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Barnardo's
Training and Consultancy



Safeguarding and Child Protection SCP2

Day 1

Barnardo's Registered Charity Nos. 216250 and SC037605

Stonewall DIVERSITY CHAMPION
INVESTORS IN PEOPLE
British Quality FOUNDATION Member
CITY & GUILDS APPROVED CENTRE

Course Details

Course Title:

Safeguarding and Child Protection (SCP2)

Course Aims:

To ensure that participants are provided with up to date information and materials about safeguarding children and young people and to offer opportunities to develop and refine skills in this area of work.

Learning Methods

There will be a variety of methods used including group work and skill based exercises

Learning Outcomes – *participants will have the opportunity to:*

- Explain and and apply the latest research and knowledge to inform best practice.
- Demonstrate through discussions and practice and an advanced understanding of current child protection issues.
- Demonstrate an awareness of the emotional dimension of safeguarding work.
- Explore different perspectives on assessment and observation, including dimensions of risk management
- Describe roles in the multi-agency process and be able to work confidently with professionals from other agencies
- Facilitate respectful, safe and realistic environments in which to engage and communicate with parents/carers where there are safeguarding concerns.
- Utilise relevant tools to support structured professional judgment
- Create and utilise opportunities for reflective practice and critical thinking
- Know how to respond using Barnardo's policies on recording, escalation, managing allegations and information sharing

Programmes Times

This is a two day programme. The training day will begin at 9.30 and end at 4.30pm

Please note the programme may change slightly to accommodate the needs of the group

Day 1

- Context and current Issues
- Acquiring and applying knowledge to inform our practice *(Attachment and Child Development)*
- The 'toxic trio' and other risk indicators
- Understanding the emotional impact of this work

Day 2

- Using Kolb cycle in work with Families and young people
- Communicating Effectively
- Process of Reflection
- Understanding Analysis
- Making Plans and moving forward
- Reflection and Evaluation

Domestic violence 'biggest factor' for social services children

By Judith Burns Education reporter

- 4 November 2016
- From the section Education & Family

Domestic violence and poor mental health are the biggest issues facing children on the books of social services in England, new figures show.

Almost half of children deemed to be in need of council support by the end of March this year were victims of domestic violence.

And poor mental health was an issue in more than a third of cases, according to Department for Education statistics.

The NSPCC said the figures were "troubling".

The overall number of children deemed to be "in need" by social services across England stood at 394,000 - a slight rise of 0.9% on the 2015 figure of 391,000 and "relatively stable", according to the government.

Of these, 50,310 were the subject of a child protection plan - up 1.2% on 2015's 49,700 and a figure which continues to rise, having been less than 40,000 in 2010.

The children on the books of social services in March faced an array of problems, the figures suggest.

These include:

- 49.6% faced domestic violence
- 36.6% had mental health problems
- 19.3% had drug abuse issues
- 18.4% alcohol abuse issues
- 17.5% faced neglect
- 6.4% sexual abuse
- 1.2% were involved with gangs
- 0.6% were unaccompanied asylum seekers
- 0.3% were victims of child trafficking

BBC News: 4th Nov 16: NSPCC Research

The largest age group was 10-to-15-year-olds, accounting for 30.6% of the children, while just under a quarter were below five years old and 52.7% of the total group were boys.

An NSPCC spokeswoman said the fact that mental health was identified as a factor in more than a third of cases "highlights why more than ever we need swift and appropriate help for those who are suffering with mental health issues".

She added: "We also know that nine in 10 children who have been abused go on to suffer mental health problems before they reach the age of 18."

The NSPCC is calling on the government to provide improved mental health support for children who have suffered abuse.

The Local Government Association said councils had faced significant funding cuts while the number of children needing help had risen.

"We cannot allow such an unsustainable pressure to build up on a service that protects our most vulnerable children," said Richard Watts, chairman of the LGA's Children and Young People Board.

"Our analysis... warns children's services face a £1.9bn funding gap by 2020. It is vital that local authorities have the resources they need to keep children and young people safe."

Mr Watts said the LGA backed urgent improvements and more investment in Child and Adolescent Mental Health Services, particularly for children in care.

A Department for Education spokesman said keeping children safe from harm was of "paramount importance" and added: "We want to make sure that social workers are supported to make the right decisions for the families they look after.

"That's why in July this year we published plans to improve children's social care, including strengthening protection for the most vulnerable, identifying children at risk as soon as possible and transforming the support available."

CASE STUDY: KATE & TOM JONES

Mother: Mrs Jones

Father: Mr Jones

Subject: Tom Jones (five years)

Subject: Kate Jones (four months)

Kate is a quiet and undemanding baby. She is small for her age and the heath visitor is concerned that her development is delayed.

Tom should attend his local primary school but his attendance is poor. His speech is delayed and he is usually dirty and unkempt in his appearance. He is unable to concentrate and is disruptive in class.

Mrs Jones suffers from depression and drinks heavily.

Mr Jones is working in a low paid job.

CHILD DEVELOPMENT EXERCISE:
CASE STUDY - KATE

O – 12 months:
The Health Visitor reported concerns regarding Kate's physical care as a baby. For example: she was underweight, her nappies weren't always changed, she had frequent colds and she wasn't always appropriately dressed for the weather.

1 – 4 years:
- As she became mobile it was observed that there were few toys in the house and Kate was often left in front of the T.V.
- Her parents varied in their responses to her demands: sometimes giving in and sometimes ignoring her.
- At this time Kate's dad lost his job and started drinking. When drunk he would sometimes hit her mum. Kate witnessed this on several occasions.
- Kate's mum became depressed and was increasingly unavailable to Kate.
- Kate's mum did not take her to playgroup.
- When she was four, Kate was offered a place at Nursery, but her attendance was poor. On one occasion she was found on the street late at night on her own; her parents were in the pub.

5 - 9 years:
- When Kate was five she started school. She was frequently late or absent. She often turned up at school in poor, unclean clothing and was called names by the other kids as a result.
- When in school, she was unable to concentrate on her work and was disruptive in lessons; she fell behind in her educational attainment.
- She was aggressive to both staff and pupils and had very few friends.
- The family moved on two occasions to different local authority areas.
- When she was six, Kate's parents split up, and her mum started a new relationship.
- When Kate was seven, her step-father began sexually abusing her on a regular basis.
- Her grandmother, whom she had been close to, died from cancer. Kate saw her before she died and went to her funeral.

10 - 14 years:
- Kate found the transition to secondary school difficult and the problems she had at primary followed her. In addition, her step-father restricted her activities, refusing to allow her to go out with anybody, children or adults.
- Kate tried to tell her mum what was happening but she refused to believe her.
- When she was 14, Kate told a teacher what was happening and she was taken into care and placed in a residential unit.

15 years plus:
- Kate's behaviour deteriorated: she challenged the staff, stayed out late, and began abusing drugs and alcohol.
- Kate found it difficult to form a positive relationship with anyone: either peer or adult.
- Staff were concerned that she was at risk of being sexually exploited.
- Kate was expelled from school.
- Her relationship with her mother was very poor: her mother blamed her for her husband's behaviour.

Development progress in infants and young children

Sheridan, M, 1988

Chart illustrating the developmental progress of infants and young children

	1 Month	3 Months
Posture and large movements	Lies back with head to one side, arm and leg on same side outstretched, or both arms flexed, knees apart, soles of feet turned inwards. Large jerky movements of limbs, arms more active than legs. At rest, hands closed and thumb turned in. Fingers and toes fan out during extensor movements of limbs. When cheek touched, turns to same side; ear gently rubbed, turns head away. When lifted or pulled to sit, head falls loosely backwards. Held sitting, head falls forward, with back in one complete curve. Placed downwards on fact, head immediately turns to side; arms and legs flexed under body, buttocks humped up. Held standing on hard surface, pressed down feet, straightens body and often makes reflect 'stepping' movements.	Now prefers to lie on back with head in mid-line. Limbs more pliable, movements smoother and more continuous. Waves arms symmetrically. Hands now loosely open. Brings hands together from side into mid-line over chest or chin. Kicks vigorously, legs alternating or occasionally together. Held sitting, holds back straight, except in lumbar region, with head erect and steady for several seconds before bobbing forwards. Placed downwards on face, lifts head and upper chest well up in mid-line, using forearms as support, and often scratching at table surface; legs straight, buttocks flat. Held standing with feet on hard surface, sags at knees.
Vision and fine movements	Turns head and eyes towards light. Stares expressionlessly at brightness of window or blank wall. Follows pencil flash-lamp briefly with eyes at 1 foot. Shuts eyes tightly when pencil light shone directly into them at 1-2 inches. Notices silent dangling toy shaken in line of vision at 6-8 inches and follows its slow movement with eyes from side towards mid-line on level with face through approximately quarter circle, before head falls back to side. Gazes at mother's nearby face when she feeds or talks to him with increasingly alert facial expression.	Visually very alert, particularly interested in nearby human faces. Moves head deliberately to look around him. Follows adult's movements near cot. Follows dangling toy at 6-10 inches above face through half circle from side to side and usually also vertically from chest to brow. Watches movements of own hands before face and beginning to clasp and unclasp hands together in finger play. Recognises feeding bottle and makes eager welcoming movements as it approaches his face. Regards still objects within 6-10 inches for more than a second or two, but seldom fixates continuously. Comerges eyes as dangling toy is moved towards face. Defensive blink shown.

Chart illustrating the developmental progress of infants and young children		
Hearing and speck	Startled by sudden loud noises, stiffens, quivers, links, screws eyes up, extends limbs, fans out fingers and toes, and may cry. Movements momentarily 'frozen' when small bell rung gently 3-5 inches from ear for 3-5 seconds, with 5 second pauses: may 'corner' eyes towards sound. Stops whimpering to sound of nearby soothing human voice, but not when screaming or feeding. Cries lustily when hungry or uncomfortable. Utters little guttural noises when content. (*Note* – deaf babies also cry and vocalise in this reflex way, but if very deaf to not usually show startle reflex to sudden noise. Blind babies may also move eyes towards a sound-making toy. Vision should always be checked separately)	Sudden loud noises still distress, provoking blinking, screwing up of eyes, crying and turning away. Definite quietening or smiling to sound of mother's voice before she touches him, but not when screaming. Vocalises freely when spoken to or pleased. Cries when uncomfortable or annoyed. Quietens to tinkle of spoon in cup or to bell rung gently out of sight for 3-5 seconds at 6-12 inches from ear. May turn eyes and head towards sound: brows may wrinkle and eyes dilate. Often licks lips in response to sounds of preparation for feeding. Shows excitement at sound of approaching footsteps, running bath water, voices, etc. *(Note* – deaf babies, instead, may be obviously startled by mother's sudden appearance beside cot).
Social behaviour and play	Sucks well. Sleeps much of the time when not being fed or handled. Expression still vague, but becoming more alert, progressing to social smiling about 5-6 weeks. Hands normally closed, but if opened, grasps examiner's finger when palm is touched. Stops crying when picked up and spoken to. Mother supports head when carrying, dressing and bathing.	Fixes eyes unblinkingly on mother's face when feeding. Beginning to react to familiar situations – showing by smiles, coos, and excited movements that he recognises preparation for feeds, baths etc. Responds with obvious pleasure to friendly handling, especially when accompanied by playful tickling and vocal sounds. Holds rattle for few moments when placed in hand, but seldom capable of regarding it at same time. Mother supports at shoulders when dressing and bathing.
	6 Months	**9 Months**
Posture and large movements	Lying on back, raises head from pillow. Lifts legs into vertical and grasps foot. Sits with support in cot or pram and turns head from side to side to look around him. Moves arms in brisk and purposeful fashion and holds them up to be lifted.	Sits alone for 10-15 minutes on floor. Can turn body to look sideways while stretching out to grasp dangling toy or to pick up toy from floor. Arms and legs very active in cot, pram and bath. Progresses on floor by rolling or squirming. Attempts to crawl on all fours. Pulls self to stand with support.

Chart illustrating the developmental progress of infants and young children		
	When hands grasped braces shoulders and pulls himself up. Kicks strongly, legs alternating. Can roll over, front to back. Held sitting, head is firmly erect, and back straight. May sit alone momentarily. Placed downwards on fact, lifts head and chest well up, supporting himself on extended arms.	Can stand holding on to support for a few moments, but cannot lower himself. Held standing, steps purposefully on alternate feet.
Vision and fine movements	Visually insatiable, moves head and eyes eagerly in every direction. Eyes move in unison, squint now abnormal. Follows adult's movements across room. Immediately fixates interesting small objects within 6-12 inches (eg toy, bell, wooden cube, spoon, sweet) and stretches out both hands to grasp them. Uses whole hand in palmar grasp. When toys fall from hand over edge of cot forgets them. (Watches rolling balls of 2 to ¼ inch diameter at 10 feet)	Very observant. Stretches out, one hand leading, to grasp small objects immediately on catching sight of them. Manipulates objects with lively interest, passing from hand to hand, turning over, etc. Pokes at small sweet with index finger. Grasps sweets, string etc. between finger and thumb in scissor fashion. Can release toy by pressing against firm surface, but cannot yet put down precisely. Searches in correct place for toys dropped within reach of hands. Looks after toys falling over edge of pram or table. Watches activities of adults, children and animals within 10-12 feet with eager interest for several seconds at a time. (Watches rolling balls 2-⅛ inches at 10 feet)
Hearing and speech	Turns immediately to mother's voice across room. Vocalises tunefully and often, using single and double syllables, eg ka, muh, goo, der, adah, er-lah. Laughs, chuckles and squeals aloud in play. Screams with annoyance. Shows evidence of response to different emotional tones of mother's voice. Responds to baby hearing tests at 1 ½ feet from each ear by correct visual localisation, but may show slightly brisker response on one side. (Tests employed – voice, rattle, cup	Vocalises deliberately as means of interpersonal communication. Shouts to attract attention, listens, then shouts again. Babbles tunefully, repeating syllables in long strings (mam-mam, bab-bab, dad-dad etc.) Understands 'no-no' and 'bye bye'. Tries to imitate adults' playful vocal sounds, eg smacking lips, cough, brr etc. (immediate localising response to baby hearing tests at 3 feet from ear and above and below ear level).

Chart illustrating the developmental progress of infants and young children		
	and spoons, paper, bell; 2 seconds with 2 seconds pause).	
Social behaviour and play	Hands competent to reach for and grasp small toys. Most often uses a two-handed scooping-in approach, but occasionally a single hand. Takes everything to mouth. Beginning to find feet interesting and even useful in grasping. Puts hands to bottle and pats it when feeding. Shakes rattle deliberately to make it sound, often regarding it closely at same time. Still friendly with strangers but occasionally shows some shyness or even slight anxiety, especially if mother is out of sight.	Holds, bites and chews biscuits. Puts hands round bottle or cup when feeding. Tries to grasp spoon when being fed. Throws body back and stiffens in annoyance or resistance. Clearly distinguishes strangers from familiars, and requires reassurance before accepting their advances. Clings to known adult and hides face. Still takes everything to mouth. Seizes bell in one hand. Imitates ringing action, waving or banging it on table, pokes clapper or 'drinks' from bowl. Plays peek-a-boo. Holds out toy held in hand to adult, but cannot yet give. Finds partially hidden toy. May find toy hidden under cup. Mother supports at lower spine when dressing.
	12 Months	**15 Months**
Posture and large movements	Sits well and for indefinite time. Can rise to sitting position from lying down. Crawls rapidly, usually on all fours. Pulls to standing and lets himself down again holding on to furniture. Walks round furniture stepping sideways. Walks with one or both hands held. May stand alone for a few moments. May walk alone.	Walks unevenly with feed wide apart, arms slightly flexed and held above head or at shoulder level to balance. Stands alone, but frequently stopped by falling or bumping into furniture. Lets himself down from standing to sitting by collapsing backwards with bump, or occasionally by falling forward on hands and then back to sitting. Can get to feet alone. Crawls upstairs. Kneels unaided or with slight support on floor and in pram, cot and bath. May be able to stoop to pick up toys from floor.
Vision and fine movements	Picks up small objects, eg blocks, string, sweets and crumbs, with precise pincer grasp of thumb and index finger. Throws toys deliberately and watches them fall to ground. Looks in correct place for toys which roll out of sight. Points with index finger at objects he wants to handle or which interest him.	Picks up string, small sweets and crumbs neatly between thumb and finger. Builds tower of two cubes after demonstration. Grasps crayon and imitates scribble after demonstration. Looks with interest at pictures in book and pats page. Follows with eyes path of cube or small toy swept vigorously from table.

Chart illustrating the developmental progress of infants and young children		
	Watches small toy pulled along floor across room 10 feet away. Out of doors watches movements of people, animals, motor cars etc. with prolonged intent regard. Recognises familiars approaching from 20 feet or more away. Uses both hands freely, but may show preference for one. Clicks two bricks together in imitation. (Watches rolling balls 2-⅛ inches at 10 feet)	Watches small toy pulled across floor up to 12 feet. Points imperiously to objects he wishes to be given. Stands at window and watches events outside intently for several minutes. (Watches and retrieves rolling balls of 2-⅛ inches at 10 feet)
Hearing and speech	Knows and immediately turns to own name. Babbles loudly, tunefully and incessantly. Shows by suitable movements and behaviour that he understands several words in usual context (eg own and family names, walk, dinner, pussy, cup, spoon, ball, car). Comprehends simple commands associated with gesture (give it to daddy, come to mummy, say bye bye, clap hands etc.) Imitates adults playful vocalisations with gleeful enthusiasm. May hand examine common objects on request, eg spoon, cup, ball, shoe. (Immediate response to baby tests at 3-4 ½ feet but rapidly habituates)	Jabbers loudly and freely, using wide range of inflections and phonetic units. Speaks 2-6 recognisable words and understands many more. Vocalises wishes and needs at table. Points to familiar persons, animals, toys etc. when requested. Understands and obeys simple commands (eg shut the door, give me the ball, get your shoes) (Baby test 4 ½ - 6 feet)
Social behaviour and play	Drinks from cup with little assistance. Chews. Holds spoon but usually cannot use it alone. Helps with dressing by holding out arm for sleeve and foot for shoe. Takes objects to mouth less often. Puts wooden cubes in and out of cup or box. Rattles spoon in cup in imitation. Seizes bell by handle and rings briskly in imitation etc. Listens with obvious pleasure to percussion sounds. Repeats activities to reproduce	Holds cup when adult gives and takes back. Holds spoon, brings it to mouth and licks it, but cannot prevent its turning over. Chews well. Helps more constructively with dressing. Indicates when he has wet pants. Pushes large wheeled toy with handle on level ground. Seldom takes toy to mouth. Repeatedly casts objects to floor in play or rejection, usually without watching fall. Physically restless and intensely curious.

Chart illustrating the developmental progress of infants and young children		
	effects. Gives toys to adult on request and sometimes spontaneously. Finds hidden toy quickly. Likes to be constantly within sight and bearing of adult. Demonstrates affection to familiars. Waves 'bye bye' and claps hands in imitation or spontaneously. Child sits, or sometimes stands without support, while mother dresses.	Handles everything within reach. Emotionally labile. Closely dependent upon adult's reassuring presence. Needs constant supervision to protect child from dangers of extended exploration and exploitation of environment.
	18 Months	**2 years**
Posture and large movements	Walks well with feet only slightly apart, starts and stops safely. Runs stiffly upright, eyes fixed on ground 1-2 yards ahead, but cannot continue to run round obstacles. Pushes and pulls large toys, boxes etc. round floor. Can carry large doll or teddy bear while walking and sometimes two. Backs into small chair or slides in sideways. Climbs forward into adult's chair then turns round and sit. Walks upstairs with helping hand. Creeps backwards downstairs. Occasionally bumps down a few steps on buttocks facing forwards. Picks up toy from floor without falling.	Picks up pins and thread etc. neatly and quickly. Removes paper wrapping from small sweet. Builds tower of six cubes (or 6+) Spontaneous circular scribble and dots when given paper and pencil. Imitates vertical line (and sometimes V) Enjoys picture books, recognising fine details in favourite pictures. Turns pages singly. Recognises familiar adults in photograph after once shown. Hand preference becoming evident. (Immediately catches sight of, and names special miniature toys at 10 feet distance. Will now usually tolerate this test with each eye separately). (Watches and retrieves rolling balls 2-⅛ inches at 10 feet)
Vision and fine movements	Picks up small sweets, beads, pins, threads etc. immediately on sight, with delicate pincer grasp. Spontaneous scribble when given crayon and paper, using preferred hand. Builds tower of three cubes after demonstration. Enjoys simple picture book, often recognising and putting finger on coloured items on page. Turns pages 2 or 3 at a time. Fixes eyes on small dangling toy up to 10 feet. (May tolerate this test with each eye separately). Points to distant interesting	Picks up pins and thread etc. neatly and quickly. Removes paper wrapping from small sweet. Builds tower of six cubes (or 6+) Spontaneous circular scribble and dots when given paper and pencil. Imitates vertical line (and sometimes V) Enjoys picture books, recognising fine details in favourite picture. Turns pages singly. Recognises familiar adults in photograph after once shown. Hand preference becoming evident. (Immediately catches sight of, and names special miniature toys at 10 feet

Chart illustrating the developmental progress of infants and young children		
	objects out of doors. (Watches and retrieves rolling balls 2-⅛inches at 10 feet) (Possibly recognises special miniature toys at 10 feet)	distance. Will now usually tolerate this test with each eye separately). (Watches and retrieves rolling balls 2-⅛inches at 10 feet).
Hearing and speck	Continues to jabber tunefully to himself at play. Uses 6-20 recognisable words and understands many more. Echoes prominent or last word addressed to him. Demands desired objects by pointing accompanied by loud, urgent vocalisation or single words. Enjoys nursery rhymes and tries to join in. Attempts to sing. Shows his own or doll's hair, shoe, nose (Possibly special 5 toy test/ Possibly 4 animals picture test)	Uses 50 or more recognisable words and understands many more. Puts 2 or more words together to form simple sentences. Refers to himself by name, Talks to himself continually as he plays. Echolalia almost constant, with one or more stressed words repeated. Constantly asking names of objects. Joins in nursery rhymes and songs. Shows correctly and repeats words for hair, hand, feet, nose, eyes, mouth, shoe on request. (6 toy test, 4 animals picture test).
Social behaviour and play	Lifts and holds cup between both hands. Drinks without spilling. Hands cup back to adult. Chews well. Holds spoon and gets food to mouth. Takes off shoes, socks, hat. Indicates toilet needs by restlessness and vocalisation. Bowel control usually attained. Explores environment energetically. No longer takes toys to mouth. Remembers where objects belong. Casts objects to floor in play or anger less often. Briefly imitates simple activities, eg reading book, kissing doll, brushing floor. Plays contentedly alone, but likes to be near adult. Emotionally still very dependent upon familiar adult, especially mother. Alternates between clinging and resistance.	Lifts and drinks from cup and replaces on table. Spoon feeds without spilling. Asks for food and drink. Chews competently. Puts on hat and shoes. Verbalises toilet needs in reasonable time. Dry during day. Turns door handles,. Often runs outside to explore. Follows mother round house and copies domestic activities in simultaneous play. Engages in simple make believe activities. Constantly demanding mother's attention. Clings tightly in affection, fatigue or fear. Tantrums when frustrated but attention readily distracted. Defends own possessions with determination. As yet no idea of sharing. Plays near other children but not with them. Resentful of attention shown to other children.
	2 ½ Years	**3 Years**
Posture and large	Walks upstairs alone but downstairs holding rail, two feet to	Walks alone upstairs with alternating feet and downstairs with two feet to

Chart illustrating the developmental progress of infants and young children		
movements	a step. Runs well straight forward and climbs easy nursery apparatus. Pushes and pulls large toys skilfully, but has difficulty in steering them round obstacles. Jumps with two feet together. Can stand on tiptoe if shown. Kicks large ball. Sits on tricycle and steers with hands, but still usually propels with feet on ground.	step. Usually jumps from bottom step. Climbs nursery apparatus with agility. Can turn round obstacles and corners while running and also while pushing and pulling large toys. Rides tricycle and can turn wide corners on it. Can walk on tiptoe. Stands momentarily on one foot when shown. Sits with feet crossed at ankles.
Vision and fine movements	Picks up pins, threads etc. with each eye covered separately. Builds tower of seven (or 7+) cubes and lines blocks to form 'train'. Recognises minute details in picture books. Imitates horizontal line and circle (also usually T and V) Paints strokes, dots and circular shapes on easel. Recognises himself in photographs when once shown. Recognises miniature toys and retrieves balls 2-⅛ inches at 10 feet, each eye separately. (May also match special single letter cards V, O, T, H at 10 feet)	Picks up pins, threads etc. with each eye covered separately. Builds tower of nine cubes, also (3 ½) bridge of three from model. Can close fist and wiggle thumb in imitation, R and L Copies circle (also V, H, T) Imitates cross. Draws man with head and usually indication of features or one other part. Matches two or three primary colours (usually red and yellow correct, but may confuse blue and green). Paints 'pictures' with large brush on easel. Cuts with scissors. (Recognises special miniature toys at 10 feet. Performs single-letter vision test at 10 feet. Five letters).
Hearing and speech	Uses 200 or more recognisable words but speech shows numerous infantilisms. Knows full name. Talks intelligibly to himself at play concerning events happening here and now. Echolalia persists. Continually asking questions beginning 'What?', 'Where?' Uses pronouns, I, me and you. Stuttering in eagerness common. Says a few nursery rhymes. Enjoys simple familiar stories read from picture book. (6 toy test, 4 animals picture test, 1st cube test. Full doll vocabulary.)	Large intelligible vocabulary but speech still shows many infantile phonetic substitutions. Gives full name and sex, and (sometimes) age. Uses plurals and pronouns. Still talks to himself in long monologues mostly concerned with the immediate present, including make-believe activities. Carries on simple conversations, and verbalises past experiences. Asks many questions beginning 'What?', 'Where?', 'Who?' Listens eagerly to stories and demands favourites over and over again. Knows several nursery rhymes. (7 toy test, 4 animals picture test, 1st or 2nd cube test, 6 'high frequency' word

Chart illustrating the developmental progress of infants and young children

		pictures).
Social behaviour and play	Eats skilfully with spoon and may use fork. Pulls down pants or knickers at toilet, but seldom able to replace. Dry through night if lifted. Very active, restless and rebellious. Throws violent tantrums and when thwarted or unable to express urgent needs and less easily distracted. Emotionally still very dependent upon adults. Prolonged domestic make-believe play (putting dolls to bed, washing clothes, driving motor cars, etc.) but with frequent reference to friendly adult. Watches other children at play interestedly and occasionally joins in for a few minutes, but little notion of sharing playthings or adult's attention.	Eats with fork and spoon. Washes hands but needs supervision in drying. Can pull pants and knickers down and up but needs help with buttons. Dry though night. General behaviour more amendable. Affectionate and confiding. Likes to help with adult's activities in house and garden. Makes effort to keep his surroundings tidy. Vividly realised make-believe play including invented people and objects. Enjoys floor play with bricks, boxes, toy trains and cars, alone or with siblings. Joins in play with other children in and outdoors. Understands sharing playthings, sweets etc. Shows affection for younger siblings. Shows some appreciation of past and present.
	4 Years	**5 Years**
Posture and large movements	Turns sharp corners running, pushing and pulling. Walks alone up and downstairs, one foot per step. Climbs ladders and trees. Can run on tiptoe. Expert rider of tricycle. Hops on one foot. Stands on one foot 3-5 seconds. Arranges or picks up objects from floor by bending from waist with knees extended.	Runs lightly on toes. Active and skilful in climbing, sliding, swinging, digging and various 'stunts'. Skips on alternative feet. Dances to music. Can stand on one foot 8-10 seconds. Can hop 2-3 yards forwards on each foot separately. Grips strongly with either hand.
Vision and fine movements	Picks up pins, thread, crumbs etc. with each eye covered separately. Builds tower of 10 or more cubes and several 'bridges' of three on request. Builds three steps with six cubes after demonstration. Imitates spreading of hand and bringing thumb into opposition with each finger in turn. R and L Copies cross (also V, H, T and O) Draws man with head, legs,	Picks up minute objects when each eye is covered separately. Builds three steps with six cubes from model. Copies square and triangle (also letters V, T, H, O, X, L, A, C, U, Y). Writes a few letters spontaneously. Draws recognisable man with head, trunk, legs, arms and features. Draws simple house with door, windows, roof and chimney. Counts fingers on one hand with index finger of other.

Chart illustrating the developmental progress of infants and young children		
	features, trunk and (often) arms. Draws very simple house. Matches and names four primary colours correctly. (Single-letter vision test at 10 feet, seven letters, also near chart to bottom).	Names four primary colours and matches 10 or 12 colours. (Full nine-letter vision chart at 20 feet and near test to bottom).
Hearing and speech	Speech completely intelligible. Shows only a few infantile substitutions usually k/t/th/g/s and r/l/w/y groups) Gives connected account of recent events and experiences. Gives name, sex, home address and (usually) age. Eternally asking questions 'Why?' 'When?' 'How?' and meanings of words. Listens to and tells long stories sometimes confusing fact and fantasy. (7 toy test, 1st picture vocabulary test, 2nd cube test. 6 'high frequency' word pictures)	Speech fluent and grammatical. Articulation correct except for residual confusions of s/f/th and r/l/w/y groups. Loves stories and acts them out in detail later. Gives full name, age and home address. Gives age and (usually) birthday. Defines concrete nouns by use. Asks meaning of abstract words. (12 'high frequency' picture vocabulary or word lists. 3rd cube test, 6 sentences).
Social behaviour and play	Eats skilfully with spoon and fork. Washes and dries hands. Brushes teeth. Can undress and dress except for back buttons, laces and ties. General behaviour markedly self-willed. Inclined to verbal impertinence when wishes crossed but can be affectionate and compliant. Strongly dramatic play and dressing-up favoured. Constructive out-of-doors building with any large material to hand. Needs other children to play with and is alternately co-operative and aggressive with them as with adults. Understands taking turns. Shows concern for younger siblings and sympathy for playmates in distress. Appreciated past, present and future.	Uses knife and fork. Washes and dries face and hands, but needs help and supervision for rest. Undresses and dresses alone. General behaviour more sensible, controlled and responsibly independent. Domestic and dramatic play continued from day to day. Plans and builds constructively. Floor games very complicated. Chooses own friends. Co-operative with companions and understands need for rules and fair play. Appreciates meaning of clocktime in relation to daily programme. Tender and protective towards younger children and pets. Comforts playmates in distress.

providing a secure base

SECURE BASE DEVELOPMENTAL CHECKLIST

This checklist addresses the key indicators of secure attachment, across all five dimensions, for different age groups of children[1]. It may be used in conjunction with the Secure Base Interview.

When there are negative responses, these need to be accompanied by a reflection on 'why?', for example, 'why is this baby not reacting to light or sound?', and also by a plan for capitalising on the strengths and repairing the difficulties.

0 - 6 months

- Does the child react appropriately (i.e. show interest/react but not panic or freeze) to light, sound, smell, touch, taste?
- Does the child show interest and pleasure in the environment?
- Does the child's face show a full range of emotions? Does the child frown, smile, laugh, rage, cry?
- Does/how does the child communicate their needs? For proximity? For food? For play?
- Does the child use a range of attachment behaviours to attract the caregiver's attention? Examples?
- Does the child accept affection/comfort? Can the child be soothed when upset/aroused?
- Is the child beginning to use the caregiver as a secure base for exploration?
- Does the child turn to/show interest in particular voices, faces, cuddles? If so who e.g. primary caregiver or older sister?
- Does the child vocalise?
- Can the child take turns with/converse with adults – initiating and responding to vocalising, facial movements?
- Does the child make choices/assert themselves?
- Is the child physically thriving and appropriately active?
- Is the child comfortable in their body - able to relax and also be active?
- Is the child sleeping regularly and in a relaxed way?
- Can the child wait – with help e.g. voice of caregiver?
- Is the child co-operating at least some of the time with nappy changes, feeding, going to sleep?
- What does the child do when stressed?
- What might be the child's internal working model of self, others and relationships? (Start with 'I' statements, I am... Other people are...).

[1] We acknowledge the contribution of a range of authors who have developed similar questions (Vera Fahlberg and Kate Cairns), and also practitioners (such as Rachel Agnew, social worker with Norfolk Adoption and Family Finding Unit) whose assessment questions we found helpful.

In this age group the therapeutic parenting focus is on awakening or reawakening the child's drive/capacity for attachment building and exploration. This is best understood in the context of enabling the child to experience a rhythm to the day, in which equilibrium is restored after both routine (feeds, nappy changes) and unexpected (a dog barking, fireworks) disruptions. As these questions indicate, the child's use of their senses and comfort in their body provides a route to make contact with and soothe the young infant, but in asking these questions we are requiring caregivers to be mind-minded and tuned in to the infant's thinking and feeling so that the child begins to trust in the availability of a secure base.

6 months - 18 months

- Does the child show a clear preference for one or more attachment figures?
- Does the child target attachment behaviours at this/these attachment figures?
- Can the child use at least one attachment figure as a secure base for exploration?
- Can the child play independently and constructively?
- Does the child protest at separation from attachment figures?
- If so, how does the child protest at separation from attachment figures?
- Does this behaviour vary between attachment figures?
- Does the child settle to play at reunion?
- Is the child less keen on/wary of/frightened of being approached or held by a stranger?
- Does the child show a full range of feelings, both positive and negative?
- Is the child's vocalising becoming more recognisable as language/conversation? (e.g. some limited vocabulary, tone, intonation)
- Is the child comfortable in their body – able to relax or be active? Mostly regular in feeding and sleeping?
- Does the child seek/accept comfort when stressed?
- What might be the child's internal working model of self, others and relationships?

During this period we are expecting to see some form of selective attachment and to be able to identify whether the attachment is more or less secure, using the patterns described earlier. The child's functioning and relationships need also to be understood in the context of the very first moves towards self-efficacy and autonomy, so play and exploration, and the early signs of communication and language readiness are important.

18 months - 3 years

- Can the child tolerate some gaps in caregiver availability?
- Does the child gain comfort from people (specific attachment figures?) rather than, or as well as objects (toys etc)?
- Is the child beginning to showing empathy (older end of this age range)?
- Can the child express a range of feelings but not be overwhelmed by them?
- Does the child use their mobility – to explore, to have fun, to approach, to learn?
- Can /does the child use language to communicate needs, feelings, ideas and goals openly and accurately? To ask questions, listen to the answers and learn?
- Can the child play let's pretend/ play symbolically? Engage in parallel play?
- Does the child ever pretend to feel what they are not feeling – seem false?
- Is the child managing increased independence without excessive assertiveness/oppositional behaviour?
- Is the child comfortable in his/her body, able to enjoy/manage sleeping, eating, toileting appropriate to his/her age?
- When stressed/anxious, does the child approach caregiver for help? (OR shut down on feelings; cling, demand and resist comfort; control others).
- What might be the child's internal working model of self, others and relationships?

At this age, autonomy – dependency issues are particularly important and children will be needing to manage separations and the availability or otherwise of their attachment figures as they become more competent walkers and talkers. The family and the physical environment will be making a big difference, with some children being expected still to be babies while in other families much more self-reliance will be expected.

Caregivers can be encouraged to simply observe and gently comment on a child's play, thus giving powerful messages to the child both of their own competence and the parent's availability and interest in whatever they do.

3 - 4 years

- Can the child take the perspective of others? Understand that others have feelings, goals that differ from their own?
- Can the child name simple feelings?
- Can the child co-operate?
- Can the child successfully keep a secret? Tell a lie but accept being found out?
- How is the child managing peer group relationships? Balanced, prosocial, increasingly co-operative? Making and keeping friends?
- Can the child cope with not winning sometimes?
- When stressed/anxious, does the child approach caregiver for help? (OR shut down on feelings; cry, cling, demand but resist comfort; control others?).
- What might be the child's internal working model of self, others and relationships?

If availability and the development of a secure base is a core task of infancy, it is mind-mindedness that is key to this crucial turning point developmentally and suggests the focus of therapeutic parenting. The child's capacity or lack of capacity at this age to reflect, to be empathic, to take the perspective of others, builds on the child's early experiences of being thought about in an attuned relationship and will be shaping the child's emergence into the world of peer relationships.

All insecure children will suffer to some extent with difficulties in making sense of the thoughts and feelings of others, but for disorganised children this lack of social or emotional intelligence will be accompanied by more deep-rooted fears that lead to the formation of controlling strategies at this age. The assessment needs to note the ways in which children are acknowledging or defending against painful feelings, which may then emerge as aggression or withdrawal. Parenting can be actively focused on a combination of promoting reflection and perspective taking and helping children to mange their feelings and behaviour in the light of this social and emotional education.

5 - 6 years

- Is the child managing the opportunities/pressures of school? Learning? Social relationships? Authority of teachers?
- Does the child have a conscience – show an understanding of and wish to abide by rules and expectations? Show shame, guilt wish to make reparation?
- Does the child cope reasonably well with being told off?
- Can the child say sorry and mean it?
- Does the child have positive self esteem – think he/she is 'good' at some things and accept that he/she cannot be good at everything?
- Does the child feel effective, able to assert themselves appropriately and make choices?
- Does the child look after things reasonably well?
- Does the child ask for help appropriately (sometimes but not excessively)?
- Does the child respond positively to praise? At home? At school?
- Does the child respect appropriate physical boundaries? With family members? With friends? With strangers?
- What might be the child's internal working model of self, others and relationships?

Assessment of children during this transition period from home to school provides rich data which can indicate the likely nature of early years' experiences and also provide some hopeful or more worrying indicators of what is in store developmentally through the rest of middle childhood, depending on what kind of caregiving is available. The ways in which parent-child attachment relationships have shaped the mind and behaviour of the child will now emerge in the relationships with authority figures and peers. The expectation that children will be ready to learn may not be in keeping with the child's capacity to concentrate and manage the stress of relationships and of success and failure, academically and socially, without direct support. It is particularly challenging for a child who has not been reliably held in mind to cope with the demands of school, where a general lack of trust in the self or other people makes meeting a big group of children and adults an overwhelming experience.

Therapeutic caregiving must be targeted towards helping the child manage this tricky combination of stresses at home and school. This may need to include not only a focus on direct support for the child but also advocacy for the child with key people in a range of environments. A thoughtful and developmentally sensitive assessment can help predict what active help may be needed for each child to negotiate this transition successfully – enjoying the new school life rather than just surviving it.

7- 11 years

- Does the child like/feel proud of certain aspects of him or herself?
- Does the child understand and accept the rules at home? At school? Have strategies for managing their behaviour?
- Is the child happy to get involved in activities – organised activities or hobbies?
- Does the child have a balanced approach to friends – values friendship but can be true to himself?
- Does the child manage the stresses of competing with others, academically and socially?
- What might be the child's internal working model of self, others and relationships?

The tasks of this age period focus on managing the developing sense of self in the context of learning and following the social rules. Thus acceptance/self-esteem building and co-operation take centre stage in terms of parenting, though as ever within the context of an available secure base to which a child can retreat when the pressures of the playground or the classroom get too much. Assessing children of this age will require a degree of sensitivity to the real world pressures as well as the inner world meanings or difficulties for the particular child. A child of different ethnicity to the rest of the school community or a child with a physical or intellectual disability may find themselves under a range of pressures from adults and peers which would make even the most secure child angry or withdrawn. But it is likely to be necessary to recognise that the child's most usual defensive strategy – such as shutting down on their feelings when stressed – will be interacting with the pressures within and outside the family.

The necessary caregiving qualities will again be a mixture of sensitive availability to the child in the home and advocacy outside of it in order to ensure that external pressures are not preventing the child from becoming confident, competent and happy.

11 - 15 years

- Is the young person's thinking and behaviour reasonably flexible and adaptable to different situations?
- Can the young person express and manage difficult feelings appropriately?
- Can the young person accept and manage his or her changing body?
- Can the young person manage the changing expectations of school?
- Can the young person manage the changing expectations of the peer group?
- Is the young person's self esteem reasonably good (can he/she enjoy success and accept a degree of failure?).
- Can the young person co-operate with parents and other authority figures?
- Does the young person enjoy learning and /or activities?
- Is the young person able to be assertively his own person? (rather than being preoccupied with/going with whatever other people want?)

In many ways the transition from 11-15 is as critical as the transitions of the early years and this parallel is often noted by researchers and parents, given the shared tendency for young teenagers to at times be overwhelmed by strong feelings and to have outbursts which may be similar to 'tantrums'. Assessment with attachment in mind should focus on the extent to which the young person is secure and psychologically robust enough to weather this big step forward towards adulthood without loss of self esteem – a special risk at around 12-13 years old – and without being drawn into negative behaviour patterns that may in some cases start to write the young person's future life script e.g. via suspension from school, offending behaviour or early teenage parenthood. Young people in this age group may still be looking for a supportive permanent family, so assessments need to look very carefully at the young person's relationships and needs. Whether young people have been through multiple placements or have just arrived in care, a new attachment relationship in a new family should still be considered as an important opportunity, even where birth family ties are strong. The two are not mutually exclusive.

16 – 21 years

- Does the young person have at least one supportive family to belong to?
- Does the young person have a secure base – preferably an attachment relationship within a network of resources?
- Does the young person have a close confiding relationship with peers/friends? Any relationship with friends?
- Is the young person engaged in purposeful activity that could offer identity and self-esteem – for example in education or at work or in fulfilling a role as a carer or parent?
- Does the young person feel competent e.g. to assert themselves appropriately, to try new things?
- Can the young person think about self and others, manage his or her own feelings and behaviour?
- Is the young person hopeful for the future?

In this age group the expression 'secure base' is used to include both the emotional support and availability of attachment figures and family membership. The transition to adulthood will need a whole range of personal skills and resources as well as external supports and resources that families, friends and, where necessary, agencies will provide.

ESTABLISHING A DAY IN THE LIFE OF A SCHOOL-AGED CHILD

Question	Factors to consider
Do you get yourself up in the morning?	▪ Is the child expected to get themselves up? ▪ Is there a regular routine or does it depend on the motivation of the carer? ▪ Does the child have to take responsibility for carers and /or siblings in the morning? ▪ Is an alarm clock /mobile phone used to make sure the child is up in time for school/playschool etc? ▪
Do you have anything to eat?	▪ Is there usually food in the house? ▪ What is available to the child? ▪ Does an adult/sibling or child themselves take responsibility for preparing breakfast? ▪ Is the child given money to buy something on the way to school? ▪ If so, what do they tend to buy?
What happens about getting dressed?	▪ Are clothes readily available, clean and in a good state of repair? ▪ Does the child have to find their own clothes? ▪ Do they have their own clothing? ▪ What happens about washing, etc? ▪ Does the child wash and brush their teeth in the morning? Is this appropriately supervised? ▪ Are there facilities available, e.g. toothbrush?
What happens if you are going to school?	▪ How does the child get to school? ▪ Who is responsible for getting the child to school? ▪ Is the child responsible for other children?
What happens at school?	▪ What is the nature of the child's relationships with their peers, teachers and support staff? ▪ What do they enjoy at school? ▪ What do they find difficult? ▪ What makes them happy and sad at school? ▪ Do they have friends? ▪ Are they bullied? ▪ What do they do at playtime?
What happens at the weekend or school holidays?	▪ Is the child expected to look after other children and/or the carer? ▪ Are they expected to do errands, etc. for the carer? ▪ How do they spend their time? ▪ Do they have any friends? ▪ Are they left unsupervised or allowed to undertake inappropriate activities? ▪ What happens about food? ***(Consider areas below)***

Question	Factors to consider
What happens after school?	▪ Are they collected from school and, if so, on time? ▪ Do they stay for after-school activities? ▪ Are they responsible for other children? ▪ Do they have friends that they see? ▪ What is the journey home from school like? (Consider opportunities for bullying etc) ▪ Is there anyone at home when they arrive? ▪ What happens when they get home? ▪ Do they have any caring responsibilities? ▪ Is food available when the child gets home from school?
What happens in the evening?	▪ Is there food available? ▪ What kind of food does the child eat in the evening? ▪ What does the child most enjoy eating? How often do they have this? ▪ Does anyone prepare an evening meal? If so, does the family eat together? ▪ If not, does the child get their own food and/or get food for others? ▪ When does the child usually have their last meal/snack? ▪ What happens if the child says they are hungry? ▪ Does the child spend their time watching TV? Do they go out - where and with whom? ▪ Does the child enjoy games and toys; which ones? Do they have toys? ▪ What do the carers do in the evening? What does the child think about their activities? ▪ Does anyone talk to the child or give them any attention? ▪ Is the child left alone or expected to supervise other children in the evenings?
What happens at bedtime?	▪ Does the child have a bedtime? ▪ Who decides when the child goes to bed? ▪ Where does the child sleep? ▪ Do they change their clothes before bed? ▪ Do they have a wash and brush their teeth? ▪ Does the child get disturbed? E.g. carers making a noise, child sleeping on settee. ▪ Is the child left alone at night and/or expected to look after other children?

Themes arising from the cases which link development and abuse and neglect

Younger children - Bruising and minor injuries

Understanding the meaning and origin of bruising and minor injuries emerged from the analysis of two of the cases as a theme for pre-mobile babies and toddlers. Bruising and minor injury tended not to be considered in the context of the child's own development and capabilities nor in the context of a good understanding of the care they were receiving.

The reasons that explanations for bruising were accepted by practitioners without sufficient scrutiny appeared to be because:

- children had complex health needs or disabilities and the bruising was somehow (but implausibly) connected with this; or
- the child's development was otherwise good; or
- the person who posed a perceived risk of harm to the child (eg a dangerous male figure) was believed to be out of the picture; or
- the parents were hostile or difficult and somehow stopped the practitioner from seeing clearly.

The Welsh systematic review group provide a clear research evidence base for having child protection concerns when there is any bruising on any pre-mobile baby. In their review of patterns of bruising in childhood, they conclude that the prevalence, number and location of bruises in children are directly linked to motor developmental ability (Maguire, Mann et al. 2005). They highlight that bruising in babies who are not independently mobile is very uncommon, whereas around 17% of infants who are crawling or cruising have bruises, and the majority of preschool and school children have accidental bruises. They also point out that a child with impaired motor development would not be expected to have the same bruising patterns as other children of the same age, but different developmental abilities.

Thus an understanding of normal motor development in childhood is essential for evaluating the significance of bruising and for distinguishing potentially abusive from non-abusive injuries. Further information for practitioners about children's developmental capabilities and accidents is available through guidelines for practitioners on accidents and child development (CAPT 2009).

What should professionals know and do*?* The need for heightened concern about any bruising in any pre-mobile baby (up to the age of around six months) is explained through an understanding of the child's physical development.

Because physical self control and independent movement is very limited in young babies, it is extremely difficult for them to bruise themselves. Any bruising is likely to come from external sources. The younger the baby the more serious should be the concerns about how and why even very tiny bruises on any part of the child are caused. The explanation, for example, as in the case of Sally , that a pre-mobile baby hurt herself while in her cot needs to be scrutinised very carefully and treated with suspicion.

Vignette - Sally

Sally was five months old when both the social worker and health visitor noticed a bruise on her face but they did not consider this to be a child protection concern. The fact that Sally was meeting developmental milestones (well enough) and her mother was thought to be cooperating with the contact arrangements for Sally with her father (who had limited and supervised contact because of domestic violence) should not have stopped these workers extending their curiosity about what might be happening in Sally's life. They needed to see things not just from Sally's perspective but also from the perspective of her young mother – who was a child herself. The serious case review revealed that Sally's mother had been feigning cooperation and was continuing her relationship with Sally's father. Since there were already concerns about Sally suffering harm (she was the subject of a child protection plan) this bruise should have put practitioners on high alert. The cause of this bruise should have been considered to be suspicious and urgent and robust enquiries should have been made. Sally's mother's supportive family and relatively problem free background are protective factors but they do not mean that the possibility of abuse can be disregarded.

Bruising in pre-school aged children

It is not surprising that bruising is more common in toddlers and especially in older pre-school age children. At this age children regularly have tumbles and accidents as they develop their gross motor skills and are exploring the world around them. However, any bruising will usually have a pattern and be on particular parts of the body, like the bony surfaces of the legs, arms and face which take the knocks in everyday falls (Maguire, Mann et al 2005). Frequent, repeated bruising in children of pre-school age might also signal that the child is not being kept safe and is not being appropriately supervised. There needs to be a sense of curiosity about how and why the bruising is occurring and how well the child is being kept safe and supervised.

Bruising in the context of complex health needs and disability

Vignette - Ben

Another young child, Ben, had numerous episodes of bruising prior to the incident of physical assault which ultimately triggered the serious case review. He also had complex health needs, but these did not restrict his mobility. The prevailing view of the multi-agency team was that the bruising was linked to his being a lively toddler and also to the demands made by his health care and health problems. The unusual pattern and site of Ben's bruising (which was not compatible with whatwould be expected in a lively toddler) did not provoke curiosity or questioning. Again, the fact that Ben was the subject of a child protection plan should have put practitioners on high alert. The pattern of Ben's bruising should have been considered in the context of his development with specific care taken not to explain away the bruises because of his health needs or disability without careful checking. In this case repeated bruising did not cause the social worker or others in the multi- agency team to think more broadly about whether these might be non-accidental injuries, "S*ome (professionals) had difficulty in believing such a sick child could be harmed deliberately*".

These cases also show that the category and primary reason for the child protection plan is not always an indicator of where the risk of further harm or recurrence of harm is coming from. In Ben's case, although the child protection plan was linked to domestic violence, it was his mother not his violent step father who was inflicting the bruising.

In these two cases involving pre-school aged children, the following questions were not sufficiently attended to:

- Does the explanation for the bruise match the child's developmental capability and likely behaviour? Was the child developmentally capable of causing these injuries to him or herself?
- Does this pattern of bruising match the particular developmental capabilities of a child of this age with these particular developmental needs?
- For a child who is otherwise meeting developmental milestones, might a parental explanation for injuries be too readily accepted?
- Is there a full understanding of the caregiving the child receives?

Who provides developmental advice? When making judgements about babies and children, social workers need access to both formal and informal advice and developmental expertise. Good relationships with health visitors and paediatricians will enable social workers to check out concerns, or to have a sounding board for discussing babies' and young children's development. A good paediatrician should be happy to talk through concerns about bruising or minor injuries in a baby or child. We have argued elsewhere that skilled use of expertise and consultation in a coordinated manner could result in more rigorous assessments and promote greater professional trust and confidence (Brandon et al 2005). These routes through to advice and developmental expertise are important for social workers working with children of all ages. As children grow older the range of possible developmental experts with whom to consult expands. Sidebotham and Weeks (2010) have summarised the likely child development contributions made by different professionals in the multi-agency context.

Emotional development and faltering weight in young children

Poor or faltering weight gain for babies and toddlers was an issue in three of these reviews. In all of these six cases, not just the three concerning faltering weight, there was little evidence of knowledge about or sufficient interest in the child's emotional development. This rarely featured in the individual management reviews or the chronologies and, in line with the findings from Ward's study of infants suffering harm (Ward et al 2010), was perhaps also often absent in practice. There were complex and differing reasons why parents appeared not to be nurturing their child. There was, however, a pattern in professionals' failure to recognise problems in the children's relationship with their caregivers and their emotional development as a key part of their faltering growth. The different issues presented in the cases and the professional responses are summarised as follows:

- Early difficulties in feeding could be linked, initially, with the baby's prematurity and subsequent complex health needs; in another case the baby was healthy at birth and the weight gain problems were not prompted by any easily recognised innate problems in the child; and in all three cases barriers to understanding development in cases of faltering growth included treating the issue primarily as a mechanical feeding problem rather than raising questions about emotional development, attachment and the parent-child relationship.

What should professionals know and do?

Practitioners need to be aware of the parents' reactions to their child, and to specifically observe and reflect on the child's responses to his or her caregivers. These are the foundations of emotional development and of attachment behaviour. What happens during feeding provides powerful clues to emotional development. In each of these examples there was an emphasis in the professional response on the single issue of feeding and the mechanics of feeding rather than any concerted attempt to try to understand the child in the context of their caregiving

environment and the different possible explanations for why the child was not gaining weight. Usually, concerns about feeding and poor weight gain did prompt the social worker to request an additional or an enhanced developmental assessment for the child if this was not already taking place. This is good practice. However, in one instance the developmental assessment used by health staff, the NFER assessment, did not take account of faltering weight which was the particular problem highlighted. The serious case review noted that developmental assessments need to be global if they are to pick up the full range of developmental issues.

Vignette – Joe

Joe was born at term, healthy and within the normal weight range. Within a month of his birth, Joe had not regained his birthweight. Instead he had slipped rapidly down the weight percentile chart. Although his mother was perturbed by Joe's lack of weight gain, her rough handling of her newborn baby was not congruent with this and he was often prop-fed. When Joe was two months old he died of unexplained causes, however, a post mortem report concluded that his growth problem made him more vulnerable to stress thus contributing to his death. The rough handling and prop- feeding are clues that point, not least, to the possibility of a lack of emotional warmth. There was also a pattern of faltering weight in his siblings.

Vignette - Melissa

Melissa was born prematurely with associated complex health needs, which meant that she was more difficult to feed and care for than a healthy baby born at term. There were concerns about her care from birth and these persisted. Melissa's mother continued to need to be prompted to feed her and it was noted that her mother was using her mobile phone almost constantly and not interacting or engaging with her. Melissa's lack of weight gain and her poor emotional development was assessed as non organic failure to thrive when she was a toddler, at which point she was made the subject of a child protection plan. This baby's failure to gain weight should have been assessed holistically in the context of her emotional need to be and feel connected with her mother as well as her physical need to be properly fed and well cared for. Poor care in this case was tolerated for a long period when evidence of impaired development had been apparent for many months.

Older Children

For the older children it was clear that to obtain a good picture of their current developmental state, professionals needed to get a sense of their developmental pathway over time. It was apparent in these cases that children who felt that their needs were repeatedly unrecognised, ignored or misunderstood were likely to become distressed, angry and desperate. Issues that prevented practitioners paying sufficient attention to the impact of maltreatment on young people's development were as follows:

- Not making a relationship or getting to know the young person.
- Not taking account of what the young person has to say to make sense of them as a person, nor to make sense of the impact that their experiences (especially of care and nurture) had on their sense of themselves and on how they behaved.
- Not speaking to the child. In one case the only consistent efforts to gain the child's view were at school (he had disabilities and global developmental delay) and the child was not spoken to during an assessment: "*This assessment fulfils the function of confirming the developmental delay ... it fails to analyse what that means to (the child) in terms of care, safety and welfare needs*" (IMR Health).
- Allowing the parents' voice to dominate (especially if they are volatile and difficult to

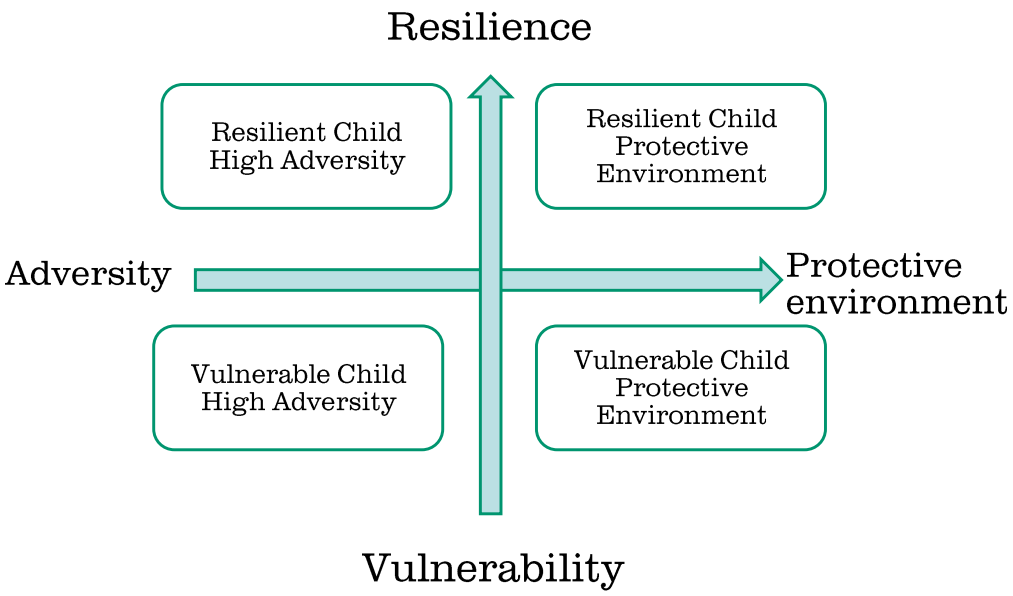
confront).

- Seeing the disability not the child and viewing a case essentially as supporting disability rather than supporting or protecting the child (including identifying and responding to signs and symptoms of harm).
- Accepting a different and lower standard of parenting for a disabled child than would be tolerated for a non-disabled child. A secondary health service acknowledged that they had different expectations of care for disabled than non-disabled children when they confirmed that in high risk disability cases locking children in their bedrooms was an acceptable strategy.
- Pockets of good development in maltreated young people do not necessarily signal resilience.

EXTRACT/

RESILIENCE & VULNERABILITY

This theory attempts to explain why some children appear to do better than others despite growing up in similar circumstances. It also provides a framework for assessing risk and focusing intervention on areas that will help the child/young person. Resilience is defined as: "*Normal development under difficult conditions*." (Fonagy et al, 1994)



Resilience and vulnerability refer to intrinsic characteristics of the child/young person. These may vary with age and some caution is required: examples of resilience factors include: the child has someone who loves them unconditionally, has a sense of humour, likes him/herself.

Adversity and Protective Environment refer to external/extrinsic factors; these are located in the family and wider environment domains/ecological levels. Examples include factors such as: race/culture, quality of community, economic situation.

Three *fundamental building blocks … associated with resilience are:*

1) *A secure base – the child feels a sense of belonging and security*
2) *Good self-esteem, that is, an internal sense of worth and competence*
3) *A sense of self-efficacy, that is, a sense of mastery and control, along with an accurate understanding of personal strengths and limitations. "This is important as it acknowledges that children are not just 'done to' but are also agents in their own right."*

(*The School Years, Assessing and Promoting Resilience in Vulnerable Children 2*, Daniel, B, and Wassell, S, 2002)
Other important factors to bear in mind include:

- Sometimes young people appear to be coping but this is at a superficial level only (eg children who are victims of early neglect may appear to be very independent and 'capable' as adolescents)
- Circumstances can change – for better or worse. Intervention has to be flexible

- Certain factors are thought to be particularly influential, eg availability of a supportive relationship, gender, ethnicity, self-esteem

Domains of resilience: These correspond to the categories outlined on Day 1 in the assessment frameworks:

- Social competencies
- Secure base
- Education
- Friendships
- Talents and interests
- Positive values

Daniel and Wassell provide a helpful framework, guidance and tools to assess resilience at three age levels: early years, school years and adolescence.

Examples of Vulnerability and Protective Factors

	Vulnerability/Adversity Factors	**Resilience/Protective Factors**
Child	Age (including early childhood trauma) Disability (physical and learning) Communication difficulties Poor attachment Non organic faltering growth Unwanted child School non-attendance Self-harming	Secure early relationship Being female Positive attitude, problem-solving approach Good communication skills Capacity to reflect Autonomy and self-motivation 'Good' looks Pleasant personality Sociability Good sense of humour 'Intelligent' ability to reflect/problem-solving skills Good self-esteem Easy temperament Positive leisure activities/ hobbies/interests Talents Age Religious faith Opportunity to rehearse tasks, make decisions, and take on responsibility Development of self-reflexivity, social understanding and skills Positive relationship/s with adults/peers Warm, supportive, secure relationships Acceptance by a responsible adult the child respects Accomplishing tasks valued by the child Basic needs met (including health) Positive childhood experiences Recognition and praise
Parents	History of abuse/neglect Unrealistic expectations of the child Lack of insight into child's needs	Consistent encouragement and support Stability and security

	Vulnerability/Adversity Factors	Resilience/Protective Factors
	Limited capacity to change Limited motivation to change Failure to prioritise child's needs Low warmth/high criticism Engaging in and condoning criminal behaviour Lack of/poor knowledge of child care and development Poor child-caring skills Child is scapegoated Child takes an inappropriate adult role Failure to protect from strangers Overprotection School non-attendance Inattention to health needs Separation from parent/carer Poor marital relationship Learning disabilities Refusal to acknowledge concerns Refusal to engage with support Intimidating behaviour Previous children on CP register Previous children removed Limited parenting strategies Limited coping skills	Positive expectations Small family size (?) Child-centred family Engagement with social services Acknowledgement of concerns Family previously coped for long periods Protective adult/presence of another safe, non-abusing parent Positive relationship with child Adult has positive childhood experiences Motivation and capacity to change Willing to try new ways of coping Acknowledges risks posed by abusive partner and the consequences of failing to protect Supportive partner/relationship Agreement re: parenting style Acceptance of disability Parental interest and involvement in education Sets clear and consistent guidance and boundaries Ability/capacity/motivation to change Absence of severe discord
Wider Family and Environment	Economic/social class Minority status (especially asylum-seeking status) Social isolation Multiple carers Instability Family breakdown Separation/loss/ bereavement Poor home conditions Poor housing Homelessness	Positive school experience One caring/respectful relationship Support, general/specialised Removal from risk environment (?) Access to facilities Supportive relationships outside the home Positive peer group Adequate housing Lack of income worries Active involvement in school and community life High morale school with positive policies for behaviour, attitudes and anti-bullying Access to a range of positive sport/leisure activities

VULNERABILITY AND RESILIENCE – KEY QUESTIONS

- What are the things that are going well in this child's life?
- To whom is this child important?
- Who is important to this child?
- Who are the people who play a positive part in the child's life (at home, in the neighbourhood, school or further afield)?
- In which fields can the child find a sense of achievement?
- Is there a concerned adult outside the home who has very regular contact with the child?
- Does the child have an adult outside the home whom he or she likes and trusts?
- Has the child a realistic way of contacting this adult when necessary?
- Has anyone discussed a fallback safety plan for an older child who may occasionally be at risk of harm due to episodes of parental substance misuse or domestic violence?
- Do these adults have the confidence and know-how to look for help if they are worried?
- Does the child relate fairly easily to peers of his or her own age (check this through adults who know the child well)?
- Do there appear to be problems of bullying or being bullied (a possible indicator of other abusive experiences in the child's life)?
- Does the child have hobbies and interests which are encouraged and supported?
- How does the child get on in school – socially as well as academically?
- Has the school been briefed adequately on the child's home situation?
- Has the school's special knowledge of the child been adequately tapped in assessing the child's developmental progress and vulnerability and strengths?
- Does the primary caregiver have role identities beyond that of caregiver? (Is he/she a club member, employee, volunteer, friend, church member, etc?)
- Does the caregiver have a record of using help well or of ambivalence or defensiveness in the face of help?
- Has the caregiver had a chance to articulate his/her worries and views as part of the negotiation or formulation of a plan to address child protection and welfare concerns?

Scenarios

1	Shaz is 16 years old and has a 6 week old baby who was born prematurely. The father of the baby is her on/off 32 year old boyfriend. Shaz has no contact with her family since she left home 10 months ago.
2	Cara is 8 years old and you notice a large burn on her arm. She tells you that she fell against the fire when mummy and daddy were fighting. She said that daddy had found them and then said 'the story is that daddy doesn't come to our house anymore'.
3	Rehana is 13 years old and has a learning disability. She attends a special school, On a visit to the family home, you notice Rehana becoming distressed and visibly cowering when a male relative comes into the room. She hides behind her mother.
4	Jason, aged 6 is physically aggressive to other children in class. He lacks concentration and throws books and objects around the room if he is challenged or frustrated. He was subject to Child Protection plan when he was 4 following evidence of neglect and physical abuse.
5	Ahmed is 10 and looks after his two brothers aged 7 and 5, taking them to school most mornings. It is known that mum suffers from depression for which she is prescribed medication. She is also a heavy drinker.

6	Mei-Lee is 5,and has been diagnosed with mild autism. Her family , where English is their second language , seem to have made her the family scapegoat; her nickname is Dumbo. She presents at school dirty and smelling of urine. She frequently has bruisies on her lower arms which parents explain are as a result of her falying her arms about.
7	Dan is 11 and has recently been diagnosed with Asperger's Syndrome. He is obsessed with knives and there some cut marks on his legs. . His father has found two penknives in his room and is concerned about his son's behaviour ,
8	Sarah is 14 years old and is a looked after child. There are frequent arguments with residential workers as Sarah is repeatedly staying out all night and ringing workers to stay she is staying with her boyfriend. She refuses to tell workers where she is going other than saying she is with her boyfriend and he is a responsible person, doesn't drink and has his own flat.
9	Pasha is 13 and has a large bruise on his jaw line which he says was caused when his dad hit him.
10	Pria is 6 months and lies awake in her pram barely moving. Her mother says all her children were like that.. quiet and undemanding . You notice in the pram soggy bread and a dirty bottle.