Patrick G. Ayre

The division of child protection from child welfare

Problems in applying the concept of 'significant harm'

Summary

The 1970s, 1980s and early 1990s saw an ever widening gap between child protection and more general child welfare services in England and Wales. Correctly allocating cases to one category or the other became a critical task for professionals working in the field. Judgements about the likelihood of a child suffering 'significant harm' are central to this task, yet little guidance is available about what the phrase means in its entirety or how it should be applied in practice. This study set out to clarify the position by examining how the phrase was used in practice by a selected sample of experienced health and social work staff. The evidence collected suggests flaws in the general approach adopted by professionals to identification and assessment in child protection cases. The data indicate a heavy concentration of attention on the weaknesses of families being assessed rather than their strengths and on parents rather than children. Problems are identified in responding effectively to long-term, chronic abuse such as emotional abuse and neglect. Changes in practice based on these findings have been implemented by a wide range of practice agencies in the study area.

Introdution

During the 1970s and 1980s, a series of celebrated child abuse scandals (Reder, Duncan & Gray, 1993) threatened to overwhelm child care services in England and Wales. Patterns of service in other European countries have been influenced by the public response to *causes célèbres* such as that of Alexander Aminoff in Sweden in 1979 (Christopherson, 1993) but the impact on child welfare in England and Wales was greatly amplified by the large number of cases brought to public attention and by the intensity of the response in the print and broadcast media.

Each of these scandals was followed by an unholy trinity consisting of:

- the aggressive public pillorying in the mass media of those agencies deemed responsible;
- the publication of ever more detailed recommendations to welfare agencies resulting from public enquiries convened to look into the tragedies;
- the issuing by central government of increasingly intricately wrought practice guidance intended to prevent recurrence.

One of the most unfortunate consequences of these developments was the opening up of a widening gulf between child protection and more general child welfare. The risks and complexities of child abuse work in this hazardous environment seemed to require that child protection services and the workers who provided them become highly specialised. The fear of missing something vital encouraged a practice so defensive that it seemed, at times, primarily calculated to protect the system rather than the child. The emphasis on the avoidance of death and serious injury led to a preoccupation with the identification and elimination of danger at the expense of preventive or therapeutic responses. This contrasted sharply with developments in continental Europe. Child welfare workers in France and Italy, for example, were placing much more emphasis on the provision of supportive services for families aimed at the prevention of abuse (Caffo, 1983; Girodet, 1989).

In the competition for scarce resources, the specialist child protection services in England and Wales always had a clear advantage, guaranteed by the awful consequences of failure in this field, not only for the children involved but also for the agencies charged with protecting them. It is, then, hardly surprising that a series of influential and important recent studies have suggested that too many families were being drawn into the scrutiny of the child protection system and further that services in the field of child and family welfare have come to concentrate so narrowly on child protection investigation that little time and money is left for anything else (Audit Commission, 1994; Department of Health, 1995). These findings are having a profound effect on the realignment of child care services in England and Wales, but the perception of child protection as a particularly hazardous activity and its enduring appeal to the media as a source of front page headlines inevitably place constraints on the rate of change.

Within this context of highly differentiated child welfare and child protection services and of an uneven distribution of resources between them, it is particularly important that the professionals operating the system are able to place cases confidently and reliably in the appropriate category. In England and Wales, this decision rests on the assessment of 'significant harm'.

Significant harm

When the Children Act 1989 came into force in October 1991, it introduced significant harm as a key concept in child care practice in England and Wales. The decision about when a 'child in need' can also be regarded as a 'child at risk', thus becoming subject to the rigours of the child protection system, turns on the judgement of whether the child is suffering or likely to suffer significant harm. Yet nowhere in the Act or accompanying guidance is the whole phrase defined, nor is comprehensive guidance given about how it is to be applied in practice. This

poses a severe challenge for child welfare professionals charged with contributing to this crucially important assessment.

Under guidance issued by central government on arrangements for inter-agency co-operation in child protection in England and Wales (Department of Health, 1991). Area Child Protection Committees exist within each local authority area to co-ordinate services and promote initiatives in child protection. These committees are made up of representatives of all the key agencies working with children and families in the area. One of their most important functions is to produce *manuals* setting out agreed procedures to be adopted in handling cases of proven and suspected abuse. Where practice issues arise which pose problems right across normal agency and professional boundaries, these committees often provide a very useful forum for multi-disciplinary problem solving. In this instance, difficulties in making consistent and reliable judgements about significant harm are faced by doctors, nurses, social workers, teachers and other child care professionals. In 1995, recognising a common need for clarification, the Area Child Protection Committee in Bedfordshire, England established an inter-agency Working Group to provide guidance on this subject.

The approach adopted

The Working Group began by trying to identify any existing published sources of assistance. It was found that the absence of a detailed definition of significant harm and of existing straightforward official guidance about how to set about applying the term in practice is noted widely in both child protection and family law literature (Adcock, White & Hollows, 1991; Freeman, 1992; Bainham, 1993) but it proved very hard to find comprehensive attempts to rectify this situation.

In the absence of detailed official or widely accepted guidance on the subject, it was decided to try to clarify the meaning of the phrase 'significant harm' by examining systematically the way it was used in practice by a selected sample of staff who were recognised as having both expertise and experience in this field of work. A research team consisting of Patrick Ayre of the University of Luton, Jane Stimec of NSPCC[1] and Stephanie Watson from Bedfordshire Social Services was established to undertake this study. NSPCC is an influential and highly-regarded, national voluntary agency working in child protection in England and Wales. Data were collected by semi-structured interviews with 25 practitioners and managers in the two local community health trusts, NSPCC and the Social Services Department who met the following criteria for inclusion:

- they had at least seven years' experience of working with children and families in a child protection context;
- they were involved in making at least ten judgements concerning significant harm each year;
- they were nominated by their employing agency as having particular expertise in this field of work.

The interviews explored specific incidents involving judgements about significant harm in cases in which the participants had been involved recently. Information was recorded on the judgement arrived at in each case and on the factors which were considered relevant to the judgement. Participants were invited to discuss both cases where they had reached the conclusion that significant harm was likely and those where they had considered it unlikely. It was anticipated that analysis of instances of the actual use of the concept of 'significant harm' by those we regard as qualified to use it properly should then allow us to generate the desired general understanding of its meaning in practice.

The approach adopted is one derived from the *Critical Incident Technique* (Flanagan, 1954) which has been described as '... a rather sophisticated method for collecting behavioural data about ingredients of competent behaviour in professions' (Crouch, 1994, p. 30). One of the principal strengths of this technique is that the examination of what happened in specific individual incidents is likely to produce more useful, specific, task-related descriptions of successful performance than the more generalised statements of values and principles often produced using more unstructured interview techniques. This methodology was employed by Dalgleish and Drew (1989) to gather from interviews with practitioners factors relevant to the assessment of risk in a child protection context.

The participants

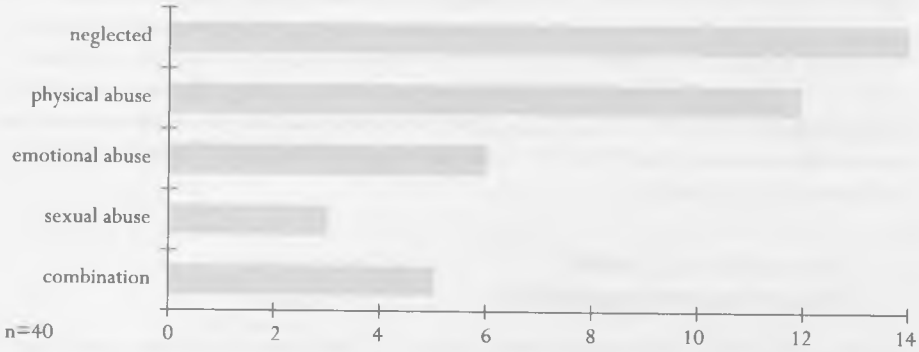
The 25 participants were nine community social workers undertaking long-term child welfare work; six health visitors (community nurses with specialist training in work with children and families); five specialist child protection social workers employed by the local authority or by NSPCC; three workers from family centres and two child protection specialists employed to chair child protection conferences. Almost half of the sample had some degree of responsibility for the supervision of other staff as well as personal practice experience. We had hoped to include a wider range of professionals in the research but it proved difficult to obtain nominations meeting the fairly strict criteria for inclusion.

Before embarking on research with a multi-disciplinary sample, it was important to consider whether factors reported as relevant by health professionals and their managers were likely to be useful to social services staff and vice versa. Research by Wheeler (1992) suggests that the processes and elements of assessment used by social workers and health visitors are in fact very similar, supporting the validity of a mixed sample. Analysis of our own findings did not yield significant differences between any of the groups involved, though the sample was of course a small one.

The cases considered

Participants in the study were asked to select for discussion with the interviewer a case or cases of their choice in which they had recently been required to make a judgement about 'significant harm'. As figure 1 shows, the 25 participants reported a total of 40 cases between them, of which 14 were said to be best described as cases of neglect, 12 were cases of physical abuse, 6 of emotional abuse and 3 of sexual abuse, the remainder being a combination of these. Using comparison with the local register of children receiving child protection services as a yardstick, it would seem that sexual abuse cases were under-represented in our sample and physical abuse cases were over-represented.

Figure 1. *Categories of abuse*



Because the professionals interviewed included health visitors and family centre managers, we anticipated that the age distribution of the children under consideration was likely to be somewhat skewed away from the upper end of the age scale. Of the 39 children whose ages were reported, 21 were under 5 years old, 13 were aged 5 to 10, and 5 were over 10. Using the child protection register as a yardstick again, the sample did demonstrate a substantial under-representation of children and young people over the age of ten, where 11 rather than 5 might have been expected.

Producing a tool to aid assessment

As Flanagan (1954) makes clear, the collection of a large sample of critical incident data will itself provide a functional description of the requirements of the activity in question. Insofar as 'the sample is representative, the judges well qualified, the type of judgements appropriate and well defined and the procedures for observing and reporting such that incidents are reported accurately', the statement of factors involved '...can be expected to be comprehensive, detailed and valid in this form' (Flanagan, 1954, p. 343). However without further analysis aimed at organizing and summarizing the basic data, it would probably be found of very little practical use.

The interviews which we conducted yielded an impressive array of factors relevant to child protection assessment which participants were taking into consideration in their decision making. These factors, numbering 401 in total, seemed to break down readily into four principal categories. These were:

- observations concerning the child;
- observations concerning the individual parents;
- observations concerning the family as whole and relationships within it;
- observations concerning the child protection system and its functioning.

Each of these main categories lent itself to further division into successive groups of sub-categories, so that finally each individual factor mentioned by participants could be located specifically within a hierarchical grid of factors going from the most general to the most specific. By this means, it proved possible to draw up a framework of four grids, reproduced in Figures 2, 3, 4 and 5, which between them summarized the whole set of factors which a group of practitioners with expertise and experience in the field had used in making judgements concerning significant harm (Ayre, Stimec & Watson, 1996). A working tool based on this framework has been produced to assist practitioners in Bedfordshire to assemble relevant information clearly and concisely (Ayre, in press).

Four grids as a result

Observations concerning the child

Factors relating to the child seemed to break down fairly readily into four distinct sub-groups. Into the first are gathered direct evidence of abuse which has come to the professional's notice, such as inflicted bruising, a child being found unsupervised in dangerous circumstances or credible allegations of abuse. Into the second and third are gathered observations which may be taken as suggestive of abuse but fall short of direct evidence. It seemed helpful to distinguish between aspects of the child's development on the one hand and aspects of the child's behaviour on the other, so these are grouped separately. Finally, the participants noted a number of elements concerned with the children's personal characteristics and their history which they considered relevant to the judgement of significant harm, so these appear as a fourth subgroup. It is beyond the scope of this research to provide detailed information about what might constitute evidence of a specific form of abuse like neglect or emotional abuse or, for example, precisely which forms of developmental delay should be considered. However, under the heading Types of Indicator are recorded a few brief thought starters concerning the sort of indication which might be observed (c.f. Figure 2).

Figure 2. *Grid one: observations concerning the child*

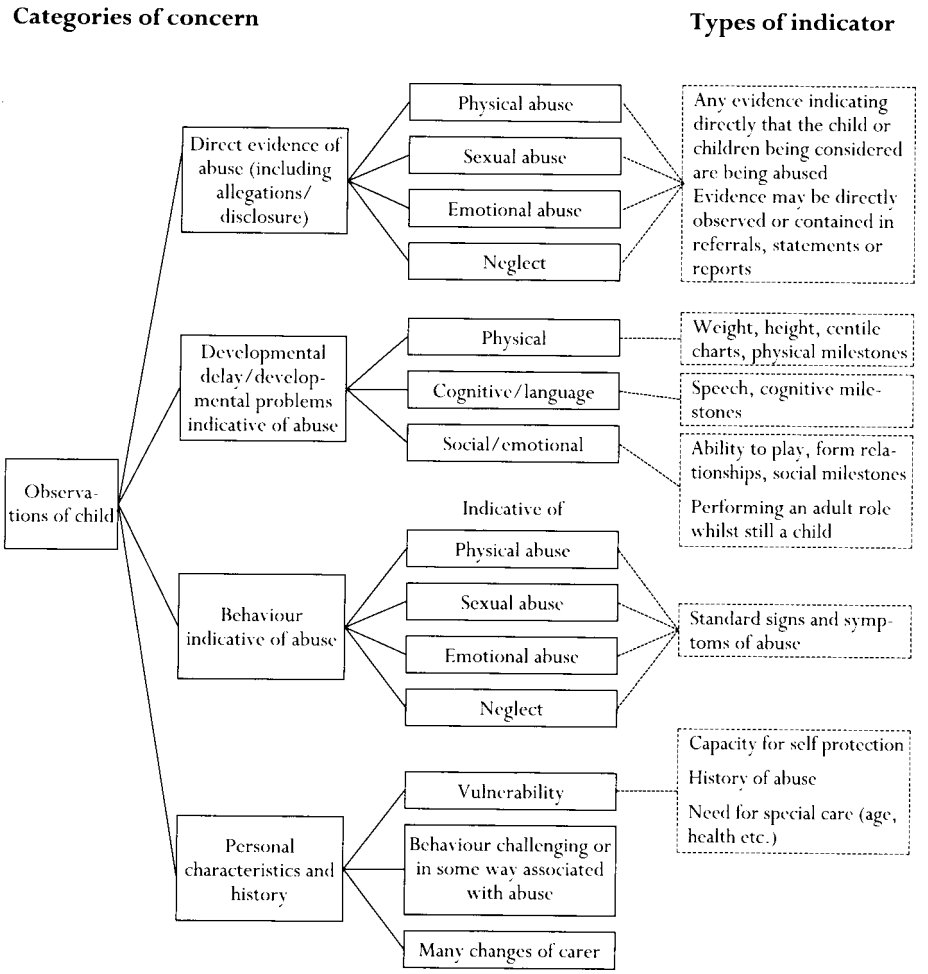
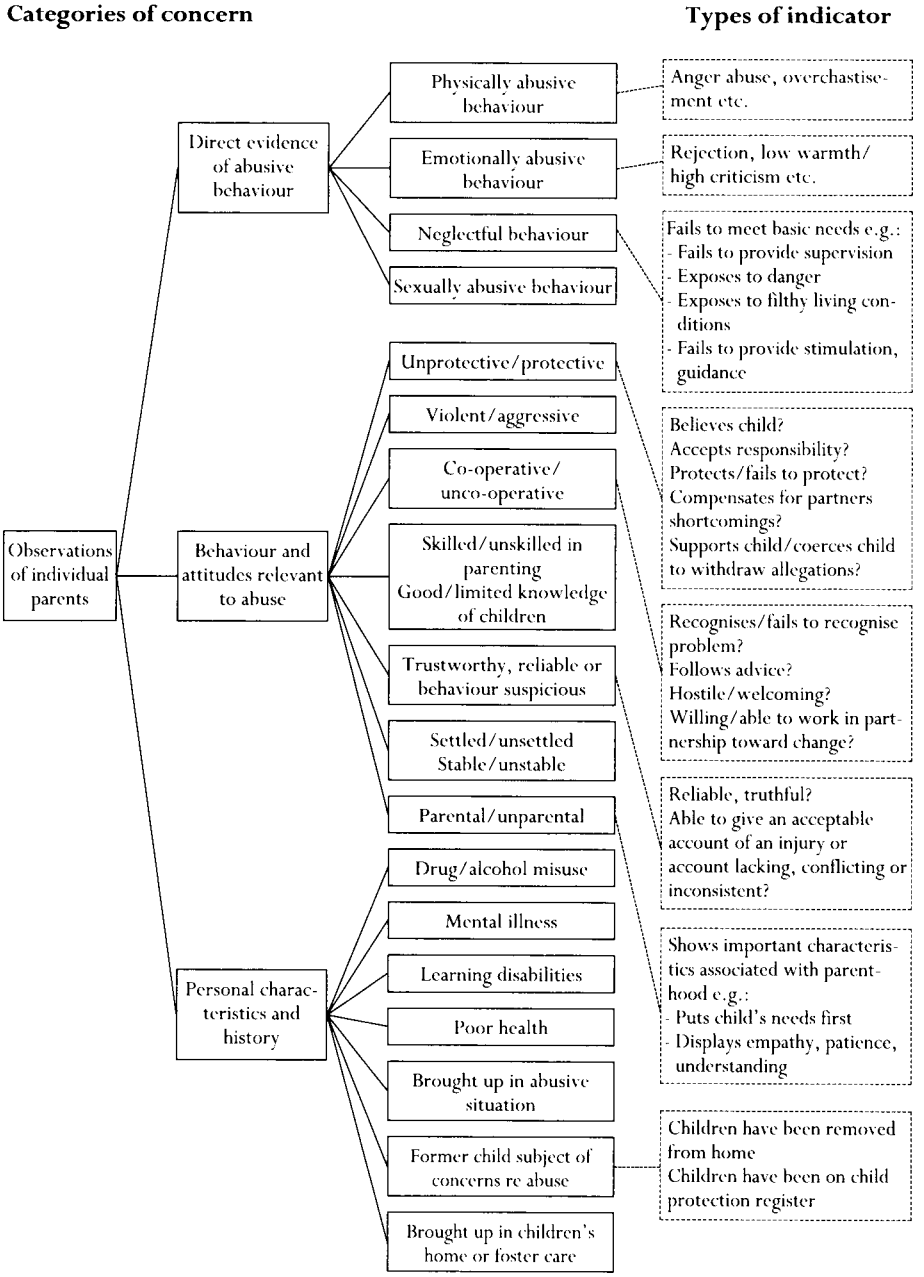


Figure 3. *Grid two: observations concerning the individual parents*



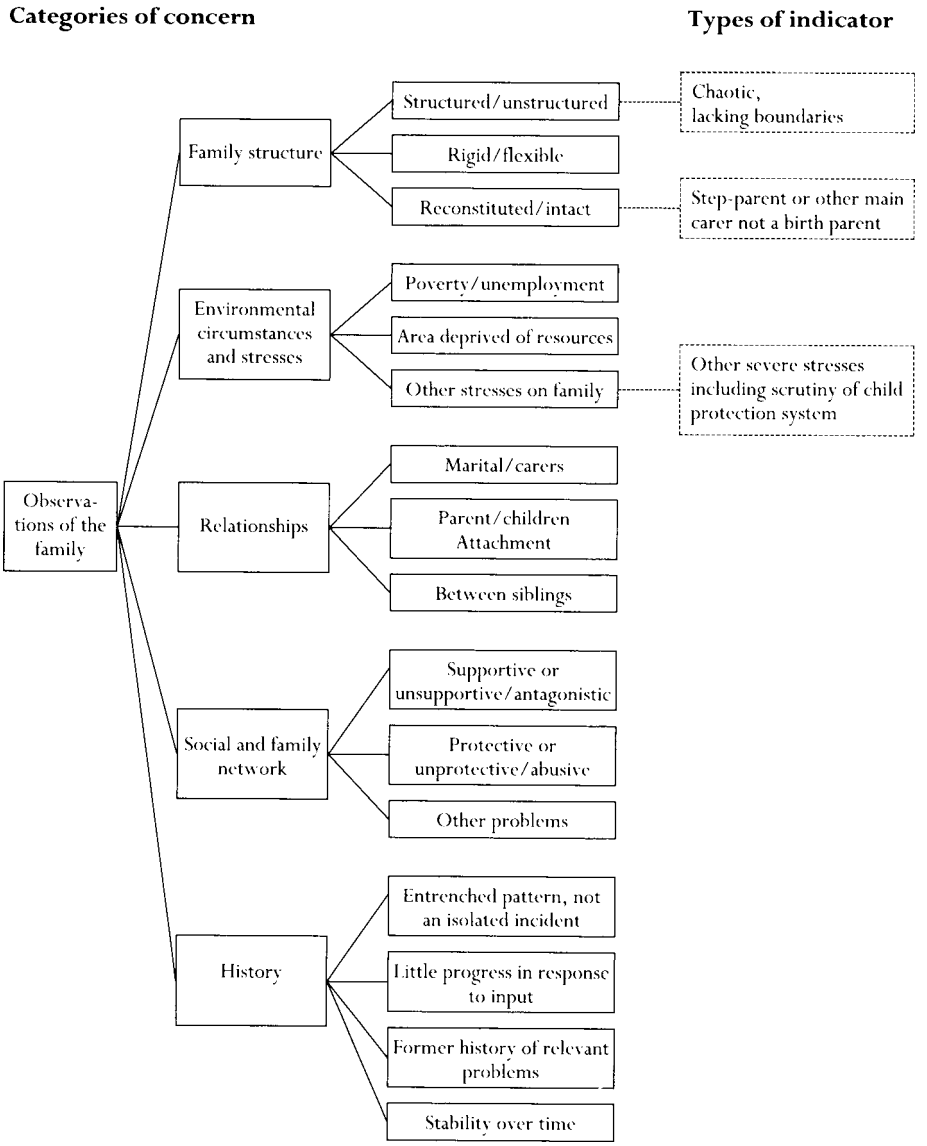
Observations concerning the individual parents

A similar approach was adopted to the classification of factors associated with the parents, though in this case only three sub-groups seemed called for. In the second of these are collected aspects of the parents' behaviour and attitudes which fall short of direct evidence of abusive behaviour but are regarded as suggestive or indicative of abuse. The very heavy weight which seems to be placed on this particular group of factors when judging significant harm is explored later (c.f. Figure 3).

Observations concerning the family as a whole

In this section are gathered factors concerned with the family's structure and relationships within it. Attention is also paid to the wider social environment within which the family functions, in terms of the level of support and resource it provides and of any stresses it causes. The family's history and in particular the history of any identified child care problems within the family were considered important by participants in the research. These factors are grouped together with judgements about the progress made in overcoming such problems (c.f. Figure 4).

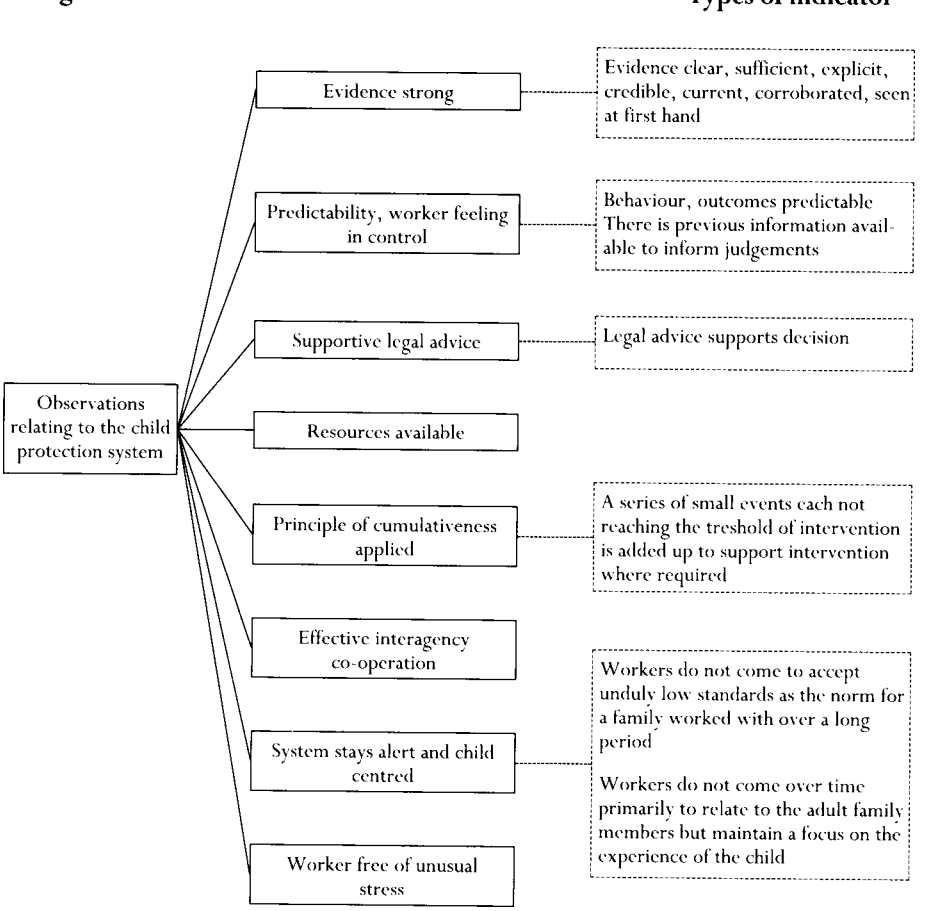
Figure 4. *Grid three: observations concerning the family as a whole*



Observations concerning the child protection system and its functioning

It was felt to be encouraging that several participants explicitly noted in interview that the likelihood of a child suffering significant harm was affected by the functioning and responses of the child protection system. The capacity of professionals and the systems in which they work to be 'dangerous' is widely understood (Department of Health, 1988; Reder *et al.*, 1993; Stone, 1993). Consistent with this, participants mentioned as relevant such factors as the importance of the effective interagency co-operation being maintained in one case, and in others the adverse effect of unusual levels of stress on the worker and of a system which was having difficulty in remaining alert and child centred. They also suggested that the system worked more reliably to keep children safe when the evidence of abuse was relatively clear and one dimensional and when workers felt that outcomes were reasonably predictable and therefore felt more secure in their judgements. The absence of necessary protective, restorative or compensatory resources was noted as making harm more likely (c.f. Figure 5).

Figure 5. *Grid four: observations concerning the child protection system and its functioning*



Using the framework and making a judgement

It is difficult for practitioners called upon to make a judgement as to whether a child is suffering or is likely to suffer 'significant harm' to assemble clearly and concisely the factors upon which the judgement can properly be made. Comparison between the circumstances of a case and the factors contained in the grids can assist in this process. The information having been assembled, however, the decision as to the significance of any harm being suffered or likely to be suffered remains essentially a matter of informed professional judgement, normally on an inter-disciplinary basis.

Sets of detailed 'benchmarks' or rating scales relating to various forms of abuse are often sought by professionals to aid their decision making. However, the more specific such guidance becomes in nominating the particular factors to be considered and the precise levels at which they become significant, the less easy it is to take account of the vital importance of the interaction of the factors with each other and with the child's wider environment.

Whilst we should applaud aids which help us to make more systematic both the collection of information relevant to our decisions and the process of decision making itself, we should be healthily suspicious of systems of scales or benchmarks which may appear to offer to make our decisions for us. Where such complex and risk-laden judgements are involved, the quest for pre-digested answers and authenticated certainties is a very natural one, but it is the very complexity of the judgements which renders simple nostrums unreliable. In such circumstances, it seems appropriate to devote more effort to exploring approaches which offer us the tools to manage more efficiently the *process* of risk assessment and decision making than those which seem to offer to supply us with the *content* or *outcomes*.

Aspects of professional decision making

Although the principal purpose of this project was to derive a framework of factors relevant to the assessment of 'significant harm', we found that close examination of the information we had collected told us a number of important things about the assessment process itself. Much has been learned in recent years from analyses of the frailty of decision making processes in a child protection context (Dingwall, Eekelar & Murray, 1983; Corby, 1987; Dingwall, 1987; Reder, Duncan & Gray, 1993; Hardiker, 1996). However, the findings of this study suggest that substantial problems may still exist. The following points are of particular interest.

Losing sight of the child

For professionals engaged in the protection of children in England and Wales, one of our supreme articles of faith is that the child is always the central focus of our concern. The tragic deaths of Lucie Gates, Heidi Koseda and especially Jasmine Beckford (Reder *et al.*, 1993) showed us clearly the danger of letting our attention slip away from the child and onto the parents. Yet, in our day-to-day practice, how often is the child really at the centre of our attention?

When we analyzed the factors reported by professionals as important in their decision making, we were rather taken aback to find that about twice as many of these factors related to parents and to observation of them as related to observations of the children. As Table 1 shows, the most reported groups of factors were those relating to, in descending order, the parents' general behaviour and attitudes, then the parents' personal characteristics and family history, then observations of actual abusive behaviour on the part of parents. Only after all these do we encounter observations relating to the children themselves. Across the whole survey, factors referring directly to the children were mentioned first in only twelve cases out of forty. Participants were more likely to report observations about the efficient operation of the child protection system than about the child's physical, social and emotional development.

It may be regarded as dangerous if more attention appears to be focused on the behaviour and intentions of the adults than on the children and what they are actually experiencing. This is particularly important in cases of neglect, where a tendency to focus on the parents and on such relatively intangible factors as 'improved attitude' or 'making more effort' may blind us to the unacceptable squalor or danger which remains.

Table 1. *Groups of factors mentioned more than 20 times by interviewed professionals (N=25) as relevant to a judgement on Significant Harm*

Group of factors	Number of times reported
Behaviour and attitudes of parents suggest likelihood of abuse	111
Personal characteristics and history of parents suggest likelihood of abuse	43
Direct evidence of abusive behaviour by parents reported	39
Direct evidence of abuse to child reported	34
Family and case history reported as relevant	31
Child's behaviour suggests likelihood of abuse	30
Effectiveness of the child protection system reported as relevant	29
Child's development suggests likelihood of abuse	22

Chronic abuse and the principle of cumulativeness

Several of those interviewed for the study expressed dissatisfaction with the response of the child protection system to cases characterized by chronic neglect and emotional abuse. In England, we have all become only too aware that chronic abuse and neglect may lead not only to the impairment of children's health and development but even, in some cases, to death (Fitzgerald, 1995). We were able to identify a number of ways in which it seems that the system's response is sometimes inadequate.

In general, the English child protection system is triggered when it is perceived that the threshold of likely significant harm has been crossed. It was suggested to us that few challenges to effective identification are presented by acute cases, particularly in the fields of physical and sexual abuse, where a serious precipitating incident comes to light which clearly crosses the threshold at once. However, many chronic cases may be characterized by a lengthy pattern of actions or incidents, none of which is in itself sufficient to trigger intervention. If we fail to recognize the cumulative impact of these incidents, we risk exposing children to serious and enduring harm.

Experience suggests that there may be three principal reasons for this failure of cumulativeness. The first is that the incidents giving rise to concern may lie scattered through the relevant files, recorded and responded to separately with no one making cumulative connections between them. They may lie unshared on the files of a variety of different interested agencies or unremarked within the files of a single agency. This type of problem is likely to be particularly prevalent in cases which are repeatedly picked up and put down by different workers who deal with the current presenting problem but do not comprehensively review the history. Many 'duty worker' and 'team responsibility' systems may be prone to this failing.

The notion of proportionality provides the second type of challenge to consistent good practice. We tend to feel that our response to any transgression should be in some way proportionate to the transgression itself. Since the English child protection system is often regarded as over-intrusive, leaving the majority of parents feeling 'frightened, ashamed, guilty and totally powerless' following a child abuse investigation (Cleaver & Freeman, 1995), many workers in England and Wales may feel uncomfortable about invoking the full might of the system over a 'minor' incident, even where this incident is just one of a very worrying series.

The third type of problem occurs when workers engaged closely with a family become acclimatised to unacceptably low standards, typified by remarks such as 'What can you expect from this family?' or 'That's the way they are; they've always been the same'. Conditions likely to cause 'significant harm' come to be regarded as the norm and all future incidents come to be judged against this depressed standard, with the result that incidents have to be increasingly serious to be identified as causing concern at all and the cumulative effect on the child is overlooked.

Accentuating the negative

The protocol for the research interviews in this study invited participants to discuss both cases where they had judged 'significant harm' to be likely and those where they had judged it unlikely. They were specifically invited to report those factors which influenced their judgement either way. In view of this, it was very striking that of the 363 factors collected which could be regarded as evaluating the strengths or the weaknesses of the families under scrutiny, no fewer than 325 (90%) were negative or identified weaknesses and only 38 (10%) were positive. Positive factors outweighed negative ones in only 2 out of 40 cases. Indeed, no positive factors at all were reported in over half the cases. Cases where 'significant harm' was judged unlikely had a higher proportion of positive factors, as might be expected, though the negative still slightly outweighed the positive.

In recent years, we have seen much emphasis within professional training for British social workers and health visitors on the importance of identifying and working with the strengths of families. The classic works on risk assessment *Risk and social work* (Brearley, 1982) and *Child abuse and risk* (Bedford, 1987) very clearly show the importance of including an analysis of strengths in our calculations.

However, the adversarial legal context within which much English and Welsh child protection work takes place calls primarily for the collection of evidence to make a case *against* the parents rather than *about*, or even *with*, them, as might be the case in France (Cooper, Hetherington, Baistow, Pitts & Spriggs, 1995) or in Germany, where action can be taken without attaching blame to parents (Christopherson, 1993). Since English child care law tends to promote a fault-oriented bias in the culture of assessment, it is in fact very difficult to find, in many of the standard works which outline the principles of family assessment, much direct guidance on the importance of gathering information on positive, protective factors (Jones, Pickett, Oates & Barbor, 1987; Department of Health, 1988; Adcock, White & Hollows, 1991; Stone, 1993). The evidence of our own research seems to support the view that the professionals involved continue to practice in an environment which encourages them to work mainly to a deficit model with a primary emphasis on identifying weaknesses rather than strengths.

Implications for practice

Some of these findings challenge British child protection agencies to consider how we might adjust our practice to improve the effectiveness of our response to abuse in general and to chronic abuse in particular. The implications for practice can be summarized under five headings.

Making information accessible

In order to ensure that important information does not remain buried within their own records, all relevant agencies in the study area have now adopted the practice of maintaining cumulative summary sheets on the front of their files. These consist of a chronological list of relevant occurrences, each entry being made contemporaneously and being no more than two or three lines in length. These summaries can be shared as part of the regular interchange of information at all formal and less formal interagency meetings, including child protection conferences, and can form part of all case reviews.

A fresh pair of eyes

To avoid the danger of workers becoming acclimatised to unacceptably low standards, cases characterized by long-term poor parenting should be reviewed at agreed intervals by another professional who is not engaged in on-going work with the family. The reviewing worker needs not necessarily be a supervisor nor even be employed by the same agency. Peer and

interagency review may sometimes have distinct advantages. In line with the British emphasis on multi-disciplinary co-operation, all reviews would involve interagency consultation.

It seems particularly important that in relevant cases, such as those characterized by chronic neglect, the review should involve a home visit where conditions *throughout* the house are explored. No proper assessment of a child's living conditions and life experience can be made without access to key areas like the bedroom, toilet and kitchen hut, without the strictures of very firm guidance, it is all too easy to be persuaded against venturing beyond the safety of the living room by embarrassment, by fear of giving offence and even by fear of what we may find.

The rule of three

As we have seen, a significant series of incidents which may add up to a very worrying pattern of abuse can be overlooked either because we get too close to the family and stop seeing things clearly or because each event is in itself too small to attract our full attention. To tackle this problem, Bedfordshire Area Child Protection Committee has decided that any agency identifying serious concern about a child will be responsible for ensuring that an appropriate review takes place promptly. As a minimum, agencies will initiate a review when they have accumulated three referrals or expressions of substantial concern or when they have noted three significantly concerning incidents. This review need not always involve a formal meeting but will involve interagency consultation and information exchange (Ayre, in press).

Maintaining a focus on the child

Whilst maintaining the child at the centre of one's focus is primarily a matter of good professional practice, it would be possible to reinforce the importance of this perspective by enshrining it in guidance on recording, report writing, planning, reviewing and supervision.

If formal reports and summary recording normally started, as a matter of routine, with observations and judgements about the child, the child's views and the child's individual experience, the focus on the child would be actively promoted. Supervisors and those chairing reviews of cases could be specifically allocated the task of trying to perceive things from the child's perspective. Good practice in this area should be reinforced during qualifying and post-qualifying training.

Recognizing strengths

It is clearly important that all reports and summary recordings used in decision making meetings with regard to children contain an assessment of the strengths of the situations being reviewed as well as the weaknesses, with a view to identifying potentially supportive and protective factors and how these might be developed further. Practice guidance, training and report formats can be adjusted to reflect this requirement.

Conclusions

In view of the importance of the central questions raised by this study, further research with a group of participants which is larger, more diverse and drawn from a wider geographical area would be beneficial. However, whilst the small size of the sample used makes it unwise to generalize too widely or assertively on the basis of this research, formal consultation conducted by the commissioning Area Child Protection Committee, with all its constituent agencies, established that a wide range of professionals identified unequivocally with the findings as 'true for us'. To date, two Area Child Protection Committees have asked the author to assist in amending their child protection manuals of procedures to address the recommendations of this study. The impact of these amendments is to be monitored over the next year.

Child care work in England and Wales over the last two decades has come to be characterized by a sharp division between child protection services and more general child welfare and an emphasis on identification and assessment at the expense of therapeutic or preventive intervention. The judgement of the likelihood of 'significant harm' has become a key activity for the professionals involved. Our research showed clearly that the experienced health and social work professionals whom we interviewed were able, in making their judgements, to draw on a very substantial array of factors relevant to assessment. However, we found evidence which suggests that the effectiveness of their work in the identification and assessment of abuse may be being marred by significant flaws in the general approach adopted. The origins of the problems identified seemed diverse, ranging from tensions in the structural underpinnings of the child protection system to failure to apply in practice principles which are universally acclaimed in theory. Nevertheless, it proved possible to suggest concrete adjustments to practice which might facilitate improvement and to have these suggestions for change accepted by Area Child Protection Committees representing a wide range of agencies working with children and their families. The results of their review into the impact of these changes will be awaited with interest.

Note

1. NSPCC historically stood for *National Society for the Prevention of Cruelty to Children*. In this modern age, the full name is considered outdated and NSPCC is regarded as the name of the organization rather than an abbreviation.

References

Adcock, M., White, R. & Hollows, A. (Eds.) (1991). *Significant harm: Its management and outcome*. Croydon: Significant Publications.

Audit Commission (1994). *Seen but not heard*. London: HMSO.

Ayre, P.G. (in press). Judging significant harm. In: Bedfordshire Area Child Protection Committee (Ed.), *Child protection manual of procedures*. Bedford: Bedfordshire Area Child Protection Committee.

Ayre, P.G., Stimec, J. & Watson, S. (1996). *Judging significant harm: Towards an operational definition*. Bedford: Bedfordshire Area Child Protection Committee/University of Luton.

Bainham, A. (1993). *Children: The modern law*. Bristol: Family Law.

Bedford, A. (1987). *Child abuse and risk*. London: NSPCC.

Brearley, P. (1982). *Risk and social work*. London: Routledge.

Caffo, E. (1983). The importance of early intervention for the prevention of child abuse. In J. Leavitt (Ed.), *Child abuse and neglect: Research and innovation* (pp. 75-82). The Hague: Martinus Nijhoff Publishers (NATO AS1 Series).

Christopherson, J. (1993). The Children Act 1989 and child protection: European comparisons. In L. Waterhouse (Ed.), *Child abuse and child abusers: Protection and prevention* (pp. 154-165) London: Jessica Kingsley.

Cleaver, H. & Freeman, P. (1995). *Parental perspectives in cases of suspected child abuse*. London: HMSO.

Cooper, A., Hetherington, R., Baistow, K., Pitts, J. & Spriggs, A. (1995). *Positive child protection: A view from abroad*. Lyme Regis: Russell House Publishing.

Corby, B. (1987). *Working with child abuse*. Milton Keynes: Open University Press.

Crouch, S. (1994). Critical incident analysis. *Nursing, 4* (37), 30-31.

Dalgleish, L. & Drew, E. (1989). The relationship of child abuse indicators to the assessment of perceived risk and to the court's decision to separate. *Child Abuse and Neglect, 13*, 491-506.

Department of Health (1988). *Protecting children*. London: HMSO.

Department of Health (1991). *Working together under the Children Act 1989*. London: HMSO.

Department of Health (1995). *Child protection: Messages from research*. London: HMSO.

Dingwall, R. (1986). The Jasmine Beckford affair. *Modern Law Review, 46*, 489-507.

Dingwall, R., Eekelar, J. & Murray, T. (1983). *The protection of children: State intervention and family life*. Oxford: Blackwell.

Fitzgerald, J. (1995). *Paul: Death through neglect*. London: The Bridge Child Care Consultancy Service.

Flanagan, J. (1954). The critical incident technique. *Psychological Bulletin, 51* (4), 327-358.

Freeman, M. (1992). *Children, their families and the law*. Basingstoke: Macmillan.

Gibbons, J., Conroy, S. & Bell, C. (1995). *Operating the child protection system*. London: HMSO.

Girodet, D. (1989). Prevention and protection in France. In M. Davies & A. Sale (Eds.), *Child protection in Europe* (pp. 13-14). London: NSPCC.

Hardiker, P. (1996). The legal and social construction of significant harm. In M. Hill & J. Aldgate (Eds.), *Child welfare services: Developments in law, policy, practice* and research (pp. 105-119). London: Jessica Kingsley.

Jones, D., Pickett, J., Oates, M. & Barbor, P. (1987). *Understanding child abuse*. Basingstoke: Macmillan.

Reder, P., Duncan S. & Gray, M. (1993). *Beyond blame: Child abuse tragedies revisited*. London: Routledge.

Stone, M. (1993). *Child protection: A model for risk assessment in physical abuse/neglect*. Thames Ditton: Surrey County Council.

Wheeler, S. (1992). Perceptions of child abuse. *Health Visitor, 65* (9), 316-319.