the confidentiality of the register. For this reason the register will be kept in conditions of the strictest security and maintained by the Deputy Director, the designated officer of the London Borough of Merton, who will receive referrals from information supplied by the Area Coordinator (also known in other Departments as the Area Manager) on Form SS.2 (see 2 (3)).

3. (4) The case conference needs to consider in particular -

a. whether the criteria set out in paragraph 1(2) are met

b. whether the child needs to be admitted to hsopital or removed to a place of safety

c. whether information should be laid before the police

d. the identification of those supportive services which are thought to be necessary to safeguard the welfare of the child if parental care in the home is to continue. The conference must be satisfied that such services are available and not merely desirable

e. the key worker, who should have primary responsibility, and who will be the professional most closely concerned with the case. The key worker is the focal point through whom all information is channelled and is primarily responsible for ensuring that it reaches all appropriate agencies. Before key workers are nominated they should be made aware of the Notes of Guidance on the role of the key worker, which is attached as Appendix 'A'.

f. If the policy to inform the parent or guardian that the child has been included in the register in exceptional circumstances is not complied with, then the full record of the reasons for the decision should be included in the case conference minutes. Parents should have been informed of the registration of their child and also be informed when the child's name is removed from the register.

As a general rule the explanation that a child's name is to be included on a register should cover -

a) the general nature of information held on registers

b) who has access to the register

c) the purpose for which it is held

d) the arrangements for de-registration

3. (5) When it is known that a family with a child on the Non-Accidental Injury register is moving to another authority, the Area Coordinator should inform the Deputy Director and the other professional agencies involved of the facts in order that the formal notification of transfer from the NAI register can be made. It should be the responsibility of the receiving authority to arrange a case conference as if the case was a new referral to their register. If geographically possible, those involved from the previous authority should attend, but, as a minimum, copies of all the available written information should be supplied to the new authority. A summary letter is not sufficient. Where practicable consideration should be given to joint visiting. Precise information on the actual date when the child was last seen should be included in the information transferred between authorities. It may be appropriate for the key worker to

contact the Social Services Department of the area to which the family has moved by telephone.

3. (6) The conference must decide when its next meeting shall be called and, in any event, a review should follow in three months and thereafter at intervals not exceeding six months. (Forms Nos CC8 and CC9).

Review form CC8 will be used for monitoring purposes and be completed by the key worker, approved by the Area Coordinator and a copy passed to the Deputy Director in addition to the other professional agencies concerned. It will be open to any of the professional agencies to request a further case conference.

3. (7) The inclusion of a child's name on the register is evidence of grave professional concern and the introduction of a system to facilitate regular monitoring of the case is recommended. Such a system should ensure regular assessment of -

a. the child's family environment (including changes in adult members - e g cohabitees - and any recent or prospective births)

b. the continued appropriateness and efficacy of the agreed plan of action and treatment

c. the continuing need for the inclusion of the child's name on the register

d. the accuracy of information held on the register

4. Cooperation with the Police

If the police are to be involved in an alleged offence they are greatly assisted if they are informed about this as soon as possible. When the decision of the police to begin inquiries is known it should be communicated to the Chairman of the case conference and to the key worker immediately; it is desirable this should happen before any such inquiries are undertaken.

5. Confidentiality of information

Social workers and others concerned with NAI need to remember the confidential nature of the information may not be accepted by some professionals. For example, probation officers or court welfare officers preparing reports for Courts may feel obliged to include in their reports any relevant matters which are disclosed to them which affect the welfare of the child. It may be sufficient for them to be aware that "for this family case conferences have been held between a number of professionals concerned with child care" which - if quoted in the report - would indicate to the Court that there had been concern for the child's welfare, without using a term such as NAI.

SIMON RODWAY

DIRECTOR OF SOCIAL SERVICES

RG/MS
21st November 1980

5. June 1984 revision - issued to accompany the Guidelines.

PROCEDURAL ORDER No. 25
Revised June 1984

LONDON BOROUGH OF MERTON

SOCIAL SERVICES DEPARTMENT

CHILDREN AT RISK

GENERAL

1.1 All social workers (including residential social workers) and day nursery officers are expected to have read a copy of the booklet, 'Children at Risk', which has been issued by the District Review Committee for the guidance of all those likely to come across situations in which children may be at risk.

1.2 It is important that this booklet should be thoroughly studied before social workers find themselves investigating an allegation of abuse so that they may take prompt effective and appropriate action, despite the anxiety and strong emotions which may be aroused by such allegations.

1.3 This procedural order is not intended to supersede the booklet but to draw attention to certain areas, where the Social Services Department has particular responsibilities.

First steps

2.1 All members of the Department and especially team leaders, duty social workers and the night duty social workers are reminded of the statutory duty of the local authority to investigate all allegations of child abuse (even where it might appear that the allegation has been made maliciously). This investigation MUST include the child (and any other children in the household) being seen by someone competent to assess the situation.

2.2 On receiving such an allegation, or on becoming aware of a situation where a child may have been abused, the social worker should promptly inform a team leader, who will share responsibility for checking whether the family is already known to other agencies and for deciding on appropriate action.

2.3 Once the child's (or children's) immediate safety has been secured, all those involved should record, in detail, with the use of skin maps where appropriate, all their observations and actions. These records should be signed and dated.

2.4 Residential social workers, who observe an injury for which there is no adequate explanation on a child at, or returning to a residential establishment should inform the child's field social worker immediately. If the social worker is not available, the team leader or another team leader for that area team should be informed. Out of office hours, the night duty social worker should be contacted.

2.5 Day nursery staff should also contact a child's social worker (or the team leader) at once if an injury is observed on a child attending the day nursery. If there is no social worker

allocated to the family, the duty social worker should be informed. Any anxiety about a child's development or concern about other possible forms of abuse should also be brought to the attention of the social worker.

Case Conferences

3.1 It is the responsibility of the area manager to convene case conferences. When a list of those to be invited has been agreed, the area manager should ensure that the person arranging the case conference has also contacted any other agencies not on the list (eg. Probation, Juvenile Bureau) to check whether they have had any recent or relevant contact with the family which they could contribute to the case conference (see 2.2).

3.2 The area manager normally takes the chair at case conferences. In the absence of the area manager, a team leader may act as Chairman, provided that he, or she, does not have line management responsibility for the case. If no such team leader is available, a request should be made to another area for help in chairing the conference.

3.3 The minutes of the case conference shall be taken by a competent person who has no other role to play at the meeting.

Registration

4.1 The decision to place a child's name on the At Risk register must be made by a case conference. The area manager is then responsible for ensuring that the record for the register is completed, checked at each review and, when necessary, updated. One copy of the record is kept in the area and the other sent to the Custodian of the Register.

Keyworker or Prime Worker and Case Coordinator

5.1 The duties of the keyworker are clearly spelt out in the guidelines and every keyworker should be familiar with them. Normally, the keyworker will be a Level 3 social worker and, in any case, should never be a student or temporary social worker.

5.2 Where a case conference nominates a prime worker from an agency other than Social Services, a case coordinator will also be appointed. The case coordinator will be of Level 3 status or above. It is vital that both the prime worker and the case coordinator are clear about their respective roles and it is one of the responsibilities of the case coordinator to ensure that a written note of the distribution of their functions and the agreed frequency of visiting is placed on the file with a copy to the prime worker.

Deregistration

6.1 Where a decision has been made to remove a child's name from the register, that name will remain in the inactive section of the register for 12 months if the decision was unanimous, 2 years if it was not. At the end of that period, the Custodian of the Register will ask the area manager whether there has been any fresh anxiety about the child's (or children's) welfare, and

if there has not, the area manager will circulate all the agencies who have been involved, reminding them of the de-registration and asking them to amend their records accordingly. (This can be done by means of SS2 forms). The Custodian of the Register will then remove the name(s) from the Register.

Simon Rodway
Director of Social Services

AL/JPD/MS
June 1984

APPENDIX C Topics covered in Guidelines analysed

(List prepared for Working Party)

TOPICS COVERED IN GUIDELINES ANALYSED

Topic		Lambeth, Southwark Lewisham	Manchester City	Hounslow	Essex	Wandsworth, Merton, Sutton AHA
1.	General information	x	x	x	x	
2.	Medical symptoms	x		x	x	x
3.	Situational symptoms	x		x	x	x
4.	Social background	x				x
5.	Procedures	x	x	x	x	x
6.	Consultation	x			x	
7.	Case Conferences	x	x	x	x	
8.	Role of Keyworker	x	x	x	x	
9.	Reviews	x	x		x	
10.	Transfers/family move	x	x	x	x	
11.	Register	x	x		x	
12.	Deregistration	x	x	x	x	
13.	Separate sections for different disciplines		x		x	x
14.	Informing parents		x		x	
15.	Lost families		x	x		x
16.	Diplomatic families		x			
17.	Role of police			x	x	
18.	Care proceedings/ Place of Safety Orders				x	
19.	Area Review Committee Membership	x			x	
20.	Borough Review Committee Membership	x				
21.	Case Conference minutes	x	x		x	
22.	Chairing Case Conferences	x		x	x	
23.	Supporting worker				x	
24.	Parents/ child attending Case Conference				x	
25.	Service families			x		x
26.	Useful addresses				x	x
27.	Check list				x	
28.	Flow chart				x	
29.	Appendix of specimen forms				x	

Analysis of Topics - II

(Chart prepared for Working Party Meeting, 6.7.81.)

ANALYSIS OF TOPICS COVERED - II

Topic	Lambeth, Southwark and Lewisham	Manchester City	Hounslow	Essex	Wandsworth, Merton and Sutton AHA
1. General Background including statutory background, basic statistical information, aspects of detection, need for action and purpose of guidelines.	1976 figures for child abuse (on cover); purpose of guidelines: to enable appropriate action, consultation and co-ordination.	Guidelines confined to injury only. Purpose: to assist assessment, prevention, appropriate intervention and professional competency within multi-disciplinary framework and system of case conferences and reviews.	Need for multi-disciplinary consultation Individual responsible for understanding procedures and taking action.	Statutory background. Procedures binding on all staff	
2. Medical symptoms including minor injuries which might alert to need for investigation; consent to medical examination.	Comprehensive list of types of injury; significance of minor injuries.		No symptoms - just procedures for hospital; also for change of GP. Consent in emergencies.	Importance of medical opinion. Brief reference to unexplained bruises, cuts, etc.	Description of possible injuries.
3. Situational Symptoms including inconsistent explanations delays in seeking treatment, etc.	"Cries for help", inadequate explanations, delays, etc.			Inadequate explanations.	"Pre-battering" symptoms.
4. Social background including common characteristics of parent, child or circumstances.	Characteristics/ stress factors frequently found in: a) parent b) child c) circumstances				List of possible predisposing factors.

	Topic	Lambeth, Southwark and Lewisham	Manchester City	Hounslow	Essex	Wandsworth, Merton and Sutton AHA
5.	Procedures including different sections for each discipline, distinction in obvious/ suspected injuries; grounds for stat. orders; importance of consultation.	General principles only. Importance of safe-guarding child, seeking medical help Stress on recording and written confirmation.	Investigate within 24 hours; police help if necessary. Detailed procedures for each profession.	Procedures for action if obvious injury and if suspicion. Different action to be taken by each agency. Grounds for POS orders. Confirmation in writing.	Immediate action. Divisions of responsibility. Subsequent action/ inaction. Recording.	Procedures for different health disciplines.
6.	Police Statutory powers of; attendance at Case Conferences; information given to.	May be invited to Case Conferences. To be informed of possible offence. Decisions to prosecute.	Police representation on Area Review Committee and Case Conferences Decisions to prosecute.	Attendance at Case Conferences. Powers to deal in emergency. Referrals to Social Services.	To be notified at once if offence appears to have been committed.	
7.	Case Conferences Composition; chairman; minutes. Parental attendance.	Check list for composition; choice of chair; decision sheet, minutes. Warning on confidentiality; limited distribution of minutes.	Smallest number in keeping with good management. Written reports to be available, if possible. Minutes to be circulated within 7 days. Warning on confidentiality.	Smallest number in keeping with good management. Chairman to be nominated before conference.	Chairman should have no other role. Content of minutes to be decided by Case Conference. Parent/child may be invited.	
8.	Duties of Case Conference including decisions about registration, keyworker, informing parent, position of	Decisions about registration, reception into care, court action, informing police, support for family. Designation of key-	Sharing of knowledge Diagnosis. Assessing risk to siblings. Keyworker. Treatment plan. Registration. Parents and child to be informed.	Decisions about sufficiency of information, degree of risk, parents' attitude, siblings and registration. Informing parents	Discuss registration information, collating activity. Treatment plan, allocation of responsibilities. Keyworker. Informing	

Topic	Lambeth, Southwark and Lewisham	Manchester City	Hounslow	Essex	Wandsworth, Merton and Sutton AHA
sibling, date of review.	worker. Position of siblings. Parents to be informed. Date of review.	Reviews. Second thoughts.	and police. Keyworker. Reviews. Oral summing up.	parents. Reviews.	
9. Keyworker including responsibilities, co-operation with, and support for.	K/W ensures decisions are implemented. Focal pt. for info. Tells parents about registration. (If from agency other than S.S.D., liaison officer appointed.)	Focal pt. for communication. Maintains contact with C.C. members. Others have a duty to support and help.	Duties of K/W. Obligations of others towards.	K/W to co-ordinate activities/ information. Duty of others to support. K/W from agency which deals with "core" problem.	
10. The Register including criteria and access to it.	Under 17 years. Actual physical injury, neglect, failure to thrive, member of same household (or regularly visited by) abusing adult. Set details to be recorded. Access only to designated staff on callback system.	Under 17 years. Actual or suspected physical injury, medically diagnosed failure to thrive. Member of household including an abusing adult. Deceased children's names to remain on register. Access to designated staff on callback system. Enquiries to be recorded and if necessary Case Conferences called.		Under 16 years. Diagnosis to be made on medical and social grounds. Physical injury. Neglect. Failure to thrive.	
11. Deregistration	Case Conference decision. Not within 12 months unless	Dereg. to take place after 12 month period of "no risk"	No criteria for deregistration given.	Children no longer considered at risk placed in inactive	

Topic	Lambeth, Southwark and Lewisham	Manchester City	Hounslow	Essex	Wandsworth, Merton and Sutton AHA
	except. circs. or made in error. (If disagree, local Standing Committee decide). Inactive section 2+ years after dereg. Dereg.: no reason to continue professional involvement.	assessment. Record to be retained further year.		section.	
12. Reviews including frequency and use of monitoring forms, rather than review conference.	At least 6 monthly, more frequently if significant change of circumstances.	Monitored by Special Unit 1 month after registration and then at 4 monthly intervals. Monitoring done by form sent to K/W and one other. Level of professional consultation to be determined without reference to registration.		Internal Social Services review quarterly. Case Conference review six monthly. Can be monitored by letter/ form.	
13. Transfers to another area (where destination is known).	Information about family to be telephoned at once and confirmed in writing. K/W to inform Register and all Case Conference members. Transfer Case Conference to be attended by both areas.	K/W to ensure info. is communicated. Case Conference, if practicable, to facilitate handover. All agencies responsible for ensuring opposite number has relevant records. K/W to inform Register.	Info. to be passed on urgently. Case Conference if necessary. Each agency to inform opposite number within 24 hours. K/W to tell family info. will be passed on.	Information to be passed by telephone as soon as possible and confirmed in writing by recorded delivery post.	Information to be passed on as soon as possible.

Topic	Lambeth, Southwark and Lewisham	Manchester City	Hounslow	Essex	Wandsworth, Merton and Sutton AHA
14. Missing Families		Social Services to try to trace through Social Security. AHA by own procedure.	K/W to co-ordinate attempts to trace. Each agency to use own procedure.		Inform Div. Nursing Officer who will inform Area Nurse.
15. Diplomatic Families		"Complex legal issues": inform Special Unit.			
16. Service families who to contact			Details for army families only.		Any service family through SSAFA.
17. Area/Borough Review Committees	Composition and functions of both committees. Detailed membership list.			Description of Area Review Committee and composition.	
18. Address list of useful contacts.		Hospital addresses/ telephone numbers given in text, passim.		Social Services, NSPCC, Police.	Clinics, Nursing Officer, Social Services.
19. Flowchart/checklist for action.				Both. Visual representation of procedures and checklist of action to be taken.	
20. Monitoring forms				Appendix of specimen forms.	

APPENDIX E

Revised Register Form

AT RISK REGISTER - FAMILY DETAILS

FAMILY NAME(S) _____ AREA _____

ADDRESS _____

Composition of Household (including adults)

Name(s)	Sex	D.O.B	Position in family	Occupation/School

Absent members of family

Name(s)	Sex	D.O.B	Relationship	Whereabouts

Close Relatives (if known)

Name(s)	Relationship	Address

REGISTRATION DETAILS

Name of child	Category	Type of abuse	Legal status/Whereabouts

Date of Registration _____ Have parents been told YES/NO

PROFESSIONALS INVOLVED	Name	Agency/Address/Tel. No.	Attended last case conference
KEYWORKER/PRIMEWORKER			YES/NO
CASE COORDINATOR			YES/NO
General Practitioner			YES/NO
Health Visitor			YES/NO
Other(s)			YES/NO

Case due to be reviewed (Month and Year) _____

DEREGISTRATION a) Date _____

b) Reason _____

c) To be removed from the inactive section (date) _____

d) Notification sent to their agencies (date) _____

C/C/11
June 1984

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Report of Proceedings of a Meeting of Officer Representatives of the Area Health Authority, the London Borough of Merton, the Metropolitan Police, the Probation Service and other interested Agencies, convened by the Merton Director of Social Services and held on 6 December, 1974 at the Town Hall, Wimbledon for the purpose of setting and considering the terms of reference of a Merton Borough Review Committee to deal with cases of Non-Accidental Injury to Children.

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4. Other Areas' Guidelines

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2. Most Bumps and Bruises are Accidents - A Few are not so easy to Explain, Guidelines on what to do about it (Essex County Council). No date given.

3. Child Abuse : The Essex Area Review Committee's Practice Document on the Management of Child Abuse in Essex for Workers in Agencies with Responsibilities towards Children. No date given, but written after the Malcolm Page inquiry and received January 1984.

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Hertfordshire : Child Abuse : Notes for the Guidance of Professional Staff in Hertfordshire - Issued jointly by Hertfordshire County Council Social Services Department and Hertfordshire Area Health Authority. October 1979.

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Islington : Child Abuse : Non-Accidental Injury to Children - Procedures (London Borough of Islington Area Review Committee). Revised - May 1982.

Kingston : Non-Accidental Injury to Children - Procedural Guidelines (Royal Borough of Kingston-upon-Thames). July 1977.

Lambeth : Child Abuse : Procedures in relation to non-accidental injury to children (Lambeth, Southwark and Lewisham Area Health Authority (Teaching) and London Boroughs of Lambeth, Southwark and Lewisham). 1981.

Manchester : Child Abuse Procedures - City of Manchester Guidelines. No date given.

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5. Relevant Legislation

Children and Young Persons Act, 1933.
Children Act, 1948.
Children and Young Persons Act, 1963.
Children and Young Persons Act, 1969.
Matrimonial Causes Act, 1973.
Children Act, 1975.
Child Care Act, 1980.