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Rethinking Child Protection Strategy: Learning from Trends

Dr Lauren Devine & Stephen Parker
March 2015

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ABSTRACT:
This Working Paper is developed from the findings of the first Interim Report of the ESRC Transformative project, Rethinking Child Protection Strategy. It considers Child Protection and Safeguarding referral, investigation and outcome trend data. The trends are analysed on a number of measures in light of the available statistical data, covering the period since the implementation of the Children Act 1989. The trend data establishes that despite the increased cost, level of intrusion into private family life and surveillance of families there is no proportionate increase in the level of child abuse found in referred children. Although the number of children referred into the system has significantly increased, the number of cases where ‘core abuse’ (physical and sexual abuse) is detected has dropped. In addition, the ratio of referrals to registrations has significantly fallen year on year. This is not adequately explained by the rise in early intervention for families as targeted early intervention occurs following the assessment stage. The paper concludes there are a number of policy questions to be addressed.
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1 Executive Summary

This Working Paper is part of a project investigating child protection strategy in England. *Rethinking child protection strategy: evaluating research findings and numeric data to challenge whether current intervention strategy is justified* is funded by the ESRC.¹ The objective of the research is to identify and challenge the accuracy of the paradigm informing assessment policy in the English model of child protection and safeguarding. We identify the paradigm as a series of ‘truths’ amounting to a ‘theory of child protection’. The paper has been developed from the findings of the project’s first Interim Report which considers data trends in child protection and safeguarding at the key pre-litigation threshold stages.

The research is informed by the tensions between the state’s competing duty to support families under s.17 by providing services where required² and to police families under s.47 by gathering evidence for use in potential litigation if significant harm, or the risk of it, is found.³ State services and interventions beyond universal service provision⁴ are triggered by referral of a child to local authority Children’s Services Departments. The local authority must decide whether it has a statutory duty under s.17 or s.47⁵ by assessing the child and their family. However, the assessment process used for both was originally intended to be consensual and to be used only where s.17 was indicated.⁶ Child abuse investigations under s.47 were carried out as a separate process. The uptake of this model to include risk assessment under s.47⁷ creates a tension between families and social workers that is not easily reconciled.

¹ ESRC grant number ES/M000990/1: £202,487. The project started on 1st September 2014 and is funded for 18 months.
² S.17 Children Act 1989
³ S.47 Children Act 1989
⁴ For example universal services provided under the NHS framework including midwifery and health visiting services. However it is noted that service users are asked for a large amount of personal data before receiving services.
⁵ S.17 refers to the requirement for a local authority to provide services for children who need them, whereas S.47 refers to the duty for a local authority to investigate a reasonable suspicion of significant harm and to decide what action (if any) to take to protect the child.
The trend data establishes that despite the increased cost, level of intrusion into private family life and surveillance of families there is no proportionate increase in the level of child abuse found in referred children. Although the number of children referred into the system (including those referred more than once in the same year) has significantly increased, the number of cases where ‘core abuse’ (physical and sexual abuse) is detected has dropped. In addition, the ratio of referrals to registrations has significantly fallen year on year. This is not adequately explained by the rise in early intervention for families as targeted early intervention occurs following the assessment stage. The paper concludes there are a number of policy questions to be addressed.

2 Introduction

In common with the rest of the UK, North America, New Zealand and Australia, England operates a residual and selective provision model\(^8\) of child welfare service provision\(^9\) and abuse prevention.\(^{10}\) The key distinguishing characteristic relies on a threshold of risk being reached before targeted and selective interventions are justified.\(^{11}\) Evidence gathering via state assessment of families is undertaken in order to justify the intervention. This is an important aspect of the system as it forms the basis of decision making about the family’s future interactions with the local authority, including the possibility for the local authority to make a s.31 Care Order application.\(^{12}\)

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\(^8\) The Anglo-American model.
\(^9\) Safeguarding.
\(^{10}\) Child protection.
\(^{12}\) S.31 Children Act 1989 applications where the local authority (or the NSPCC) apply for an order taking a child into ‘care’ (children in ‘care’ are now known as ‘looked after’ children).
This model differs from the comprehensive and universal provision model\textsuperscript{13} encompassing Belgium, Sweden, France and Germany. Under this model the concept of child protection is embedded within universal child welfare or public health services and is intended to be voluntary and collaborative. Its focus is on family unity as opposed to individual rights, and professionals aim to interact with the family as a whole. The purpose of assessment is to provide a supportive or therapeutic response to meeting needs or resolving problems. Resources are available to a higher number of families at an earlier stage.\textsuperscript{14}

In the Anglo-American model the key characteristics are adversarial, bureaucratic and investigative, with an emphasis on professionals’ primary responsibility being the child, not the family. While there are significant variations in implementation, particularly in relation to mandatory reporting, the UK, Canada, the USA, New Zealand and Australia all operate within a shared model.\textsuperscript{15} This approach prioritises children’s rights as paramount and creates a policy tension if the aim of the state is also to ‘work with’ families to avoid public family law proceedings under s.31 to remove children from their parents. The purpose of assessment is to decide whether the local authority is under a duty to provide services on the basis of ‘need’ and/or to instigate a plan for coercive intervention.\textsuperscript{16} Assessment is also a means of evidence gathering for litigation. The provision of services is intended to avoid the litigation threshold being reached. Families are thus in a coercive relationship from the outset: if they refuse services they are likely to be deemed unwilling to ‘work with’ the professionals and consequently risk more extreme interventions.\textsuperscript{17}

\begin{itemize}
\item \textsuperscript{13} The Continental, Western European model.
\item \textsuperscript{16} Under the Public Law Outline (PLO).
\end{itemize}
2.1 Methodology

The project’s methodology is designed around four areas of investigation. This Paper explores the findings of the first area, reported in the project’s First Interim Report:

1. **A trend analysis of the level and outcome of family surveillance and interventions at the threshold levels**;
2. **A statistical evaluation questioning the use of risk assessment as a predictive and a diagnostic aid in social work assessment given the high prevalence of false positives and false negatives inherent in this approach**;
3. **A meta-analysis of public inquiry and serious case review findings and recommendations**; and
4. **An impact assessment of the outcome of family assessment (considering the costs and benefits)**.\(^{18}\)

The trend analysis involved obtaining the available numeric data in relation to the stages of the process from referral to application for a s.31 Care Order. This data was not readily available in an accessible format as it is held piecemeal by a number of different government departments. Operational definitions and categories have changed from year to year making comparisons difficult. In addition, since the mid-1990s the approach to social work assessment of families changed following the refocusing debate.\(^{19}\) One of the aims of this research project is to provide readily available comparison data to enable future measurement of cost, efficiency, trends, welfare satisfaction and effectiveness.

Data has been collected at each threshold stage of decision making. The thresholds are passed when a local authority decides a family has met the criteria for increasingly coercive interventions. **Figure 1 - England’s selective threshold model** shows the key threshold levels:

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\(^{18}\) The multi-factorial consideration includes the economic, welfare and social costs and benefits.  
The quantitative data analysis provides an overview of the number of affected families at threshold stages 1-4. Threshold 5 has only been operational since April 2014 so it is too early for comparative data to be available. Threshold 6 involves decision making surrounding legal proceedings and as such is informed by different principles. It therefore cannot be analysed as a comparable process.

Our findings indicate increasing numbers of referred children. There is also a significantly increased level of assessment and interventions short of s.47 Inquiries and s.31 applications. This has reduced rather than increased cases of substantiated child abuse. Later stages of our research will conclude on the reasons for this.

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20 Under the Public Law Outline (PLO).
21 The ratio of referrals matched against substantiated child abuse indicates a drop. The ratio of children concluded to have experienced some level of substantiated abuse (indicated by a CPR/CPP) as a proportion of the total number of referrals was 24.1% for 1991-1992 and 7.3% for 2013-2014.
3 The ‘Truths’

The underlying truths in child protection and safeguarding emerged following research studies, government and NGO reports and successive political agendas. However there is no gold standard methodology as it is interdisciplinary and therefore adopts a number of methodologies with differing confidence limits. There is no meta-analysis of the methodologies and research results. Following a literature review and findings from the pilot study\(^\text{22}\) we have identified the following as the key underpinning truths requiring investigation. Figure 2 - The truths underpinning the theory of child protection shows how, taken together, they create the paradigm on which policy is based:

1. A high prevalence of child abuse exists and can be defined and identified;\(^\text{23}\)
2. The state has a moral and statutory duty to identify child abuse, and to mitigate it by taking steps to protect a child once it has done so;\(^\text{24}\)
3. In order to do so a system of risk prediction is possible with a sufficiently accurate confidence limit so as to justify coercive interventions;\(^\text{25}\)


\(^{25}\) See for example Gough, D. (1988) Approaches to Child Abuse Prevention cited in Browne, K. et al (Eds.) (1988) Early Prediction and Prevention of Child Abuse, Wiley, Chichester; Browne, K. & Saqi, S. ‘Approaches to Screening for Child Abuse and Neglect’ in Browne, K. et al (1988) Early Prediction and Prevention of Child Abuse, Wiley, Chichester pp. 57-85. However, the results are statistically overwhelmingly inaccurate: using the risk factors the Browne et al researchers identified they predicted that in a population of 10,000 families 12.28% would be at risk of abusing their children, i.e. 1,228 families. However the researchers reported that in their sample of 10,000 families only 40 cases of actual abuse were found (i.e. 0.4%). Using their 82% sensitivity checklist (from Fig 1 at p.71) they found that 33 of the 40 abusers were found in the 12.28% identified by risk analysis, while 7 were not identified by this method at all. This appears a good result at first sight, except that to identify the
4. Timely, consensual early intervention is an appropriate welfare response to mitigate the risks of future abuse in families identified as high risk;\(^{26}\)

5. Failure to predict and prevent serious cases of child abuse should be investigated by Public Inquiries (PIs) and Serious Case Reviews (SCRs) which aim to find evidence of how points 1-4 can be ‘done better’. The aim of the PIs and SCRs is to strengthen the existing procedures.\(^{27}\)

33 real abusers they also wrongly identified 1,195 (i.e. 1,228 less 33) non-abusers as abusers. That equates to a detection efficiency of 2.7% (i.e. 33 / 1,228) or an error of 97.3% in their prediction and completely missing 17.5% of cases of actual abuse (i.e. 7 / 40).


4 The Law

The Children Act 1989\textsuperscript{28} came into force in 1991 and is a consolidating Act that places a duty on local authorities to investigate cases where children may be at risk of ‘significant harm’ and to identify children who may be ‘in need of services’. The Children Act 1989 pre-dates the Human Rights Act 1998\textsuperscript{29}, whereas the Children Act 2004\textsuperscript{30} was implemented post. However, despite the broad aim of the Human Rights Act 1998 to protect \textit{inter alia} individual freedoms and privacy the more recent legislation is more intrusive than the position prior to its implementation. S.47 Children Act 1989 is concerned with children suffering or at risk of suffering

\textsuperscript{28} c.41
\textsuperscript{29} c.42
\textsuperscript{30} c.31
significant harm. This section is intended to be coercive. S.17 is concerned with children in need who, together with their families, need support services. S.17 is not intended to be coercive.

On the face of it the intention of the legislation is to create a clear separation between families who do not need coercive intervention, and families who do. Despite this, policy has moved towards an integrated system whereby one, comprehensive assessment is undertaken to decide where on a continuum a family should be categorised. The presumption is that unless family ‘problems’ are caught early they are likely to escalate into child abuse. This policy direction has weakened the separation between coercive and non-coercive involvement into private family life and has conflated the use of assessment to provide supportive services with a fishing expedition into family life to decide whether there are grounds to apply to the court for a s.31 Care Order. The policy interpretation of ss.17 and 47 has blurred the boundary between the coercive and non-coercive parts of the Children Act 1989 which were deliberately kept separate. Part III inter alia concerned consensual services for children and their families whereas Part V inter alia concerned non-consensual investigations into suspected significant harm to children. The type of harm that the 1989 Act envisaged and aimed to prevent was primarily serious physical harm. Concern about fatal physical abuse of children had been raised by public inquiry findings into child deaths as a result of parental or state harm. The threshold for interference is where ‘significant harm’ or the risk of it is ‘reasonably suspected’. The law has expanded duties in the 2004 Act to extend beyond this threshold and also beyond the threshold in s.17 relating to ‘children in need’.

Clarifying the extent of the public law legal framework in relation to rationed welfare provision is therefore more difficult since the Children Act 2004. The 2004 Act introduced ss.11 and 12 which created a duty for state agencies to make arrangements to safeguard and promote the welfare of children under s.11 and enabled data-basing of children under s.12. The notion of ‘safeguarding’ which under the 1989 Act was mentioned in s.17 in relation to specific categories of children (‘children in need’ and s.47 children at risk of ‘significant harm’) was expanded under s.11 of the 2004 Act to apply to children generally. As a result, family surveillance and intervention has become a costly growth industry.\(^{32}\)

S.11 of the 2004 Act requires state agencies generally to ensure that their ‘functions are discharged having regard to the need to safeguard and promote the welfare of children.’\(^{33}\) This moves beyond children who need services and children who are suffering (or at risk of suffering) significant harm to include all children and all agencies involved with children; a huge expansion. This prompted the provision in s.12 of the 2004 Act to enable the state to collect and retain data about all families in order to discharge their duty to all children. S.11 seems to cross the Rubicon from selective non-consensual interference in respect of suspected ‘significant harm’ and consensual interference in respect of children ‘in need’, to potential assessment of any family to ‘safeguard and promote welfare’, facilitated by mass surveillance of all families via data collection and retention in databases.\(^{34}\)

There is nothing inherently wrong with a statutory provision considering the welfare of all children as opposed to a targeted selection of the population. However, there is a danger that in a selective service provision model the expansion to include all children, underpinned by the Every Child Matters\(^{35}\) targets for all children, could be

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\(^{32}\) Wrennall reports that in the UK the ‘Total gross expenditure on children in care in 2007-08 was £2.19 billion’ and that in ‘the US, the Child Protection expenditure is estimated to be $11.2 billion’, (1998 figures); Wrennall, L (2010) ‘Surveillance and Child Protection: De-mystifying the Trojan Horse’ Surveillance and Society 7(3/4) 304-324, p.309

\(^{33}\) Section 11(2)(a) Children Act 2004 c.31

\(^{34}\) The Court of Human Rights have found that to arbitrarily database citizens breaches Article 8 of ECHR, see for examples: Amann v Switzerland (27798/95) (2000) 30 EHRR 843; S v UK (30562/04) & Marper v UK(30566/04) (2009) 48 EHRR 50

used as a compliance tool enabling local authorities to police parental non-compliance with government ideals of child rearing if their children are not meeting government targets. This goes much further than the provisions of the 1989 Act which were not intended to interfere with parental autonomy unless it was necessary to prevent significant harm. Non-consensual surveillance and early intervention policies are now practiced in much wider circumstances than was envisaged when the Children Act 1989 was implemented.

Commentators such as Wrennall36 and Anderson et al.37 argue that the current framework furthers collective government’s e-Government agenda in relation to data collection and retention in respect of all children in the form of databases, and by extensive and intrusive assessments.38 Concerns have been raised that practices are unlawful, or at least have the potential to be so, as they operate on the fringes of acceptable intrusion into private life.39 Research findings raise concerns that this is causing undue harm and distress to families.40 In addition to the obvious concern that this ‘system overload’ could cause some children to be ‘missed’, and left in a dangerous situation, there is also growing concern from a number of voluntary organisations, MPs41 and Peers42 that this is facilitating referrals amounting to


39 Anderson – see note 37 above.

40 This is an important area for further research. See the wealth of anecdotal and research evidence to suggest surveillance and interference is causing distress of varying degrees to many families. See for example information presented by organisations such as FASO, Online at: http://www.false-allegations.org.uk/, Families for Justice, Online at http://justice-for-families.org.uk/index.php, FACT, Online at: http://www.factuk.org/, and also for example papers such as Robertson, B. (April 2002) The Harm Caused by False Allegations Paper submitted to the Home Affairs Committee Enquiry, Commons Select Committee, Online at http://www.coeflic.demon.co.uk/commons_select_committee.htm, [Accessed 18 February 2015]


42 Earl Howe, Peer, the then Shadow Minister for Health, see for example: Earl Howe, House of Lords, Child Abuse, Hansard, 17 October 2001, COL 646, ‘...many innocent people are being wrongly accused of child abuse and whose lives in consequence are being turned upside down without due justification….children are made to live in constant fear of being parted from their parents. The climate is like that of a witch hunt in which the voice of reason and all sense of proportion is lost.’
unfounded allegations, and also referrals which are being made at too low a level. This type of referral may be pursued to the detriment of families using already overstretched resources. This issue requires further research to ascertain the depth and scale of the problem.

A mix of intended and unintended results can therefore be identified from the complex strands that make up the nature and purpose of the legal framework. The figures below represent the purpose of the child protection and safeguarding legislation, matched against the unintended consequences (see Figure 3 and Figure 4 below).

Figure 3 - The legislative intention of the Children Act 1989 ss.17 & 47 and the Children Act 2004 ss.11 & 12

(1) Children Act 1989
Ss. 17 & 47 are enacted to detect & prevent ‘significant harm’ and identify ‘children in need’

(2) Children Act 2004
All agencies involved with children are to police families to ‘safeguard & promote the welfare’ of all children

To collect data in the form of databases to enable ‘safeguarding’ to occur
In attempting to prevent the most serious types of child abuse (restricted in s.47 to ‘significant harm’ as opposed to simply ‘harm’) the legislation has expanded to create a paternalistic system of mass surveillance and targeted interference which affects all families regardless of whether they are aware of it or consent to it. Our research investigates the consequences of this strategy. The legal issues listed below represent the key factors contributing to the loss of balance between state powers and private rights:

- The move from the concept of parental ‘ownership’ to the concept of parental responsibility and state duty: Parents are responsible for children and the state is responsible for policing parents to ensure they discharge that responsibility. If, in the opinion of the local authority, they do not, the state has a duty to intervene;
- To discharge its duties the state must police parents. Policing is undertaken by mass surveillance of all families. The use of personal data and databases as ‘intelligence’ places all families under the surveillance umbrella, enabling local authorities to detect a failure to discharge parental responsibility;
- If failure is suspected, there is progression in the level of policing from mass surveillance to targeted interference via state assessment;
- In this circumstance parents are expected to comply with state requirements before coercive measures are scaled back. Non-compliance may ultimately result in a local authority making a s.31 Care Order application to assume parental responsibility for the child, removing them from their family;
- Where a child dies as a consequence of a failure to intervene, a PI or more latterly a SCR will be held. Their findings have been used as evidence the system should be strengthened with more stringent referrals and interventions. This has led to policies driving towards higher levels of surveillance of all families, higher targeted referrals and extensive early interventions.

5 The Data

The first stage of the project involved sourcing and mapping the available data at each stage of threshold decision making. This gives a clear picture of the number of families passing each threshold of intervention. The data has been collected from a number of sources.\(^{43}\) The research presents comparative year on year data to enable trend analysis over a lengthy period from the implementation of the Children Act 1989 to the most recent data which is for 2013/2014.

- **Table 1:** shows the available year on year data for each threshold;
- **Figure 5:** presents this same information in a bar chart;
- **Figure 6:** shows the ratios of the number of children referred to local authorities for each year compared to the number of children who, after assessment, become the subject of a Child Protection Plan (CPP).

\(^{43}\) See section: 8.2 Statistical Data Sources, References & Bibliography on p. 60 below.
There is a significant upward trend in referrals. There is no corresponding upward trend in the estimated prevalence of child abuse in England.\(^{44}\) The number of families passing through the threshold points shows that the likelihood of a child being referred to Children’s Social Care departments has increased, while conversely the chance of the child then being registered with a CPP (formerly known as registration on the Child Protection Register (CPR)) has reduced. The ‘cut off’ point of registration with a CPP can be argued to be the point at which at least some evidence of abuse has been established, although this cannot be assumed: threshold decision making does not necessarily equate to evidential findings.\(^{45}\)

**Table 1** gives the year on year comparison of numbers at each of the threshold stages. This gives information about the number of families passing each threshold of intervention. The data shows a marked increase in the number of referrals and assessments but does not show a corresponding increase in the identification of significant harm, or identification of the risk of it. Calculation of ratios 1 (B/A),\(^{46}\) 2 (C/A)\(^{47}\) and 3 (D/A)\(^{48}\) provides indicative information about how the thresholds are operating and their relationship to the entry threshold level:


\(^{45}\) In Gibbons, J. *et al* (1995) *Operating the Child Protection System Studies in Child Protection*, HMSO, London, the authors suggested that a Child Protection Conference should be the point at which ‘abuse’ should be considered to be substantiated. A Child Protection Plan (CPP) occurs following a Conference. It is unclear how strong evidence needs to be however, or whether any evidence is required at all (see later discussion in this paper re Parton *et al*.’s findings in Parton, N., Thorpe, C. & Wattam, C. (1997) *Child Protection, Risk and the Moral Order* MacMillan, Basingstoke. It is by no means certain that this threshold measure is a reliable indicator as a consequence of the lack of transparency, consistency across areas and lack of a process of audit of decision making. Even when cases reach court the standard of proof is on the balance of probabilities so ‘proof’ even in litigated cases simply means ‘more probable than not’.

\(^{46}\) Ratio B/A = the number of children who are either on the Child Protection Register (CPR) or who have a Child Protection Plan (CPP) as at 31 March, compared to the number of referred children in the year to 31 March.

\(^{47}\) Ratio C/A = the number of newly registered (i.e. on the CPR or have a CPP) children as at each year compared to the number of referred children in each year.

\(^{48}\) Ratio D/A = the number of families not assessed following referral as at each year compared to the number of referred children in each year.
Table 1 - Available numbers at each threshold of decision making

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals (A)</td>
<td>160,000</td>
<td>547,000</td>
<td>657,800</td>
</tr>
<tr>
<td>Initial Assessments</td>
<td>120,000</td>
<td>349,000</td>
<td>308,500</td>
</tr>
<tr>
<td>Continuous Assessments</td>
<td>n/a</td>
<td>n/a</td>
<td>175,300</td>
</tr>
<tr>
<td>Families assessed following referral</td>
<td>120,000</td>
<td>349,000</td>
<td>483,800</td>
</tr>
<tr>
<td>Families NOT assessed following referral (D)</td>
<td>40,000</td>
<td>198,000</td>
<td>174,000</td>
</tr>
<tr>
<td>Core Assessments</td>
<td>n/a</td>
<td>120,600</td>
<td>170,600</td>
</tr>
<tr>
<td>All Assessment</td>
<td>120,000</td>
<td>479,600</td>
<td>654,400</td>
</tr>
<tr>
<td>Conferences</td>
<td>40,800</td>
<td>43,700</td>
<td>65,200</td>
</tr>
<tr>
<td>Number of Children on Register/CPP at 31 March (B)</td>
<td>38,600</td>
<td>34,100</td>
<td>48,300</td>
</tr>
<tr>
<td>New Registrations/CPPs in year (C)</td>
<td>24,500</td>
<td>37,900</td>
<td>59,800</td>
</tr>
<tr>
<td>Ratio 1 (=B/A) (calculated by author)</td>
<td>24.1%</td>
<td>6.2%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Ratio 2 (=C/A) (calculated by author)</td>
<td>15.3%</td>
<td>6.9%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Ratio 3 (=D/A) (calculated by author)</td>
<td>25.0%</td>
<td>36.2%</td>
<td>26.5%</td>
</tr>
</tbody>
</table>

Figure 5 below presents the information from Table 1 in a bar chart.

5.1 Period 1991/1992 to 2013/2014 (22 years):

The data is presented for the overall 22 year period studied, with a sub-division reflecting policy change (see below). The significant data findings from the overall period are:

- The number of referrals to Children’s Services Departments in England (Variable A) more than quadrupled, increasing from an estimated 160,000 to 657,800 a year. This is an increase of 311% while the population of children in England remained stable at about 11 million. This large rise is not explained by population increase. It could be driven by:
  - Changes in referral practices and criteria;
  - The result of an increase in the incidence of children who are in need of state intervention;

49 Data from Government sources from 1989 to 2014 (see Section 8.2 on p. 61)
o A change in the number of children who are suffering (or likely to suffer) significant harm.

o Changes to thresholds of acceptable parenting practices.

- If a risk of, or actual significant harm is found during assessment the local authority places the child on the CPR or, more recently, forms a CPP. Once a CPP is in place the child is monitored. Parents are expected to change their behaviour. Table 1 shows that the number of children placed on the CPR or with a CPP in the same period (Variable B) only rose from 38,600 (1991-1992) to 48,300 (2013-2014), a rise of 25%. This is disproportionately low when matched against the 311% increase in referrals.

- Despite the large increase in children referred to Children’s Social Care it would appear very few of those referred children were considered to require ongoing non-consensual intervention. An important question is why there is such a large increase in referrals if prevalence studies suggest a high level of child abuse in the population but the number of families concluded to need non-consensual intervention only rose by a small amount.

- There are a number of factors that could explain this. These factors will be examined during the lifespan of the research project, reported on in the Interim Reports and in the project’s Final Report. Initial suggestions, however, are:

  o Children who are referred are not predominately children who are being abused;

  o Abused children are referred but are not assessed, or are categorised under s.17 rather than s.47;

  o There may be an over-referral rate of s.17 which are masking some serious cases which are missed in the mass of referrals;

  o Cases are ‘caught’ at s.17 level and receive early intervention services, preventing an escalation to a s.47 threshold.

  o The prevalence study numbers may simply be incidence examples.

Using the ratio of the number of children registered on the CPR or who have a CPP as at 31st March to the number of referrals in the year (i.e. \( B / A \)) gives a change from 24% (1991-1992) to 7.4% (2013-2014).
Not all referrals lead to an assessment. The numbers of families assessed per year has risen in the period from an estimated 120,000 (1991-1992) to 483,800 (2013-2014). Expressed as a percentage the number of referrals which led to assessment rose from 25.0% to 26.5%. Why all referrals are not assessed is unclear, but the percentage over the period appears to have stayed almost the same. This also requires further investigation, particularly in light of the statistically significant changes in referral and outcome ratios noted above.


The 22 years covered by this analysis have been subdivided into two sections: 1991/1992 to 2008/2009 and 2008/2009 to 2013/2014. These periods reflect changes in policy and/or practice.

- **Section 1**: In the seventeen years after the Children Act 1989 came into force (the period 1991/1992 to 2008/2009) the number of referrals of children into Children’s Services Departments more than trebled (242% increase) while the number of children registered on the CPR or with a CPP fell by 12%. The data shows that the vast majority of referred and assessed children were considered to fall below the threshold for registration. Added to the number of referrals which were not assessed at all, this measure implies there are vastly more referrals than actual cases where children have been significantly harmed, or where children are at risk of significant harm.

- **Section 2**: In the subsequent five years (i.e. from 2008/2009 to 2013/2014) referrals increased again by a further 20%. Children with a CPP increased by 42% from 2008/2009 but by only 25% when compared to 1991/1992. The proportion of referrals which did not meet the threshold criteria for assessment in 2008/2009 rose to 36.2% from the 1991/1992 figure of 25%. However, by 2013/2014 this had fallen back to 26.5%. The reasons for this are not clear and need further investigation, but the Children Act 2004 coming into force and the ‘Baby P’ effect are likely factors (see later section on p.36).

Figure 5 (below) shows the numbers of children passing through the decision making stages of the referral system using the data in Table 1. Although the number of referrals for 1991/1992 are eclipsed by the 2008/2009 and 2013/2014 numbers
the number of conferences and registrations on the CPR or formation of CPPs are very similar. The number of children (and their families), who are not assessed following referral is much greater post 1991/1992.

Continuous Assessments are a new development following the Munro review and report. Continuous Assessment combines Initial and Core assessment, replacing both. Core Assessments were more in depth assessments that followed an Initial Assessment, should one be considered necessary. There are therefore no comparative numbers for Continuous Assessments from earlier years. For this analysis the important issue is whether children (and their families) are assessed at all post referral and this is achieved by combining the types of assessment for comparative purposes (e.g. into an ‘All Assessments’ category). For 2013/2014 summing the number of Initial Assessments and Continuous Assessments together gives the most accurate number of families initially assessed following referral. This is then used to estimate the number of families not assessed following referral, subtracting the sum from the total number of referrals in the year (to give D).

The next analysis shows the proportion of referrals that, following assessment, result in escalation across the threshold to the non-consensual stages of the process. This is measured by the number of registrations on the CPR or formation of a CPP following assessment.

Figure 6 shows the ratios (B/A, C/A and D/A), calculated from Table 1 and expressed as a bar chart.
Ratio 1 (B/A) is the proportion of referred children (and their families) who are on the CPR or who have a CPP at 31 March in the year of interest as a percentage of the referrals in that year (i.e. from 1 April to 31 March). For example in 1991/1992 the relevant dates are 1 April 1991 and 31 March 1992. The referral is an indication that a trigger threshold has been exceeded to bring them to the attention of the local authority Children’s Services Department.

The decrease in the value of Ratio 1 over time raises questions about why increasing number of families are being referred and/or assessed but then do not pass the threshold for registration or a CPP. The possibilities are listed on p.20. These areas require further research.

It is important to note that Ratio 1 (B/A) is not measuring the proportion of children referred who result in registration on the CPR or a CPP. Referrals happen throughout the year and the number registered on the CPR or with a CPP is

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measured as at 31 March. It is however the best measure available. More detailed data is held by local authorities but is not made available.

**Ratio 2 (C/A)** is included for completeness. In theory it provides a more accurate estimate of referred children resulting in CPR registration or a CPP. However this measure has its own limitations. Ratio 2 (C/A) is the proportion of referred children who are added to the CPR or have a CPP in the year of interest as a percentage of the referrals in the year (i.e. from 1 April to 31 March). However, this will include additions to the CPR and formations of CPPs which were referred in a previous year and misses those referred in year but are added after the year end.

**Ratio 3 (D/A)** provides a different performance measure. It looks at the proportion of children (and their families) not assessed following referral in each year (i.e. the number of children not assessed in the year as a proportion of referrals in the year 1 April to 31 March). The number not assessed is a calculation of the number of referrals, less the number assessed in year as a proportion of those referred in the same year. This is an approximation as the available statistics are not sufficiently detailed to match each individual referral against whether it did, or did not result in an assessment but provides the best analysis possible from the data. The reasons why such a large proportion of referrals are not assessed include:

- Some children should not have been referred in the first place and are not assessed because they do not meet any criteria for assessment. Third party referrals may tend to be risk averse and referrals could be made ‘just to be on the safe side’, to avoid the risk of criticism, or because child protection training (e.g. for educators and the NHS) suggests reporting should be routine based on ‘signs of abuse’ detected from children’s behaviour. This issue will be considered in the project’s second Interim Report on the use of risk assessment in child protection.
- Poor decision making. Some children who should be categorised as reaching the threshold criteria for assessment could be missed in the large overall number of referrals, resulting in continuing non-fatal abuse or fatality. This would explain the large number of PI and SCR reports (which will be considered in the project’s third Interim Report);
- A lack of resources leading to prioritisation of only the most serious referrals. Given the relatively stable numbers over the years it could also be indicative
of pragmatism by a system struggling to cope with limited resources, high expectations of child abuse prevention strategies and sanctions for high profile failures.

5.3 Trend analysis

This section provides a trend analysis of the available data for the threshold stages 1-4 in Figure 1. These are the stages which occur before the situation has reached a point where litigation is contemplated. The evidence is compiled from government and associated statistics. This analysis involved assessing how much data was available and where there are gaps, collecting the data, identifying thresholds and carrying out the trend analysis. This work underpins the later stages of the project which will conclude with a suggested efficiency measure of the system.

The relationship between referrals, the state’s response to them and their outcome are of interest as they have implications for the whole of the system in relation for example to costs, resources and the positive and negative implications for families.52

The data provides an analysis of the threshold stages from referral through to a decision to register a child either on the CPR or for a CPP.53 The assessment, set out in Working Together54 and Framework for the Assessment of Children in Need and their Families55 describes the framework for decision making to decide an outcome of ‘no further action’ (NFA), that services should be provided under s.17 and/or that the case should be escalated into s.47 processes. The manner and type of assessment has been subject to several policy changes since the implementation of the Children Act 1989. The latest change took place in 2013 with a new edition of Working Together to Safeguard Children56 published in light of Munro’s

52 All these are possible ‘efficiency’ or ‘success’ criteria depending on the reason for the measurement. For example, a high level of spend may be justified if it significantly increases welfare. However a high financial spend may not be justified if there is weak evidence to demonstrate it results in an increased level of welfare.
53 See the threshold diagram. Figure 1 on p. 8.
recommendations. This removes the separations between types of assessment and time constraints for them to be carried out. This poses a problem for comparative data analysis as the changes in assessment policy and purpose make it difficult to directly compare the threshold data year on year. The significant changes have occurred at the following points:

- At the point of implementation of the Children Act 1989. Initially data was not systematically collected or collated by central government so the early available data is based on an official estimate. The data in relation to 1991/92 has been obtained from Messages from Research and is compared with the government Statistical Release Data released for later years. 1991/1992 was selected as it was the first data set that was collected following the Children Act 1989. Data for 2008/2009 and 2013/2014 is used for comparison with the 1991/1992 data;

- Between the implementation of the Children Act 1989 and the mid-1990s referrals were ‘screened out’ of child protection assessments as opposed to ‘screened in’. This meant all referrals were initially treated as allegations of child abuse;

- In the mid-1990s there was a policy shift in assessments to the opposite approach; ‘screening in’ referrals as opposed to ‘screening out’. This meant all referrals were initially treated as requests for services for children in need;

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58 Department of Health (1995) Child Protection Messages from Research HMSO, London, provides useful numbers although it is noted on p. 28 that the results are not precise.

59 See Section 8.2 Statistical Data Sources, References & Bibliography on p. 60 below.

60 The 1991/1992 data has been obtained from Gibbons, J. et al (1995) Operating the Child Protection System: Studies in Child Protection, HMSO, London as there were no Statistical First Releases from government departments at that time giving referral numbers.
In 2013, following the Munro Review and Report, the different types of
assessment were removed. All referrals are now assessed for both risk and
need in a Continuous Assessment.  

The challenges presented by these changes are compounded by the changes to the
categorisation of child abuse, reflecting changes in political and policy emphasis.
Following the Children Act 1989, interest in child protection data analysis focussed
on children on the CPR, ‘looked after’ by a local authority or were the subject of a
court order or a s.47 Inquiry. Hence when Gibbons et al. did their research, the
numbers they derived for referrals and assessment decisions were estimates rather
than precise numbers although they were based on internal government data. The
first official referral figures published by the Department of Health were not made
available until 2002. This data, however, is not centrally audited by government
for consistency across local authority areas, and there is no central audit of the
methods and accuracy of decision making.

It was estimated that in 1991/1992, 160,000 referrals a year were made. It is
unclear how many were intended by the referrer as allegations of child abuse rather
than general concerns or expressions of a family’s need for services. The flowchart
in Messages from Research shows 120,000 cases filtered out of the child protection
process at the early stages, and this, together with the associated text, implies that
many referrals related to children were better categorised as being ‘in need’ than
‘abused’. Whether there are a number of children in need in addition to the
160,000 referred children is not explicit, although it is implied there may be some

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61 This has been piloted in a number of local authorities in 2013/2014 where ‘local authorities now
have the flexibility to carry out a single continuous assessment within 45 working days.’ Department
62 See Table 2 on p. 34.
London.
65 Department Of Health (2003) Personal Social Services: Local Authority Statistics: Referrals,
Assessments and Children and Young People on Child Protection Registers. Year ending 31 March
67 This is implied throughout the discussion in Gibbons, J. et al (1995) Operating the Child Protection
System: Studies in Child Protection, HMSO, London (see particularly pp. 47 and 78) and Department
27,28,39,55 and 56)
from the flowchart which shows an un-numbered category of children in need who received services but did not appear to be subject to a child protection investigation first. Messages from Research states that they can interpret from Gibbons et al.’s research that 25,000 s.47 Inquiries a year occur where suspicions of maltreatment or neglect are unsubstantiated, but this number does not appear on their flowchart.

The majority of the data collected and analysed for this research relates to the period when Initial Assessments were carried out to identify whether a referral related to ‘need’ or ‘risk’, and which would progress to a Core Assessment. The two are essentially the same process, but the first occurred within seven days of the referral whereas the second occurred within thirty five working days. Both assessments relied on the same framework. A s.47 Inquiry, carried out by means of a Core Assessment, was the longer assessment pre-Munro recommendations. The method of assessment attracted criticism about its suitability. Davies for example critiqued the use of a Core Assessment for investigating child abuse, concluding that:

‘A s.47 is not a Core Assessment. When the Children Act 1989 stipulated the duty to investigate the assessment framework had not been published therefore it is reasonable to question how a s.47 can be the same as a Core Assessment? A Core Assessment is a

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69 Ibid at p.25
70 Ibid at p.28
71 This framework forms the basis of all government protocols for children. Common Assessment Framework, Initial and Core Assessments and all the Integrated Children’s Systems are included within this framework, with standard forms for all processes including child protection conferences and s.47 Strategy meetings. Recommendation 1 of the Munro Report recommends inter alia abolishing the difference between the two assessments and the time limits. This could have serious adverse consequences for families in relation to the additional strain they are placed under during what could become an ‘open-ended’ assessment. This potential harm must be balanced against any potential increased efficiency in the system. No such analysis has taken place. ‘Recommendation 1: The government should revise both the statutory guidance, Working Together to Safeguard Children and The Framework for the Assessment of Children in Need and their Families and their associated policies to... remove the distinction between Initial and Core Assessments and the associated timescales in respect of these assessments, replacing them with the decisions that are required to be made by qualified social workers when developing an understanding of children’s needs and making and implementing a plan to safeguard and promote their welfare.’ in Munro, E. (2011) The Munro Review of Child Protection: Final Report, A Child Centred System Department for Education, HMSO, London. Executive Summary, p.10, Online at: http://www.official-documents.gov.uk/document/cm80/8062/8062.pdf, [Accessed 12 January 2015]
completely different tool from that of investigation. Assessment focuses on children and their families and not on targeting perpetrators of child abuse and seeking justice for children. An investigation jointly with police of actual or likely significant harm must always involve a focus on strategies to target perpetrators and to assess risk to the child. A Core Assessment is not an assessment of risk.  

It is noted, however, that a Core Assessment was still instigated in a broader range of circumstances than alleged child abuse if more time to assess was needed following an Initial Assessment. All types of assessments occur prior to a decision to hold a Child Protection Conference. This takes place if a decision other than ‘no further action’ (NFA) is reached. The Assessment Framework in Figure 7 shows the remit of assessment, forming the basis of all government protocols for assessing children. This remit remains under the new Working Together to Safeguard Children framework which renders the distinction between the different types of assessment obsolete:

Overall the key trends for all types of assessment across the whole of the 22 year period shows:

- **Referral trends**: A consistent upward trend of referrals into the system; but a consistent downward progressing beyond each threshold stage;

- **Assessment trends**: Regardless of assessment policy relying on ‘screening in’ or ‘screening out’ of child protection investigations, only a very small minority of referred families reach the threshold of significant harm triggering the local authority to take legal action to protect the child.

- **Categorisation of abuse trends**: There has been a marked change in the number of CPR registrations and CPPs placed in each category. Emotional

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abuse and neglect now form the largest categories. This replaces ‘core abuse’ (physical abuse and sexual abuse). These trends raise questions about referral policy and processes, and threshold decision making.

Trends and the decision making process were considered in 1997 by Parton et al. Parton et al referred to earlier research by Lindsey in 1994 which concluded that the number of reports of child abuse and neglect had increased in recent years. Parton et al.’s data from Australia, the USA and the UK support a conclusion of an upward trend of referrals. The increase is not a phenomena restricted to England; it is evident in most, if not all jurisdictions operating a selective service provision model. The findings of this project are directly applicable to all jurisdictions operating a similar model of child protection and rationed welfare service provision.

Parton et al consider ‘funnels and filters’, or professional responses to child abuse reports. Throughout their evaluation, child abuse allegations are largely treated as unproblematic, i.e. allegations are not treated as mixed with referrals for other reasons, although there is a mention of ‘child abuse and neglect reports and referrals’ in relation to Parton et al.’s reference to Lindsey’s findings. Parton et al refer to Cant and Downie’s findings, also from 1994, which demonstrated in relation to data from Western Australia that despite an increase in allegations ‘from less than 3,000 in 1989/90 to nearly 8,000 in 1993/94 the number of substantiated allegations remained fairly constant in line with population growth.’ These findings are similar to the findings in this paper, which show that despite an increasing number of referrals the number of substantiated cases of significant harm to children do not proportionately correspond to the number of referrals.

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80 Ibid, n 78, at p.1.
81 Ibid, at p.3 and see Figure 1.4 ibid at p.4.
Parton et al.’s funnelling and filtering examination shows that as cases move through the primary, secondary, tertiary and quaternary stages significantly fewer numbers are involved. The findings are also fairly consistent regardless of the system under examination. For example, Thorpe’s studies of Western Australia and a local authority in South Wales found the process of filtering was very similar despite different laws and procedures. Parton et al describe the funnelling and filtering as ‘diagnostic deflation’ whereby despite a large number of referrals in, decreasing numbers progress through the successive stages of substantiation.

Our data analysis reveals a similar pattern, shown in a number of Figures and Tables. The remainder of this chapter provides the trend analysis data for:

- Changes to the categorisation of child abuse;
- Referral and decision making trends;
- Additions to the CPR and formation of CPPs;
- Year to year comparative data; and
- Summary of key findings.

5.3.1 Changes to the categorisation of child abuse

The data in Table 2 explains the government’s changing classifications of types of abuse. Until 2000 there were multiple categories which mixed in different types of child abuse, and catch-all categories such as ‘multiple’ or ‘grave concern’. These were abolished as they were seen as being vague and over-used. Post 2000 categories were introduced which forced more specific decisions to be made about categorisation at the point of referral: Figure 8 goes on to illustrate the data concerning all categories of suspected child abuse and potential need. The changes to the categories reflect the tension between the desire to accurately categorise and define child abuse, and the dilemma over how to categorise referrals when the

83 Ibid, p.8 and p.11
84 Ibid, p.12
reason for the referral may be considered to be a mix of needs, behaviours, concerns and/or suspicions. Once a child is registered on the CPR or has a CPP the reason for the registration or creation of a plan is broken down by type of abuse and noted as ‘suspected’, ‘substantiated’ or a ‘significant risk’.

**Table 2 - Government child abuse categories**

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</thead>
<tbody>
<tr>
<td>Neglect, physical abuse and sexual abuse</td>
<td>Neglect only</td>
<td>Neglect, physical injury &amp; sexual abuse</td>
<td>Neglect</td>
</tr>
<tr>
<td>Neglect and physical abuse</td>
<td>Physical injury only</td>
<td>Neglect and physical injury</td>
<td>Physical abuse</td>
</tr>
<tr>
<td>Neglect and sexual abuse</td>
<td>Sexual abuse only</td>
<td>Neglect and sexual abuse</td>
<td>Sexual abuse</td>
</tr>
<tr>
<td>Physical abuse and sexual abuse</td>
<td>Emotional abuse only</td>
<td>Physical injury and sexual abuse</td>
<td>Emotional abuse</td>
</tr>
<tr>
<td>Neglect (only)</td>
<td>Multiple categories</td>
<td>Neglect alone</td>
<td>Multiple / not recommended by 'Working Together'</td>
</tr>
<tr>
<td>Physical abuse (only)</td>
<td>Other</td>
<td>Physical injury alone</td>
<td>Missing/Unknown or Missing/ Indeterminate</td>
</tr>
<tr>
<td>Sexual abuse (only)</td>
<td></td>
<td></td>
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<tr>
<td>Emotional abuse (only)</td>
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<tr>
<td>Grave Concern</td>
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</table>

5.3.2 Referral and threshold decision making trends

**Figure 8 - Referral and threshold decision making trends** shows the number of children passing through the safeguarding and child protection system and how it has changed from year to year. Government data collection and recording policies
changed between 1991/1992 where data estimates were reported by Gibbons et al. Operating the Child Protection System remains the most reliable figures that can be used for comparison. After 2001/2002 referral data was recorded in the Statistical Release Data. The number of children on the CPR or with a CPP was published throughout. Policy and procedures also changed several times via statutory guidance revisions so there is no directly comparative data. Consequently the gap in the comparable data between 1991/1992 and 2001/2002 is indicated by the dashed lines linking the data sets.

The overall increase in referrals between 1991/1992 and 2001/2002 is significant. From 1991/1992 to 2001/2002 the referral rate increased from the 160,000 per year estimate to a peak of 569,400 referrals per year, a 256% increase. The most likely reason for this is the change in assessment policy following the refocusing debate, and the rise in popularity of early intervention strategies. It is notable, however, that despite the overall increase in referrals between 1991 and 2014 there are periods where referrals appear to have fallen then risen. The reasons for this require further investigation, but possible reasons may be the effect of the rule of optimism; or the effect of refocusing with its emphasis on family support, the Children Act 2004 followed by the 'Baby P effect' and the significant media and public repercussions.

Overall since 1991/1992 to 2013/14 a trend of referral can be seen indicating an 311% increase against a steady child population size. The level of Initial Assessments rose by 302% over the period. The number of children who are investigated and are found to be 'at risk' is represented by children registered on the

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87 Ibid.
90 Fourfold increase = 311% increase, based on 160,000 referrals in 1991/1992 to 657,800 cases in 2013/2014; see Table 1 on p. 19. 
91 Note however the uncertainty over whether there are more cases of ‘need’ that did not travel through the referral route (Department of Health (1995) Messages from Research HMSO, London at p. 28, discussed earlier in this paper).
92 The 2013/2014 figure also includes the newly piloted continuous assessments which replaced Initial Assessments in some areas.
93 Fourfold increase = 302% increase, based on 120,000 Initial Assessments in 1991/1992 to 483,800 Initial and Continuous Assessments in 2013/2014.
CPR or children with a CPP. Similarly to Parton et al.'s reports of other research findings these figures have remained relatively constant.\(^9^4\)

This raises questions about the nature of the decision making process and the reasons for decisions to establish why an increasing number of families are being referred but the number of substantiated instances of child abuse is not significantly increasing.\(^9^5\) The NSPCC’s prevalence studies authored respectively by Cawson et al and Radford et al suggest that there is a higher level of abuse than is detected, although we do not necessarily agree their findings relate to prevalence as opposed to incidence. The studies are of value in describing the retrospective recollections of young adults about their childhood experiences and highlight a disjoint between the low level of participants who considered they had been abused, and the significantly higher proportion considered to have been abused by the NSPCC.\(^9^6\) However, even if the prevalence is not known, if it is accepted that there are a significant number of undetected cases it may suggest a system coping with an increased level of bureaucracy and data with insufficient benefit in respect of reduced harm. Alternatively there could be a large number of referrals relating to need which receive attention elsewhere and would therefore not be expected to enable a finding of abuse.

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\(^9^5\) Other issues that could be considered include whether the incidence of ‘child abuse’ is not increasing, but the reporting of is; whether the increased incidence of referral is the result of professional anxiety about failing to identify ‘risk’ and ‘need’ and the resultant consequences, i.e. adverse publicity, loss of job, failure to protect children?


Figure 8 - Referral and threshold decision making trends

Data from Government sources from 1989 to 2014 (see Section 8.2 on p. 62)
5.3.3 **Additions to Child Protection Registers and formation of Child Protection Plans**

This section considers trends in relation to the additions to the CPR and formations of CPPs by:

- Category of abuse; and
- Age of child.

**Figure 9** and **Figure 10** show the breakdown of abuse by category type of children on the CPR or have a CPP. **Figure 9** gives the number of children in each category in each year, while **Figure 10** shows the proportion of the children in each category of abuse as a percentage of the total on the CPR or who have a CPP.

In theory if no evidence of need or risk of harm is found a decision of NFA should be taken. If there is evidence of either risk or need, a Child Protection Conference should be held in order to decide whether a CPP should be made (formerly registration on the CPR). The Child Protection Conference stage is considered the first threshold stage where some evidence of parental insufficiency is necessary for the threshold to be reached.\(^97\)

Over the 22 year period considered, the proportion of referrals which resulted in children being added to the CPR and more recently formation of a CPP gradually increased from 45,300 in 1991-1992 to 48,300 in the 2013-2014 (a 6.6% rise). This indicates a small increase in assessments concluding there was either a risk or actual significant harm. This may indicate an increased level of success in detection, but needs to be considered against the backdrop of the disproportionately higher increase in referrals, a 311% rise from 1991/1992 to 2013/2014. An alternative explanation is that it may be due to a policy to engage families with the government's notions of societal norms and values and engagement with early intervention strategies introduced via increased use of s.17. The data relies entirely on self-reporting by local authorities so it is not possible from this data to establish the

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\(^97\) This was an idea first introduced by Gibbons *et al* as the first point in the process at which there should be an assumption that some evidence of child abuse was able to be substantiated. Using this criterion only 7% of referrals reached this criterion in the years Gibbons *et al* considered. Gibbons, J. *et al* (1995) *Operating the Child Protection System Studies in Child Protection*, HMSO, London.
quality or consistency of decision making, or the methods by which decisions are made.\textsuperscript{98}

Analysis of the data concerning cases reaching a Child Protection Conference shows the increase to be attributable to children registered in the categories of neglect and emotional abuse, whereas physical abuse and sexual abuse registrations have fallen by half over the same period.\textsuperscript{99} On analysis, the trend of physical abuse and sexual abuse are downward while emotional abuse and neglect are on an upward trajectory. Neglect and emotional abuse now make up 76% (2013/2014 data) of the abuse cited for the children having a CPP compared with only 20% in 1992.\textsuperscript{100} Sexual abuse and physical abuse in 1992 accounted for 32% in 1991/1992 compared to only 14% in 2013/2014.

There may be a number of reasons for the trend. It is possible that ‘core abuse’ is now less prevalent than twenty years ago, or that there has been a transfer effect: cases which would have been registered as physical abuse may be categorised as neglect or emotional abuse. These categories rely less on forensic evidence and are thus more difficult to challenge, and there may be less opposition from parents who may perceive them to be less punitive categorisations.

The increase in emotional abuse and neglect also corresponds to the categories of child abuse with the most potential for an expansion in interpretation. Also, behaviours constituting emotional abuse may now have changed. Society is increasingly focussed on children’s feelings. Parental behaviours that may have been considered acceptable in relation to children’s emotional treatment and wellbeing in the past may not be considered acceptable by the government today. It could also be the case that whole population instances (as opposed to reported cases) of what is considered to be emotional abuse and neglect are increasing while instances of sexual abuse and physical abuse are diminishing. It could also be the

\textsuperscript{98} This is the primary area that from these findings we have flagged for future research.

\textsuperscript{99} The 1991/1992 figures for ‘physical’ and ‘sexual abuse’ accounted for 32% of children on the CPR at 31 March (i.e. 14,700 of 38,600). In comparison the 2013/2014 figures for ‘physical’ and ‘sexual abuse’ halved to 14% (i.e. 6,400 of 48,300).

\textsuperscript{100} The 1991/1992 figures also had the now defunct category of ‘grave concern’ (12,900 children) which could be argued to include significant elements of emotional abuse although this is not specified. Adding in this category and the ‘mixed’ category (2,000 children) to the neglect and abuse gives 53% (i.e. 23,900 of 38,600).
case that detection of suspected sexual abuse has become less prevalent since its peak in the 1980s and early 1990s. On the one hand controversial theories such as recovered memories of sexual abuse may have contributed to a rise in reported suspected cases,\textsuperscript{101} whereas over-reporting and investigation of suspected sexual abuse led to the Cleveland scandal and associated Public Inquiry.\textsuperscript{102}

A general point relevant to all categories of child abuse is that societal changes alter perceptions of what constitutes abuse. Cultural and time driven norms and values drive changes to acceptable parenting practices and standards of living for children. These change over time and what was once considered acceptable may now be unacceptable.

\textsuperscript{101} There is an extensive body of literature and research on this issue. For example Scheflin and Brown's comprehensive review of scientific studies of recovered memories of sexual abuse, Scheflin, A. and Brown (1999) 'The false litigant syndrome; nobody would say that unless it was the truth', 27 The Journal of Psychiatry and Law, pp. 649-705.

Figure 9 - Children on the CPR / with a CPP by category 1988 - 2014

Data from Government sources from 1989 to 2014 (see Section 8.2 on p. 62)
**Figure 10** – Proportion of children on the CPR / with a CPP by category 1988 - 2014\(^{103}\)

![Proportion of children on the CPR / with a CPP by category 1988 - 2014](image)

**Figure 11** shows the age of children on the CPR or with a CPP. The data shows a fall in the number of older children and a steady rise of children under one years of age, including data for unborn children over the last two decades. There was a steady decline in the mid age ranges although in the last couple of years these have shown an increase. The reason for this is not clear, although it is notable that older children are able to corroborate whether or not they have been abused during an assessment, and can also refuse an assessment.

\(^{103}\) Data from Government sources from 1989 to 2014 (see Section 8.2 on p. 61).
5.3.4 Year to year comparative data

In the 22 year period 1991/1992 – 2013/2014 the number of referrals has dramatically increased while the incidence of ‘core abuse’ has reduced. The number of children on the CPR or with a CPP has remained relatively stable. However as a percentage of the total number of children referred the proportion has dramatically fallen from 24.1% to 7.3%.

It is important to note that detecting suspected child abuse or the risk of it is not the only aim of the assessments and that assessment practice has changed over the years to focus on the use of the Framework for the Assessment of Children in Need and their Families. However, every assessment considers significant harm, the

104 Data from Government sources from 1989 to 2014 (see Section 8.2 on p. 61).
risk of significant harm and need\textsuperscript{106} and there are increasing numbers of assessments occurring. Consequently a steadily rising number of families are being assessed in relation to significant harm and risk as well as need. It could be assumed that increased assessment would result in an increase in detection as the 'net' has widened. Even allowing for false positives and negatives an overall proportionate upward trend might be expected. However the total child population in both is almost the same.

\textbf{Table 3} and \textbf{Table 4} show the year to year comparative referral/abuse detection ratios. The detection performance can be expressed as a ratio i.e. the number of substantiated cases compared to the number of referrals into the system for investigation and assessment (\textit{ratio 1} = B/A), \textbf{Table 3} or the converse (\textit{ratio} = (A-B)/A), \textbf{Table 4}.\textsuperscript{107}

\textbf{Table 3}, shows the ratio of referrals which were decided after assessment to amount to significant harm, or the risk of it: Using all abuse categories, the 1991-1992 rate is 24.1\%\textsuperscript{108} dropping to 6.2\%\textsuperscript{109} in 2008-2009, rising to 7.3\%\textsuperscript{110} in 2013-2014. If only 'core abuse' cases are considered then this figure is dramatically lower: 9.2\%\textsuperscript{111} for 1991-1992 and 1.2\%\textsuperscript{112} for 2008-2009, falling to 1.1\%\textsuperscript{113} in 20013-2014.

\begin{table}[h]
\end{table}


\textsuperscript{107} Using the nomenclature of Table 1 on p.18.

\textsuperscript{108} i.e. 38,600/160,000 x 100 = 24.1\%

\textsuperscript{109} i.e. 34,100/547,000 x 100 = 6.2\%

\textsuperscript{110} i.e. 48,300/657,800 x 100 = 7.3\%

\textsuperscript{111} i.e. 14,700/160,000 x 100 = 9.2\%

\textsuperscript{112} i.e. 6,400/547,000 x 100 = 1.2\%

\textsuperscript{113} i.e. 6,970/657,800 x 100 = 1.1\%
Table 3 – Ratios of referrals which did substantiate significant harm or risk of significant harm: total number of referrals

<table>
<thead>
<tr>
<th>Year (1 April to 31 March)</th>
<th>Ratio of referrals where Significant harm (or risk of) substantiated: Total number of referrals</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(All abuse categories)</td>
<td>(Core abuse only)</td>
</tr>
<tr>
<td>1991 - 1992</td>
<td>24.1%</td>
<td>9.2%</td>
</tr>
<tr>
<td>2008 - 2009</td>
<td>6.2%</td>
<td>1.2%</td>
</tr>
<tr>
<td>2013 - 2014</td>
<td>7.3%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Table 4, below is the converse of Table 3 and represents the same data from a non-substantiation perspective. This data will be the subject of the second Interim Report, considering risk assessment.

Table 4 - Ratios of referrals which did not substantiate significant harm or risk of significant harm: total number of referrals

<table>
<thead>
<tr>
<th>Year (1 April to 31 March)</th>
<th>Ratio of referrals where Significant harm (or risk of) NOT substantiated: Total number of referrals</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(All abuse categories)</td>
<td>(Core abuse only)</td>
</tr>
<tr>
<td>1991 - 1992</td>
<td>75.9%</td>
<td>90.8%</td>
</tr>
<tr>
<td>2008 - 2009</td>
<td>93.8%</td>
<td>98.8%</td>
</tr>
<tr>
<td>2013 - 2014</td>
<td>92.7%</td>
<td>98.9%</td>
</tr>
</tbody>
</table>
5.3.5 **Summary of key findings**

- In terms of performance, the increased number of referrals is resulting in an increased number of families who are subject to assessment, but no directly proportionate increase in the amount of detected child abuse;

- There could be several reasons for the increase in referrals. It is too early in the project to draw firm conclusions but some of the reasons could be due to an increase in child abuse; an increase in need compared with 1991/1992; or a change in what constitutes good enough parenting such that referrals would be made in 2013/2014 in circumstances that would not have warranted referring in 1991/1992;

- The Child Protection Conference data, however, does not show a proportionate upward trend. The number of referrals significantly increased over the period but there is no significant proportionate trend in the number of families who progress to a conference.\(^\text{114}\) The number of assessments that progressed to a Child Protection Conference is relatively constant at 40,800 in 1991/1992 to 43,700 in 2008/2009 (a rise of 7.1%), followed subsequently by a rise to 65,200 in 2013/2014 (a further rise of 49.2%). This needs to be placed in the context of the number of referrals entering into the system which rose by 311% over the same period.

- The number of registrations following a Child Protection Conference has increased but there are changes in the categories of child abuse that are given as the reason for registration. Overall, much less ‘core abuse’ is recorded.

6 **Discussion: Trends & the threshold decision making process**

A fundamental point of conflict and concern about the assessment system surrounds the issue of threshold decision making, particularly at the points of referral and assessment. The many questions identified by our trend data supports this as a

\(^{114}\) This is Gibbons et al.’s estimate of the point where substantiation is necessary in order for a family to progress beyond the assessment stage. This approach does not take account of the problem of false positives and false negatives. Gibbons, J. *et al* (1995) *Operating the Child Protection System: Studies in Child Protection*, HMSO, London.
point of concern. Parton et al looked at the decision making process and noted that ‘outcomes in child protection, however they are measured, are the product of information, decisions and actions.’\textsuperscript{115} Smith’s explanation of decision making schemata\textsuperscript{116} suggests that it might be assumed that once a family is subject to a referral the schema operates in such a way that a likely outcome would that a family would travel across the thresholds. In other words, there is a presumption, or confirmation bias, operating from the outset that a family would only be referred into the system for good reason. Those referred into the system should ideally represent families where the ‘significant harm’ or ‘child in need’ threshold is met as a consequence of correct identification and referral.

The numbers, however, demonstrate a different scenario: an increasing number of families are referred into the system, but the trend data shows there is no corresponding increase in the number of substantiated cases of child abuse, bearing in mind Cawson et al and Radford et al suggested prevalence of abused children of around 10% of the whole of the child population in England.\textsuperscript{117} Alternatively, the data might suggest that decisions following referral are incorrectly categorised in a significant number of cases. Further research into the decision making process is needed as the key to understanding the process lies in obtaining detailed information about it at the threshold stages. A large scale follow on project is planned at the end of this project to gather up to date information evaluating the decision making process in light of our data findings.

In the 1990s Parton et al considered post-referral categorisation, drawn from cases of alleged ‘sexual abuse’.\textsuperscript{118} They observed that:

\begin{itemize}
\end{itemize}
‘To understand founded or unfounded reports, cases registered or not registered, children placed in substitute care, judged to be ‘at risk’ and so forth, it is necessary to understand the decision making process.’

The researchers identified ‘drop out points’ as points within the assessment process where, once established, a family is likely to ‘drop out’ of the process. Parton et al considered these occur where:

- Despite something having happened to a child no further service is required and the problem is unlikely to re-occur;
- Where something might have happened but it is unlikely to re-occur;
- Where it is impossible to resolve whether or not ‘something’ has happened; and where the maternal response is acceptable to the investigators.

Although the most obvious reason why cases would be filtered out at the investigation stage is because cases are not substantiated, Parton et al observe decisions are ‘contingent on situated moral reasoning at the time of the investigation’ as opposed to a forensic examination for evidence that certain events had, or had not occurred. Having shown that many cases are inconclusive in relation to evidence of specific events, Parton et al make the point that cases which do not proceed past an initial visit to a family from a social worker could, in reality, either be ‘real cases’ or referrals made in error. Consequently he argues that claims about over or under reporting on the basis of ‘no further action’ cannot be made. This is consistent with our findings. The changes in categorisation, the post-refocusing approach to assessments, uncertainties over the quality and consistency of decision-making, and the absence of data concerning budgetary or other practical constraints make it difficult to conclude. Local authorities have limited budgets in relation to child protection and safeguarding services so some system of prioritisation must operate. It may be that the system can only manage a fixed proportion of cases each year as a result of a resources cap or internal targets.

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119 Ibid, at p.192
120 Ibid, at p.211
121 Ibid, at p.195
Parton et al found that, although the task in relation to assessment is to decide what happened so as to inform decisions about what should happen next, ‘decisions about what actually happened are rarely reached and that most cases are never resolved one way or another.’\(^{122}\) Where there was no conclusion about substantiation but no further action was taken Parton et al found the ‘issue of proof in such cases was suspended’.\(^{123}\) This suggests that the important decision making factors during and following assessment are not based on establishing whether or not actual events occurred, but on more subtle factors. To help explain the complexity of decision making in situations where facts may be difficult to verify Parton et al drew on Garfinkel’s findings from a study of jurors’ decision making which found that jurors apply the ‘rules of daily life’ and the possibility that jurors define decisions retrospectively.\(^{124}\)

Parton et al also found that family characteristics that were relevant in decision making and found that age, gender and family structure ‘are in some way very relevant to decision-making in cases of alleged sexual harm or injury’.\(^{125}\) These are the ‘core abuses’ that Creighton identified in the Register studies.\(^{126}\) Allegations that were ‘non-specific’ tended to result in no further action, and the accounts of the adults and children involved did not act as a criteria in all cases in relation to whether further action was taken.\(^{127}\) Maternal response was an important factor, where a ‘negative’ or ‘unsatisfactory’ maternal response was ‘much more likely to warrant further action’:\(^{128}\)

‘Maternal response as classified by the social worker was the most influential single factor in determining whether children came into care…it was where the mother’s response was deemed unsatisfactory that children ended up in substitute care.’\(^{129}\)

\(^{122}\) Ibid, at pp.192-193
\(^{123}\) Ibid, at p.196
\(^{127}\) Ibid, n 125, at pp.203-204
\(^{128}\) Ibid, at p.204
\(^{129}\) Ibid, at p.205
From the findings Parton et al conclude that the mother’s response during assessment leaves social workers concluding that they are in some ways unable to protect their child. They note that ‘concerns about a mother’s ability to ‘cope’ are expressed as justification in and of themselves’:\textsuperscript{130} in other words no substantiation or direct evidence is needed in relation to decisions at the early thresholds. This suggests that the question of whether parents (particularly mothers) are deemed to be ‘working with’ professionals is perhaps more important than the events leading to the referral or whether those events can be substantiated.

Parton et al.’s findings suggest that rather than any forensic, evidence based process of filtering, decision making is based on moral judgements and a recorded narrative from which subsequent readers of the information on the case file could use to see how decisions were informed. Decisions seemed to be based on social work impressions, not just of the index event but of the surrounding responses. Observations were recorded without need for evidence based justifications. The rule of optimism identified by Eekelaar et al.\textsuperscript{131} may help to explain the dramatic increase in s.17 cases but no corresponding increase in s.47 cases.

The overall conclusions Parton et al draw may be relevant to all types of assessment, not just for those relating to alleged sexual abuse. It provides useful information about how decisions were made in the early 1990s where forensic evidence may be uncertain but awareness of the concept and reality of ‘sexual abuse’ was ascending, as were the highly contested theory that suppressed memories of historic sexual abuse could be recovered through therapy.\textsuperscript{132} He concludes that investigation and decision making is not a forensic process of fact finding to establish what ‘really happened’ as ‘finding out what has ‘really happened’ merely provides the orientation for the response to a report.\textsuperscript{133} As a consequence of

\textsuperscript{130} Ibid, at p.207
the lack of proof most cases they analysed were left uncertain as to what exactly has occurred. This is consistent with our findings.

The latest government statistics show that of 657,800 referrals only 483,800 resulted in assessments, presumably those considered to be most urgent.\footnote{DfE (2014) SFR43/2014, Characteristics of children in need in England, 2013-14, issued 29 October 2014, TSO, London.} There is no data to explain the decision making process in these cases. Summarising the most likely reasons it may be that:

- By detecting need and providing early intervention services some referrals do not escalate to the threshold of coercive intervention;
- Cases are categorised under s.17, enabling early intervention. This may be consensual, but there are questions surrounding whether consent is free and informed. Families may consent through fear or threat of escalation into more coercive measures if they refuse services and monitoring;
- Some cases of significant harm or the risk of significant harm are missed (in other words false negatives occur. The findings of PI and SCR reports conclude this is happening in at least those cases);
- Budget or resourcing constraints are a factor in decision making;
- Many cases involve incorrect, mistaken or false referrals.

Referrals cover a wider population than allegation, notably cases of suspected or actual ‘need’. From the stage where assessment ends, cases are increasingly less likely to progress through the later threshold stages. The tertiary and particularly the quaternary stages of intervention are where major decisions and different considerations come into play. Legal review of the merits of taking such cases forward beyond the threshold stages 1-4 will include \textit{inter alia} the nature and quality of the evidence that will be presented, and whether there is a reasonable prospect of success. It is at this point the assessment schema moves from using the discourse of the social sciences to a legal discourse if further action is to be taken beyond the assessment stages. This shift seems to make a significant difference to the numbers progressing beyond this stage.
In *Operating the Child Protection System* a chapter is dedicated to ‘The Question of Substantiation’. In considering this issue Gibbons *et al* admit that:

‘So far we have treated the reported concerns about child maltreatment (the allegations, or referrals) as non-problematic; as if a reported concern about maltreatment was the same as a ‘case’ of maltreatment.’

This is an unsatisfactory situation for both investigator and the investigated families if the reason for referral amounted to a disputed allegation, or where the reason for the referral (even in cases of suspected ‘need’) is disputed because parents do not agree that they are unable to meet their child’s needs. The local authority’s position in respect of such families is that there is no mechanism to demonstrate ‘innocence’ whereas the family’s position is likely to be that no ‘guilt’ has been demonstrated. There is therefore a grey area leaving both sides dissatisfied with the outcome, and in a potentially conflicted and litigious relationship if a pre-requisite to prevent cases escalating from s.17 to s.47 is that parents concede that ‘working with’ social workers means agreeing with them.

7 **Conclusions**

The data and trend analysis raises some interesting questions about the accuracy of the truths informing the theory of child protection. The methodology underpinning the prevalence number studies raises questions over whether they should be taken to be reliable across the population. If it is the case that more children are being referred than are being abused then it does raise legitimate questions of the number of families subjected to screening; a process which is known to be stressful and in some cases harmful. It raises categorisation questions about the use of s.17


137 There is a large body of literature highlighting harm caused by referral and assessment. Research findings consistently linked suspicion and investigation as causing harm rather than the wider issues of power relations and state interference, although it is sometimes difficult to separate out the harm caused by assessment from harm which occurs later in the process. See for example: Dale, P, Green, R and Fellows, R (2005) *Child protection assessment following serious injuries to infants: fine
measures and whether they have become a quasi-coercive stage masking the clear divisions envisaged in the Children Act 1989, ss. 17 and 47. If there is a tendency towards over-referral the ability of social workers to carry out timely and effective reports is compromised. Serious cases are likely to be missed. There are dangers in relation to both false positives and false negatives.

The findings discussed in this Paper provide a framework for further analysis of the data as the project progresses. The project’s findings have already demonstrated that the number of referrals has dramatically increased although the number of substantiated child abuse cases has not. The number of substantiated cases of ‘core abuse’ has dropped from 9.2% to 1.1% of referrals. The number of referrals has increased by 311% but despite this SCR findings consistently find threshold decision making errors. The system is utilising ever increasing resources to detect abuse that is either not there on the scale suggested by Cawson et al and Radford et al; is undetected; or is being ‘caught’ at the primary and secondary stages. The inability to separate out from the available data what is happening and address this question could prompt more rigorous government data collection to inform further research. It could also prompt investigation of whether there is damage to families and children who are subject to assessment, particularly in cases where there has been an allegation. The present framework can equally be equated to a fishing

expedition for evidence to justify coercive interventions and potential s.31 applications to remove children from families as well as a gateway to services and support. There are obvious tensions and conflicts inherent within this approach.

Further investigation is needed to investigate why there is uncertainty and ambiguity in the collected data and how these issues can be resolved. In part it may be because there is no limit to the behaviours that could be added to the categories of ‘child abuse’. As a result, it is difficult to accurately measure how widespread it is; if we don’t know what it is we can’t measure it’s quantity; some abused children may not be referred at all, or some potential child abuse may be addressed through early intervention strategies and consequently never categorised as abuse.

Despite these issues, it has become commonly understood that there is a high level of undetected child abuse which is part of the paradigm underpinning the theory of child protection. Under the current system the predominantly welfarist approach is providing rationed but consensual services to those who request them under s.17 and those who do not as a way of subverting escalation to s.47 measures. The data illustrates the role of s.17 is expanding and this raises a number of interesting questions about how prevalence studies are understood in this context, and the consequences of mixing welfare and policing roles. The difficulties and complexities of separating data relating to family welfare from data relating to family policing leave a number of important questions for future research. What can be concluded, however, is that there is no data from the prevalence studies when matched against the trend data to suggest there is a statistically significant reduction in child abuse under the current policy.

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138 It is noted there are many reported incidences of requests for service that are not met.
8 References

8.1 Articles, Books & Media


Child Abuse Investigations: The Families’ Perspective Parents Against INjustice (PAIN), 3 Riverside Business Park, Stansted, Essex CM23 8P.


FACT, Online at: [http://www.factuk.org/](http://www.factuk.org/)


FASO, Online at: [http://www.false-allegations.org.uk/](http://www.false-allegations.org.uk/)


8.2 Statistical Data Sources, References & Bibliography


### 8.3 Legislation

Children Act 1989 c.41

Children Act 2004 c.31


Human Rights Act 1998 c.42

### 8.4 Case Law

*Amann v Switzerland* (27798/95) (2000) 30 EHRR 843

8.5 Embedded links

*Rethinking child protection strategy*, Online at:
http://www.uwe.ac.uk/bl/research/childprotectionstrategy.aspx, [Accessed 20 February 2015]