INTRODUCTION: WHY A SAFEGUARDING CHILDREN GUIDE FOR NURSES MIDWIVES?

Introduction

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This chapter will help you to:

- define safeguarding and associated concepts;
- debate the importance of the universality of the nursing and midwifery professions to safeguarding practice;
- compare and contrast the core attributes of safeguarding with the defining attributes of nursing;
- understand the need to promote and protect the best interests of the child.
Introduction

The provision of care to families where issues of possible or actual child maltreatment have been raised is probably one of the most difficult and challenging areas of contemporary practice that nurses and midwives will encounter. Experience suggests that there are three key elements that will help practitioners face such challenges and make a confident, valuable and unique contribution to safeguarding children and promoting their welfare. These elements are:

- a sound knowledge base;
- accessibility of supportive advice and clinical supervision; and
- engagement in integrated working with other children’s services.

Clearly this book cannot provide all of the above. However, what it does aim to do is to provide knowledge for practice in a way that serves to encourage nurses and midwives to be proactive in supporting children and young people to achieve optimum health and well-being and to ensure a timely and professional response to any concerns.

**Points for reflection**

Have you ever come off duty with a feeling that all was not well with a child, young person or their family?
Or wondered whether an expectant mother would be able to provide for the needs of her newborn baby?
Or whether an adult you are caring for has health or social problems that may interfere with their ability to parent?
Have you felt able to take action to share your concerns?

This book will help you to develop your knowledge and skills in safeguarding children, explain how the actions that may be taken by nurses and midwives can protect children and young people from harm, and how you can seek local support.

**Next steps**

As you progress through the book make a note of the actions and pathways that you may follow in ensuring the safety and well-being of a child or young person who you may recognise to be at risk of, or suffering from, significant harm. This should include noting which guidance informs your actions and who else is likely to be involved.

This opening chapter introduces the concept of safeguarding children and young people. The chapter includes a review of the
Victoria Climbie case and the subsequent developments in policy that have sought to improve the lives and life chances of all children. The overarching aim of safeguarding work is to make sure that children and young people are able to reach their potential and enter adulthood successfully and, with appropriate support, knowledge and understanding, nurses and midwives can make a significant contribution to achieving this. The core attributes of these professions and those of safeguarding are discussed and seen to be symbiotic. The chapter closes with an outline of the remainder of the book.

What is ‘safeguarding’?

Interestingly, it would appear that ‘safeguarding’ is a term that has increasingly replaced the notion of ‘protecting children’ when referring to the prevention of, and response to, child abuse and neglect. Recent statutory reconfiguration of the ‘Area Child Protection Committee’ (ACPC) to the ‘Local Safeguarding Children Board’ (LSCB) in England and Wales under the auspices of the Children Act 2004 illustrates the case in point. Safeguarding is best thought of as an umbrella term for a number of different, but related, actions that ensure the well-being of children and young people, all of which may be encompassed within the professional activities of nurses and midwives.

A basic definition of safeguarding is provided in a joint inspectorate review of services for children, young people and their families: here it is suggested that at its simplest safeguarding means ‘keeping children safe from harm such as illness, abuse or injury’ (Commission for Social Care Inspection et al. 2005: 5). However, this definition says little about how this can be achieved. The recent Government guidance for England, *Working Together to Safeguard Children*, opens by emphasising that safeguarding children and young people is primarily accomplished through good parenting: ‘Good parenting involves caring for children’s basic needs, keeping them safe, showing them warmth and love and providing the stimulation needed for their development and to help them achieve their potential, within a stable environment where they experience consistent guidance and boundaries’ (HM Government 2006a: 1).

The guidance also recognises that parenting can be challenging and that parents may require support and help. It notes that early engagement and partnership with professionals is of key importance. Furthermore, the guidance suggests that where parents seek help from the wide range of services available to families this should be seen as a sign of responsibility not of failure. The need for competent
professional judgement, based on a sound assessment of the needs of the child or young person and the parents’ capacity to respond to these needs is made clear at the outset. The guidance notes that the requirement for any compulsory intervention in family life should be seen as ‘exceptional’ (p. 2). This is important because it supports the notion that universal services, such as health and education, have a key role to play in early intervention and support to families experiencing difficulties. Other countries in the UK take a similar stance.

Safeguarding and promoting the welfare of children and young people is thus seen to encompass a number of separate, but interrelated activities (HM Government 2006a). These include: protecting children from maltreatment; preventing impairment of their health and development; and ensuring that they are safe and well cared for. The overarching aim of safeguarding work is to make sure that children and young people are able to reach their potential and enter adulthood successfully.

Child protection is clearly seen as an important part of safeguarding, but refers specifically to the actions undertaken to protect children who are at risk of, or suffering from, significant harm. Crucially, the guidance suggests that proactively safeguarding children and promoting their welfare will reduce the need for interventions to protect children. It thus appears that in comparison with previous child protection guidance there is considerably more emphasis on promoting welfare rather than simply recognising and responding to child abuse and neglect. This has important implications for nurses and midwives who are engaged primarily in preventative services as well as other, more specialist health services that care for children, young people and their families in a variety of settings. Nevertheless, in common with the previous editions of Working Together the emphasis on joint working between agencies and professionals remains, with the recognition that some of the most vulnerable children, especially those at risk of social exclusion, will need coordinated help from a number of agencies including health, education and children’s social care.

The need for joint working and its perceived failings are often reflected in the public inquiries into headline child maltreatment tragedies. Perhaps most notably this includes the [then] Department of Health and Social Security’s (DHSS) report into the death of Maria Colwell (DHSS 1974) and the London Borough of Brent’s inquiry into the death of Jasmine Beckford, published in 1985. Both have been instrumental in the setting up of multi-agency child protection systems and the production of Government guidance and legislation to better protect children. The death of Victoria Climbie and Lord Laming’s subsequent inquiry report, published in 2003, have been pivotal to new guidance and legislation. The new guidance and legislation not only seek to ensure better protection of children, but also to introduce and to
develop wider policies to improve the outcomes for all children and young people, particularly those who are most disadvantaged. The timeline illustrated below, which has been adapted from Corby (2006), provides a quick overview of the key events that have influenced the development of policy and practice in this dynamic field.

1974 Maria Colwell inquiry (non-accidental injury)
   Formation of the child abuse prevention system
1975 Susan Auckland inquiry and Children Act
1974–80 Seventeen public inquiries into child abuse deaths
1980 Broadening of concerns (child abuse)
1981–85 Fifteen public inquiries into child abuse deaths
1984 Short report
1985 Jasmine Beckford inquiry
   MORI poll survey into child sexual abuse
1986–91 Twelve public inquiries into child abuse deaths
1986 Draft Working Together guidelines (child protection)
1987 Kimberley Carlile and Tyra Henry inquiries
1988 Cleveland inquiry and new Working Together guidelines
1989 Children Act
1991 New Working Together guidelines
1995 Child Protection: Messages from Research
1996 National Commission of Inquiry into the Prevention of Child Abuse
1999 New Working Together to Safeguard Children
2000 The framework for assessment of children in need and their families
2000 Safeguarding Children Involved in Prostitution
2002 Safeguarding Children in Whom Illness is Fabricated or Induced
2003 The Victoria Climbie inquiry: Report of an inquiry by Lord Laming
2003 Every Child Matters Green Paper
2004 The Chief Nursing Officer’s Review into the nursing, midwifery and health visiting contribution to vulnerable children
2004 National Service Framework for Children, Young People and Maternity Services: Core Standards
2004 Every Child Matters: Change for Children
2004 Children Act
2005 Safeguarding Children: The Second Joint Chief Inspectors’ Report on Arrangements to Safeguard Children
2006 New Working Together to Safeguard Children

Other ‘headline’ cases that have also been influential in contemporary policy development across the UK include the death of Lauren
Wright (Norfolk Health Authority 2002), Ainlee Walker (who was also known as Ainlee Labonte; Newham Area Child Protection Committee 2002) and Kennedy McFarlane (Hammond 2001; Scottish Executive 2002). However, the importance of the Victoria Climbie inquiry and its findings and recommendations are of particular significance to the nursing profession and are thus outlined in the following section.

The Victoria Climbie inquiry

The report of Lord Laming's inquiry into the death of Victoria Climbie makes disturbing reading (Laming 2003). The report contains vivid details of the appalling maltreatment suffered by this young girl and it clearly highlights 12 key occasions where opportunities to intervene to protect her were missed. Laming described the extent of failures in the system as ‘lamentable’ (p. 3). Nursing staff and their medical colleagues were among the numerous professionals from a range of agencies and organisations who were seen to have failed in their duty to protect Victoria. As Corby (2006) notes, the main recommendations of the report centre on strengthening inter-agency processes, record keeping and information sharing rather than developing the expertise of practitioners per se. Nevertheless, whilst Stevenson (2005b: 97) is clear that the ‘gross deficits’ highlighted in the report do not reflect usual practice in the UK, there are important messages for nurses, especially those working in hospital settings, and thus an outline of the case, drawn from the inquiry report, is given below.

Victoria’s story

Victoria Climbie was born on the Ivory Coast on the 2 November 1991. She was said to be a lovable and intelligent child who, in 1998, was apparently taken by a great aunt to France, and subsequently to England with a view to obtaining a better education and more opportunities for the future. However, what followed was an almost unbelievable sequence of escalating violence and maltreatment that implicated both the great aunt (Marie-Therese Kouao) and a new partner (Carl Manning) as the perpetrators.

The physical abuse and neglect suffered by Victoria ultimately led to her death, aged 8 years and 3 months, on 25 February 2000. The post-mortem, undertaken by a Home Office pathologist, said to be the ‘worse case [of child abuse] he had ever dealt with … or heard of’ (Laming 2003: 1), found 128 separate injuries on her body. It transpired that Victoria had been beaten with implements such as shoes, football
boots, a coat hanger, a wooden cooking spoon and a bicycle chain. Furthermore, she was also said to have spent long periods of time tied up in a bin-bag, covered in urine and faeces and made to eat leftover food off a piece of plastic ‘like a dog’. When Victoria was admitted to hospital in a moribund condition she was found to be bruised, deformed, hypothermic and malnourished. Kouao and Manning are currently both serving life sentences for her murder.

Whilst it is likely that Victoria was hidden from view for much of her last remaining days it transpired that during her time in England she was known to three housing authorities, four social services departments, two police service child protection teams and a National Society for the Prevention of Cruelty to Children (NSPCC) family centre. She was also admitted to two separate hospitals, the first time because of concerns about various cuts and marks on her face and hands and the second time following a scald to her face. The second admission spanned 13 days. Victoria was also seen at some point by a practice nurse, who undertook a ‘new patient’ review. In addition to the contact Victoria and her great aunt had with statutory agencies, she was seen from time to time by distant relatives and also members of the church. For a brief period of time Victoria was also cared for by a childminder. However, she did not, despite the given reasons for her coming to Europe, attend school whilst she was in England. What is notable about the contributions to the inquiry made by the ‘lay people’ who had contact with Victoria, is that they had evidently been concerned about her welfare and in some instances had taken action in contacting statutory agencies to share their concerns.

With the benefit of ‘retrospectoscopy’ (Alper 2005) it is clear that Victoria Climbie was a victim of severe physical abuse and neglect and the failure of so many agencies to protect her seems astonishing. But, as Corby (2006) has highlighted, much of the contact with agencies was centred on issues of homelessness and securing accommodation, rather than responding to any jointly held concerns about Victoria’s safety and well-being. Nevertheless, the focus on the (very real) needs of adults has been documented previously as being a fundamental issue in failings to protect children (London Borough of Brent 1985; Cantrill 2005). In these instances the children and young people appear to take on an invisible quality in the shadow of the problems faced by their parents and carers.

The inquiry recognised that there were some reports of concern from professionals and others who knew Victoria during her short time in the country. She had been noted to be small and frail and had been seen to be inappropriately dressed. The possibilities of child maltreatment were raised by individual health professionals during both hospital admissions. However, as Laming notes:
The concerns that medical and nursing staff at the hospital told me that they felt about Victoria never, in my view, crystallised into anything resembling a clear, well-thought-through picture of what they suspected had happened to her and that would have helped social services in determining how best to deal with her case.

(Laming 2003: 274)

The contribution of the nursing staff, albeit given in hindsight to the inquiry, reflects important omissions and failures in the documentation and reporting of their espoused concerns. Basic social history data, such as where Victoria was at school, does not seem to have been collected (and specific enquiries should always be made of any school-aged child who is missing, or frequently absent, from education). It may be unfair to be judgemental, and to question professional practice, without knowing more about how well the nurses involved in the care of Victoria were prepared or supported in safeguarding practice. It can also be very difficult for nurses and midwives to challenge the clinical decisions made by other colleagues. Nevertheless, the above quote suggests fundamental principles of assessment and care-planning were not followed through. Because of their involvement with the family during Victoria’s hospitalisation, several members of the nursing staff were called to give evidence to the inquiry panel.

**Nursing evidence to the inquiry**

In their evidence to the Laming inquiry nursing staff reported observing and discussing possible physical and behavioural indicators of abuse. These included seeing lesions that they later considered to be serious deliberate physical harm such as burns, belt marks and bites. As worrying were their reports of witnessing Victoria’s demeanour in the presence of Kouao and Manning. This was described as a ‘master and servant’ relationship that they illustrated by describing how Victoria would stand to attention and change from being lively and vivacious to withdrawn and timid on their infrequent visits to the ward. On one occasion she was seen to ‘wet herself’ in their presence. Furthermore, unlike possibly every other child admitted to hospital in the UK, it was perhaps notable that Victoria’s ‘parents’ brought her no treats during her relatively lengthy admission; nursing staff even provided her clothing.

The inquiry report suggests that ‘failure of nursing staff to record their observations in the notes, and the consequent discrepancy between the levels of concern they expressed in their oral evidence and that reflected in the records made at the time, was a matter which arose
with depressing regularity’ (Laming 2003: 261). Laming argued that nurses have a vital contribution to make in recognising and reporting abuse and that this includes a fundamental responsibility to record suspicious injuries. I share this viewpoint and have previously expressed much the same sentiment, based on duties and responsibilities, to the children’s nursing profession (Powell 1997). However, the scale of the challenge of ensuring that such a large and diverse workforce, with many competing priorities and responsibilities, attain competence in safeguarding children practice, as well as having the knowledge base to understand ‘normal’ childhood and family life should not be underestimated.

Inquiry recommendations

Not surprisingly the inquiry made a number of recommendations for health services, especially in relation to the need for good record keeping and documentation of concerns. In addition, the recommendations point to the need to ensure that difference of opinion is reconciled and that any actions or referrals are carefully documented and followed through. Discharge of a child from hospital back into the community is seen to be a pivotal point for ensuring continuity of care and follow-up, particularly if there are outstanding issues or concerns about a child. This may well be a point at which nursing and midwifery staff, who arguably have a greater degree of continuity of care for inpatients when compared with their medical colleagues, can intervene to ensure that it is safe to discharge a child from both a medical and a social perspective.

The Government response

The death of Victoria Climbie and the subsequent inquiry report were highly significant in the development of the Every Child Matters: Change for Children policy programme. This in turn incorporates the National Service Framework for Children, Young People and Maternity Services in England (NSF) (DH 2003; DH, DfES 2004b). The NSF, which also drew on lessons to be learnt from the Kennedy Report of the public inquiry into children’s heart surgery in Bristol (Kennedy 2001), provides an important benchmark for the health and social care of children, young people and their families. Although the Kennedy and Laming reports were looking into disparate areas of care, a unifying theme was the call for professionals to centre their practice first and foremost on the needs and well-being of the child. The NSF, which is evidence-based, outlines 11 national standards for children’s health and social care that form the basis on which service providers will be inspected and is of vital
importance in guiding and developing nursing and midwifery practice. The central thrust of the NSF is that services should be high quality, personalised and centred on the needs of women and children. However, it also picks up on the themes of promoting health and tackling inequalities. Core Standard Five, which relates specifically to safeguarding children, is outlined below, although wider safeguarding practice provides an important thread throughout the whole document.

National Service Frameworks

In England the NSF Core Standard Five states that: ‘All agencies work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed’ (DH, DfES 2004: 145). A number of markers of good practice are suggested. These place an emphasis on the local development of safeguarding policies, procedures and practices, including those concerned with recruiting and managing staff. Prevention is seen to be key with the focus on activities to make certain that children and young people achieve optimal outcomes. The NSF advocates actively involving children, young people and families in assessment processes and ensuring the accessibility of universal services, such as health, education and housing. Particular note is made of the increased likelihood of harm being suffered by children and young people with disabilities, an issue that is highlighted in Chapter 5 of this book.

The standard states categorically that all staff (whatever their level) should understand their roles and responsibilities in safeguarding and promoting the welfare of children and young people. It recognises that they will need both training and support to enable them to do so. The standard also states that senior management must take responsibility for the actions of its staff and that difference in professional opinion will need to be managed. Although a timescale of 10 years has been given for the achievement of the English NSF standards (i.e. working towards achievement by 2014), safeguarding is considered to be a priority. Indeed, the part played by hospital-centred failings in the development of the standards (Kennedy 2001; Laming 2003), led to the early publication of Standard Seven entitled ‘Getting the Right Start: National Service Framework for Children: Standard for Hospital Services’ which, as the title implies, focuses on the care provided to children and young people in hospital (DH 2003). Many of the safeguarding messages contained in this standard were reinforced by the publication of the Core Standards document and, importantly, this included the notion of both individual and corporate responsibilities.

Similar proposals have been incorporated into the Welsh National Service Framework for Children, Young People and Maternity Services
Chapter two of this document highlights core universal standards for all children and young people. Standard Six relates to safeguarding children:

In every area, there are multi-agency and multi-disciplinary systems and services in place, in line with local Area Child Protection Committee (ACPC) procedures, which safeguard and promote children’s welfare and development. These systems enable clear identification of risk, referral to the appropriate statutory agency with the duty to investigate and multi-agency participation in interventions to achieve the best possible outcome for children.

(Welsh Assembly Government 2005: 21)

One of the strengths of the Welsh NSF is that it is matched by an impressive audit tool and some tight deadlines for achievement of its standards. Throughout the UK there is considerable activity currently to improve the lives and life chances of all children and young people. The tragic death of Victoria Climbie, and others who have died from child maltreatment, may have acted as an important catalyst for action, but the wider improvement for the well-being of all children and young people is, perhaps, a fitting legacy.

A safeguarding guide for nurses and midwives

An important driver for writing this book is a belief that the nursing and midwifery professions have not yet reached their potential in what they can uniquely offer the safeguarding agenda. Nor is there necessarily recognition by the professions and others as to what this ‘unique contribution’ may be. This may be due in part to the nursing and midwifery professions’ own history of subservience to the dominant paradigm, but it is also likely to be a reflection of a crowded and adult-centric pre-registration curriculum and limited access to continuing professional development in safeguarding children’s practice. Perhaps, more worryingly, Nayda (2004), who observed the child protection practice of registered nurses in Australia, describes ‘systematic malpractice’ whereby nurses defer decision-making in child abuse cases to medical staff and fail to meet the legal and ethical standards of client advocacy ascribed to contemporary practice.

Yet there are pivotal reasons why nursing and midwifery professionals can, and should, be key players in the field. These include: the universality of nursing and midwifery services for expectant and new parents, children, young people and families; the increasing recogni-
tion of professional accountability as the nursing and midwifery professions take independent lead roles in the provision of modern child- and family-centred health care services in a range of traditional and non-traditional settings; and the shared core attributes of the professions and of safeguarding philosophies. These themes, which will provide a thread throughout the text, are introduced below.

The universality of nursing and midwifery

The universality of nursing and midwifery services means that there are unparalleled opportunities for practitioners to play key roles in safeguarding children and promoting their welfare. Unlike many other professionals who engage in child protection work, the fact that all children, young people and their families will have contact with nurses and midwives, suggests that there will be important opportunities for the provision of preventative support and guidance as well as the early recognition, and where necessary referral, of concerns about possible or actual child maltreatment.

In the UK we expect that every pregnant woman will have access to, and engage with, high quality maternity services. It is also increasingly recognised that for the majority of women, pregnancy and childbirth are normal life events and that care of these women and their babies may be exclusively midwifery-led. Recent guidance for England (HM Government 2006a) acknowledges the importance of midwives in contributing to the identification and care of vulnerable women, especially those who are suffering from domestic violence, in itself an important risk factor for child maltreatment.

Children, young people and their families will continue to have access to nursing services throughout childhood. Specialist Community Public Health Nurses (SCPHNs) practising as health visitors, school nurses, family health nurses (in Scotland) and public health nurses (in Northern Ireland) provide a range of universal services based largely on promoting health and provision of support to individuals, families and communities. In comparison with other groups of nurses and midwives, SCPHNs have tended to play a more dominant role in traditional child protection practice, with a natural progression for some to specialise in lead roles as Named and Designated Professionals. However, recent intercollegiate guidance on the safeguarding roles and competence of health care staff (Royal College of Midwives et al. 2006) recognises that there will be other groups of nurses and midwives who will increasingly have the skills, knowledge and competence to undertake these leadership roles. This reflects the findings of The Chief Nursing Officer’s Review into the Nursing, Midwifery and Health Visiting Contribution to Vulnerable Children (DH, DfES 2004a) which emphasises the responsibility for all nurses and midwives who work with children,
young people and their families to engage in safeguarding children work.

Other nursing and midwifery professionals who will have contact with many children and young people include those working in General Practice and in National Health Service (NHS) Direct and Walk-in Centres. A further group will practise in more specialist or targeted services such as learning disability and child and adolescent mental health services (CAMHS). A significant number of children and young people will also access hospital-based services such as emergency departments and minor injury units, as well as various inpatient and outpatient settings. The inquiry into the death of Victoria Climbie, which is outlined earlier in this chapter, has been central in recent efforts to improve safeguarding practices within hospital settings and the inquiry’s recommendations carry important messages for the nursing profession. In addition, it should be noted that because safeguarding children policy and legislation in the UK applies to all children and young people up to the age of 18 years (generally 16 years in Scotland), whether or not they are living independently, those nurses and midwives who are practising in what might be considered to be ‘adult services’ (e.g. gynaecology) will also have a contribution to make to safeguarding and promoting the welfare of young people cared for in these areas.

Furthermore, it is important to consider the broad range of services that nurses and midwives provide for adults who are parents or carers. In some circumstances, for example where parents have mental health problems, are misusing substances or have other health problems that prevent them from responding to their children’s developmental needs, nurses and midwives will need to ensure that the welfare of children, including unborn babies, takes priority in any care-planning processes.

Case example
Lola, aged 21 years, was taken to the emergency department, having taken an overdose of benzodiazepines after an argument with a boyfriend. She is a single parent living with a 14-month-old daughter. What are the safeguarding issues?

The key safeguarding issue here is that in taking an overdose Lola has not considered the welfare of her child. Indeed, if she was alone with her daughter at the time of the overdose she has jeopardised her daughter’s health and safety as well as her own – the outcome may well have been two fatalities.

Other concerns may arise from the effects on the child of having a depressed mother and her ability to provide the emotional warmth and stimulation essential for her daughter’s development.
Is the argument with the boyfriend part of a spectrum of domestic abuse? If so there are clear links to the increased risk of all forms of child maltreatment.

Is Lola isolated from family and friends? Is she experiencing the effects of poverty and deprivation? Social exclusion is an important risk factor for child maltreatment.

Professional accountability

Nurses and midwives practise in a range of primary and acute care settings. A key unifying factor for the professions, wherever they practise, is the essential role of nurses and midwives in the assessment of health needs for the planning and delivery of care. As Fitzgerald (2002) notes, assessment is a continuous process that should carry on throughout the nurse/patient relationship. This is an important aspect of the increasing autonomy and independence of the profession. Nurses and midwives are expected to base their assessment on formal frameworks that seek to identify the impact of health needs on the daily lived experiences of the ‘patient’ and their ‘family’. Many of these frameworks reflect the development of professional theory and practice since the 1970s and demonstrate that assessment should move beyond the purely physical, embracing psychological, socio-cultural and environmental factors.

Assessment frameworks support nurses and midwives in exercising a high degree of clinical judgement in deciding which actions need to be taken to meet the assessed health needs. Such decisions are made in partnership with the patient and/or their carers. However, what is crucial here is that registered nurses, midwives and SCPHNs are personally and professionally accountable for their practice. This means that they are responsible for their actions (and omissions) in spite of any instructions from other professionals. As we note in places throughout the text, the challenges of safeguarding children and young people can lead to differences of opinion within health care teams. It is thus important that nurses and midwives understand how to seek help to address dissonant viewpoints. The continuity of relationships with ‘patients’ and their families, together with the ability to engage in meaningful holistic assessment are important factors in ensuring the safety and well-being of children and young people.

In the UK, the Nursing and Midwifery Council (NMC) set the standards for the conduct, performance and ethics of the nurses, midwives and SCPHNs who are on the professional register (NMC 2004a). The purpose of the professional code is to inform the professions of what is required of them in exercising their professional
accountability in practice. The document also serves to inform the public, other professionals and employers as to the standards expected of nurses, midwives and SCPHNs. Notably, practitioners must:

- ‘Protect and support the health of individual patients and clients
- Protect and support the health of the wider community
- Act in such a way that justifies the trust and confidence the public have in you
- Uphold and enhance the good reputation of the professions.’

(NMC 2004a: 4)

In achieving the above, the professional code acts as an important guide to issues which may concern nurses and midwives in exercising their responsibilities in protecting children and young people. This includes guidance on confidentiality, consent and information sharing which may sometimes be perceived as actual or potential barriers to good safeguarding practice. Chapter 4, which outlines professional roles and responsibilities, revisits the code and explains how practitioners can act to safeguard children and young people, whilst keeping to the requirements of their professional regulatory body.

Core attributes

Nurses and midwives are thus autonomous professionals working with individuals, families and populations in a diversity of settings. The multiplicity of roles has led to difficulties in defining what it is that nursing and midwifery actually is and what it actually does. In the UK, the Royal College of Nursing (RCN) have undertaken extensive consultation in an effort to delineate the characteristics of contemporary nursing and midwifery (RCN 2003). One of the purposes of this work is to provide a tool to help to describe the professions to those who may have a rather narrow and stereotypical image of a subservient professional caring for sick people. In contrast to this image, albeit still recognising the essential caring role, key concepts that define modern nursing are said to include the notions of promoting health, prevention, minimising suffering, empowerment, partnership and holism. 'Partnership' is described as being with patients, their families and in collaboration with the wider multidisciplinary team. This work appears to build on the Government's ambitious plans for a new patient-centred NHS, which emphasises not only the crucial role of nurses and midwives in promoting health but also in reducing inequality (DH 2000a).

Attributes of modern nursing and midwifery have much in common with the core attributes of safeguarding, i.e. assessing need and working in partnership with individual children and young people,
their families and multidisciplinary teams to promote physical and emotional well-being and ensure safety. Taken together with the profession’s universality and accountability this arguably place nurses and midwives at the forefront of safeguarding practice.

This chapter has aimed to provide the rationale for a book on safeguarding specifically aimed at nurses and midwives. Thus far I have argued that this rests on the universality of the professions; the recognition of professional accountability; and the notion of promoting health and well-being as a core purpose of nursing and midwifery. In addition to the rationale already expressed for writing a book such as this, it is notable that it would be extremely unusual for a nurse or midwife not to come across a child protection issue in the course of their practice. This includes not just those nurses working primarily with children and young people, but also those working with vulnerable adults who are parents and carers. Indeed, I would go as far as suggesting that those who go through their careers without encountering a single case of child maltreatment either at work or in their local community may well have knowingly or unknowingly failed in their duty to protect children and young people. Clearly, this is difficult to accept.

Child abuse and neglect have a serious impact on health and development and the effects can last a lifetime. Indeed, there is increasing evidence of the links between childhood abuse and long-term health problems, including major causes of morbidity and premature death in adulthood (NCIPCA 1996; Felitti et al. 1998). The work of Perry (2002) in relation to the severe effects of early global neglect on neurological development has demonstrated the importance of social interaction, communication and touch for normal brain growth and development. Southall et al. (2003) note that maltreatment interferes with children’s emotional and physical development and results in ‘dysfunctional adults’ (p. 102) who suffer from low self-esteem, emotional immaturity, poor coping strategies and mental health problems. For many, but not all, abused children, the effect of child maltreatment does not bode well for their future roles as parents. Inter-generational transmission and child maltreatment itself are both common and potentially preventable. The suggested scale of the problem provides a tentative evidence base on which to inform the development of the education, research and practice of nurses and midwives in this field.

**The scale of the problem**

In contrast with headline cases, fatal or grievous abuse is rare. Most cases of child maltreatment will be of a less dramatic nature, although as with Climbie, the challenge is that a child or young person who is at risk of, or suffering from, maltreatment will rarely be initially
'diagnosed' or 'labelled' as such. Yet, in his evidence to the Laming inquiry, Dr Chris Hobbs, one of the UK’s leading medical experts on child maltreatment suggested that ‘Maltreatment is the biggest cause of morbidity in children’ (Laming 2003: 284). The inquiry report develops this proposition by comparing the likely prevalence of maltreatment with other common health problems in childhood. The suggestion, which may be surprising to some, is that the scale of maltreatment is probably greater than that of well recognised childhood health problems such as diabetes and asthma and should be approached with the same importance and care. This seems to echo Dubowitz and King (1995) who argue that child abuse and neglect, alongside other childhood psychosocial problems, may represent a ‘new morbidity’ in pediatrics that will increase proportionally in the work of professionals as overall improvements in child health are sustained. Hall and Sowden (2005) also recognise that serious, acute childhood illnesses have become less common, but suggest that the care and resources for modern paediatric problems such as psychosocial and Behavioural disorders are inadequate.

Thus, the issue of ongoing assessment, which reflects a full social and developmental history, as well as a careful evaluation of the presenting signs and symptoms, becomes crucial. The notion of the ‘lived daily experiences’ of the child is an important facet of any assessment. This may mean that the nurse or midwife needs to draw information from external sources to inform their clinical judgement. The assessment should be balanced and include a consideration of the strengths and abilities of the parents as well as any risks to the child (Daniel 2005). In all cases the views or perspective of the child or young person should be taken into account. The rights of children and young people to be heard and to be protected from maltreatment, to be healthy, to be safe, to be well cared for and to have the opportunities to achieve their potential, form the underpinning philosophy of this text.

Underpinning philosophy

Child-centredness and children’s rights theories are increasingly reflected in the philosophy of many professionals and groups whose personal and professional lives bring them into contact with children. Many will have been influenced (as I have been) by the commendable work of those authors who have promoted the importance of giving children a voice (e.g. Butler-Sloss 1988; Alderson, 1993; Newell, 1989; Archard, 1993, 2003). The children’s rights movement is given global recognition in the inception of the Convention of the Rights of the Child, adopted by the General Assembly of the United Nations on the
20 November 1989. The Convention, ratified by the UK in 1991, establishes the incontestable rights of children and young people (defined as those less than 18 years of age) and outlines the actions and responsibilities of governments in ensuring that all services for children are offered in a child-centred, rights-based framework. It proposes both welfare rights (such as food, health care, housing and education) and protective rights (from child maltreatment). Both sets of rights reflect safeguarding practice. The rights to protection are enshrined in Article 19 which states:

State parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has care of the child.

Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child, and for those who have care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow up of instances of child maltreatment described herefofore, and, as appropriate, for judicial involvement.

(Article 19, Convention on the Rights of the Child)

A commitment to the Convention is reflected in recent legislation and policy for children in the UK. This may be exemplified by the appointment of Commissioners for Children to all four countries of the UK. However, there is still much to be achieved (e.g. Children’s Rights Alliance for England 2005; Croke and Crowley 2006). As public servants nurses and midwives are ‘agents of the state’, they therefore have a duty to abide by its legislation and policy, including that for safeguarding children. The remainder of this book, which builds on the fundamental rights of the child to be safe from harm, helps them to do so.

Outline of the remaining chapters

Chapter 2 considers contemporary childhood in the UK and explores current challenges to health and well-being. In exploring the nature of childhood, the chapter also considers parenting, particularly in terms of an analysis of ‘good-enough’ parenting as a precursor to under-
standing concepts of safeguarding and child maltreatment. The issues of discipline and corporal punishment are also considered.

Chapter 3 outlines theories and definitions of child maltreatment, especially in relation to recent broadening of our understanding as to what may be considered to be abusive, and how this impacts on policy and practice. This links to a consideration of the epidemiology of maltreatment and the difficulties associated with measurement.

Chapter 4 concentrates on professional roles and responsibilities in the identification and referral of child maltreatment. The chapter draws on current policy in the UK, as this ultimately guides practice.

The next few chapters seek to provide an overview of safeguarding children in special circumstances, many of which will be familiar to nurses and midwives. Chapter 5 considers the needs of vulnerable children; including those who are disabled, victims of sexual exploitation (including ‘on-line’ abuse) or seeking asylum. It also covers the issue of domestic violence, particularly in relation to midwifery practice. Chapter 6 outlines the challenges to protecting children who are at risk of being, or are victims of, fabricated or induced illness.

A whole chapter – Chapter 7 – is devoted to a consideration of neglect and the challenges that it raises for nurses and midwives. The chapter will reflect back to Chapter 2’s deliberation on what is meant by ‘good-enough’ parenting. Chapter 8 considers fatal abuse and the new processes being put in place to review all child deaths. The guidance on serious case reviews is also explained and the chapter highlights the significance of the involvement of health services in cases where children have died from their abuse. The final chapter looks at the way forward in safeguarding practice for nurses and midwives and celebrates the contribution that the professions can surely make.

### Messages for practice

- Child maltreatment is one of the most difficult and challenging aspects of nursing and midwifery practice.
- The overarching aim of safeguarding work is to make sure that children and young people are able to reach their potential and enter adulthood successfully.
- Safeguarding children and young people is primarily accomplished through good parenting. Nurses and midwives can provide advice and support to encourage this.
- Universal services, such as health and education, have a key role to play in early intervention and support to families experiencing difficulties.
- The importance of the Victoria Climbie inquiry and its findings and recommendations are of particular significance to the nursing profession.
Nurses and midwives who are practising in what might be considered to be ‘adult services’ (e.g. gynaecology, occupational health) will also have a contribution to make to safeguarding and promoting the welfare of young people.

Attributes of modern nursing and midwifery have much in common with the core attributes of safeguarding, i.e. assessing need, working in partnership with individual children and young people, their families and multidisciplinary teams to promote physical and emotional well-being and ensure safety.

Children and young people have a right to be heard and to be protected from maltreatment, to be healthy, to be safe, to be well cared for and to have the opportunities to achieve their potential.

Recommended reading