



## Report of the Review of Family Z

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# Introduction

## Why this case was chosen to be reviewed

- 1 The case was brought to the attention of the Local Safeguarding Children Board (LSCB) Serious Case Review (SCR) sub-group at the end of September 2010, at the close of the legal processes. The sub-group considered whether a serious case review could yield useful lessons but agreed on the basis of information that was known at the time, that the case should not be the subject of a serious case review. They agreed that it did meet the criteria for a review to be considered. The group also agreed the importance of making the learning from any review accessible quickly. The process of information gathering through chronologies was set in train at this point.
- 2 The sub-group was keen to trial systems methodology for serious case review via the model developed by the Social Care Institute for Excellence (SCIE), *“Learning Together to Safeguard Children “*. This approach is consistent with *Working Together to Safeguard Children 2010* Chapter 8, 8.17, which advocates the methodology as something that might be considered where a case is felt not to meet the criteria for serious case review.
- 3 Shortly after this, SCIE and the London Safeguarding Children Board sought expressions of interest in a London project to pilot the methodology. Haringey LSCB applied and was accepted. The project started at the end of January 2011; the final report was submitted to Haringey LSCB in March 2012.

## Succinct summary of case

- 4 The case in question involves the chronic neglect of a number of children – both boys and girls - who were removed from home by the police under powers of Police Protection and placed in local authority care at the end of April 2009. Both parents were arrested, charged and convicted and both have served custodial sentences. At the point that the children were taken into care they were known to a range of agencies and had been known to children’s social care since 2002.

## Methodology

- 5 The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the ‘deeper’, underlying issues that are influencing practice more generally at the time. It is these generic patterns that count as ‘findings’ or ‘lessons’ from a case and changing them will contribute to improving practice more widely.
- 6 Using a systems approach for studying a system in which people and the context interact requires the use of qualitative research methods to improve transparency and rigour. The key tasks are data collection and analysis. Data comes from structured conversations with involved professionals, case files and contextual documentation from organisations. Because the serious case review sub-committee had already set in train a process for

gathering additional information through chronology-building prior to starting the SCIE 'Learning Together' pilot, the Review Team for this case did have access to a merged chronology of multi-agency involvement. Since the absence of several staff made data collection through structured conversation more difficult, the chronology was actively used and useful as an additional factual reference point.

## Review team

- 8 The case review has been carried out by a Review Team led by two Lead Reviewers. Collectively, their role is to undertake the data collection and analysis, and assist the Lead Reviewers in writing the final report. SCIE provided methodological oversight, quality assurance and mentoring. Ownership of the final report lies with the LSCB as commissioner of the case review.
- 9 The review team was made up of senior representatives from different agencies. Review team members did not have any responsibility in relation to the case being reviewed; they were independent. It was a deliberate mix of people who had had previous experience of being part of a Serious Case Review Panel and senior operational managers who had not - in order to give more managers the opportunity to develop skills in managing the process. The Team benefited from two further independent members who were keen to learn about the model – from the Metropolitan Police and the London Safeguarding Children Board.

LSCB Vice Chair – Lead Reviewer  
LSCB Business Manager - Lead Reviewer 2  
Head of Service, Children's Social Care  
Designated Doctor for Child Protection  
Designated Nurse for Child Protection  
Head of Housing Support & Options  
Designated Teacher for Child Protection, a secondary school  
Reviewing Officer, Metropolitan Police Review Team  
Regional Safeguarding Advisor, London Safeguarding Children Board

- 10 The two Lead Reviewers undertook training and received supervision on the SCIE 'Learning Together' model over the course of the review period.

## Scope and terms of reference

- 11 In line with qualitative research principles, reviewers endeavour to be as open minded as possible in order that the focus is led by what they actually discover through the review process. This replaces the serious case review approach of identifying what you believe to be the focus of inquiry before you start, through the agreement of terms of reference.
- 12 The Review Team set the parameters for detailed analysis on the period between 2005 and 2009, when the children were removed into local authority care by the police. Although agencies had been periodically involved with the family since at least 2002, it

was in 2005/06 that the case escalated to the level of a child protection investigation and it was on the lead-in to this and beyond that the Review Team chose to focus, while referencing earlier events as relevant. There were also practical reasons why this approach made sense, in that access to individual practitioners who had been involved with the case pre-2005 would have been more difficult. Our review of the chronology of agency involvement in its entirety provided no reason to think that the earlier period would have produced learning that was substantially different than that outlined in this report.

## Sources of data

### 13 Data from practitioners

The systems approach requires the review team to learn how people saw things at the time and explore with them ways in which aspects of the context were influencing their work. This is known as the 'local rationality'. It requires those involved in a case to play a major part in the review in analysing how and why practice unfolded the way it did and highlighting the broader organisational context.

The Review Team conducted structured conversations with the following people, who together formed the **Case Group** for the review. At least two members of the Review Team were involved each time:

#### **Children's Social Care**

Senior practitioner (in team in 2006)  
Social worker (involved 2007 and 2009)  
Social worker (involved 2009)  
Child Protection Adviser (in same part of team 2006)  
CP Conference minute takers (in team in 2006)  
AD Safeguarding (Service Manager 2006-2009; different service)  
Senior Team Manager (joined Haringey in Feb 09)  
Independent Reviewing Officer for children 2009

#### **Education**

Head of Primary School (involved at time)  
Deputy Head, Secondary School (involved at time)  
Manager, Education Welfare Service (involved at time)

#### **Police**

Detective Sergeant, Police Child Abuse Investigation Team (involved at time)

#### **Health**

School Nurse (involved 2006; 2009)  
Health Visitor (involved early 2006)  
Clinical Community & Antenatal Midwifery Manager, North Middlesex University Hospital (Named Midwife for Child Protection up to August 2008)

## **Housing/Urban Environment**

Tenancy Management Team Leader (involved post review period)

Enforcement Response Service Manager – manager of

Pest Control Officer (involved at time)

## **Structure of the review process**

14 Using the SCIE 'Learning Together' model (Fish, Munro & Bairstow 2008), gathering and making sense of information about a case is a gradual and iterative process. The Review Team held a number of analysis meetings and the emerging narrative and learning from these – the findings as viewed at this point - was presented to the Case Group in what are known as 'Follow On' meetings. Over the course of this review the Review Team met 10 times, over a full day for the first Analysis Meeting and thereafter over a morning or an afternoon. Three of these meetings included the case group, one for an introductory session and then for two half-day (Follow On) meetings to present the emerging analysis. Attendance at all meetings was excellent and anyone who did send apologies had legitimate reasons for doing so.

## **15 Data from documentation**

The Review Team drew on the following case-related documentation:

Children's social care electronic files – incl. assessments and documentation relating to child protection conferences and core groups

Children's social care chronology for care proceedings

Psychiatric reports for care proceedings

Pest control report to care proceedings

Housing report to care proceedings

Primary school report to care proceedings

Education Welfare Service records

Health visiting records

School nursing records

Midwifery records

A&E records

GP records

Police Crime Report Information System (CRIS) record of investigations

Additional information was gathered from consideration of a range of contextual material:

Implementation of Framework-I Red Amber Green (RAG) rated reports 2005; 2006

Annual Performance Assessment 2005

Joint Area Review inspection report October 2006

Haringey Children & Young People's Service: Stay Safe Delivery Plan 2006

Haringey Children & Young People's Service: performance data re. numbers of children on Child Protection Register 2006

LSCB Quality Assurance datasets 2006, 2007, 2008

Joint Area Review inspection report December 2008

Framework I log of new users Nov 08 – April 09

The various newspaper articles relating to Peter Connelly October 2008 – February 2009

**16 Data from family, friends and community**

The Review Team were keen to involve family members and benefit from their perspective on their involvement with the various agencies. The Review Leads wrote to both parents in prison, informing them of the Review and inviting them to contribute. Immediate agreement was received from the father. No response was received from the mother. Contact with father was delayed due to media interest at that time; both parents were approached again in writing following their release from prison but neither responded.

- 17 On the advice of the current social worker and independent reviewing officer we have not spoken directly to any of the children, who are considered to be still too vulnerable. We have tried to gather their views from interviews that formed part of the initial care proceedings and reflect them where we can in the body of the review.

**Limitations**

- 18 No social work staff who were directly involved with the case at the time were still working in the borough in the same capacity although two were who became involved at the point that the children were taken into care. The Lead Reviewers did manage to trace one key social worker that had left the borough who was willing to participate – and we are very grateful to him for his contribution. The review was therefore only able to speak directly to one of the 6 (including a Team Manager) social work staff who were involved with the family between 2006 and 2007. Access to health visiting staff was similarly limited.
- 19 The Review Team dealt with the shortage of people directly involved in the case work by involving practitioners that were in the same team or service at the time that the case was held there. A range of staff at different levels of seniority participated in the process. This gave us a very rich picture of the context in which people were working during the period under scrutiny.
- 20 Haringey's context is unique in terms of the intense national political and media interest that followed the deaths of Victoria Climbié and Peter Connelly in 2000 and 2007 respectively. It is fair to say that the media focus has often not been constructive and at times its impact has been damaging on staff morale, recruitment and retention. The fact that so few of the allocated social workers were available was in some respects a direct result of this and those who did contribute were, in light of this, understandably anxious at first.

**Publication of the report**

- 21 The main section of the report contains the findings of the case review. It applies systems thinking to an analysis of multi-agency practice at the time and draws upon this to provide the LSCB with a number of suggested ways forward. The Secretary of State for Education Michael Gove clarified recently that in his view the way to reduce the risk of

repeating mistakes in child protection was to focus on why professionals acted in the way they did and to explain what was preventing them taking the right action at the right time. It is for this reason this report is published.

# 1. The findings

What light has this case review shed on the reliability of our systems to keep children safe?

## Introduction

- 1 The purpose of a case review is to achieve a safer child protection system, one that is more effective in its efforts to keep safeguard and protect children. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies in the child protection system. The particular case acts as 'a window on the system' (Vincent 2004: 13).
- 2 Case Review findings therefore need to say something more about the LSCB area/agencies, current systems and how things can be improved for the future. It makes sense to prioritise the findings to pinpoint those that most urgently need tackling for the benefit of children and families – and these may not be the issues that appeared most critical in the context of a particular case.
- 3 In order to help with the identification and prioritisation, the systems model that SCIE has developed includes 6 broad categories of these underlying issues. The ordering of these in any analysis is not set in stone and will shift according to which is felt to be most fundamental for systemic change:
  1. Response to incidents and crises
  2. Longer term work
  3. Cognitive and emotional biases
  4. Family- professional interaction
  5. Tools
  6. Management systems
- 4 Each category may have many subcategories and it is the subcategories that stand out most clearly in this report. They state succinctly what the problem is and are therefore helpful to the reader. There is, of course, overlap between categories.

## Synopsis of the sense that the review team have made of professional practice in this case

- 5 This is a case of chronic neglect, over a period of approximately 7 years, by the parents of a number of children, both boys and girls, aged between 8 months and 16 years at the point when all the children were taken into police protection in April 2009.
- 6 The family first came to the notice of Children's Social Care in 2002 following an anonymous referral that the children were inappropriately dressed, smelt and were dirty. An initial assessment was undertaken and the case was closed. There then

followed a period of four years within which there were a handful of further referrals - from a primary school, a secondary school and a play setting and anonymously from members of the public - in relation to symptoms of neglect: dirty and inappropriate clothing, poor hygiene, persistent head lice, poor school attendance. Each of these referrals was treated in isolation from the others. The family raised their own concerns in relation to their housing situation within this period and a social work core assessment was undertaken in 2003 following an incident of domestic violence which resulted in the parents separating. There is evidence in this assessment that mother had been willing to talk to the social worker at this point, as detail about her childhood and background appears in the record. The social worker does not, however, get to any analysis beyond recording what she has been told.

- 7 As a universal health service, GPs are theoretically well placed to recognise when families are struggling. In this case, only one child was registered with a GP shortly after birth, otherwise the family used Accident & Emergency if they needed medical attention and immunisations were all outstanding as the mother had reported a phobia of needles. Another social work assessment started in 2005 had concluded that the main risks to the children were the failure to take up immunisations and health appointments. No further action was taken.
- 8 The only occasion when a co-ordinated multi-agency response was attempted to improve the children's parental care and home circumstances was between February 2006 and November 2006. During this ten month period all the children in the family were placed on the Child Protection Register for neglect having been appropriately assessed as having met the threshold of being at risk of significant harm. Yet that intervention too proved ineffective in achieving sustained improvement. Judgements about parenting capacity were made entirely on the presentation of the children and mostly without reference to the parents themselves, who hardly turned up to any multi-agency planning meetings between the Initial Child Protection Conference in February and the final Review Conference in November, although the child protection plan was noting actions for which they were responsible.
- 9 Compounding this lack of engagement with the family on the ground, no multi-agency assessment was undertaken during the period that the children were on the Child Protection Register. As a result there was never any considered multi-agency professional view to assist the conference with decision-making. The social work report to the Initial Conference noted the fact that the father had not allowed access to the children's bedrooms in January 2006 but this was not picked up by the conference (or by the social worker) as a risk factor despite the fact that the same social worker had noted the presentation of the younger children at this time as 'flat' and 'unresponsive' – common developmental risk indicators. Once again the social report was essentially unprobing and the overriding professional response was to focus on the symptoms of neglect and their resolution.
- 10 The behaviour of both parents at this point did make meaningful assessment more complicated, as did the turnover of social work staff – there were three different social

workers allocated to the case between January and June 2006. Attempts by social workers to visit were met either with a closed door or with open hostility; although the father was apparently living separately to the rest of the family he generally seemed to be there whenever a social work visit was planned. Access to the home was denied completely to one social worker between May and June.

- 11 The obstruction of both parents and aggression towards different social workers (and the inability of those workers to find any challenge to this) meant that no meaningful work took place with either parent or with the children. The speed with which social workers could be allocated and then change was itself a product of the growing attraction for some at the time of agency working. Professional involvement was inconsistent and caseloads high – both factors which made it easier for the professional focus to be on symptom rather than cause. The apparent and sudden co-operation of the parents prior to the final Child Protection Review Conference in November was sufficient to divert professionals into thinking that there was no longer a child protection issue. Just prior to deregistration the family home was clean and tidy; the children looked clean and well nourished.
- 12 Once their names were removed from the Child Protection Register the children became ‘Children in Need’ under s.17 of the Children Act 1989, but the fact of this carried absolutely no substance. No multi-agency planning meetings took place and a social work team manager made the decision to close the case in April 2007 following a three month period during which he had also decided to take allocated social work responsibility for the children away from a social worker and to visit them himself. There is no record on the system that he ever visited. Three months later pest control was called to deal with a rat infestation.
- 13 The children’s names were removed from the Child Protection Register even though they were still not registered with a GP at this point – a task that had been a requirement of the Child Protection Plan. It is of note that facilitating GP registration would normally fall within a health visitor’s responsibility and that the health visiting service was significantly stretched in 2006 and over most of the period covered by this review. The Review Team heard how a single health visitor’s case load had around 700 children aged between 0 and 4 years at a point when the organisational links between GPs and health visitors had changed. From 2006, health visitors were no longer based in GP practices and the frequency of liaison meetings between a GP practice and a health visitor moved to one every 4-6 weeks. The vulnerable children who were discussed at those meetings came to notice in the first place through their registration with the GP. The children in this case were not registered with a GP until October 2007 and then registration appears to have been tokenistic as there is no evidence in GP records that they ever attended.
- 14 The involvement of statutory services with the family following deregistration and beyond was episodic and reactive to incidents such as injury to a particular child, which were then treated once again in isolation from each other and from any wider analysis of the family history. The parents continued to be hostile and acquired a reputation

with the social work service for being both difficult and for being unremarkable in the context of other cases of the time. The wishes and feelings of the children are barely evidenced in the various reports and other documents that the Review Team consulted. No social work, police or health professional saw the children's bedrooms between January 2007 and their removal into the care of the local authority in April 2009, despite the fresh referrals made over this period.

- 15 Concerns about the well-being of the children escalated towards December 2008, from the primary school and Education Welfare Service in particular and prompted by falling rates of attendance at school. Parents again denied access to the home. The Education Welfare Service Manager, backed by the primary school, persisted with her attempts to get a child protection referral accepted, knocking ever more loudly on the social work front door. An email from her to the social work Team Manager in January 2009 said, "How can we rule out neglect if no-one has seen the children?" The reply maintained that the case "does not meet the threshold for any kind of strategy meeting". Just two days later a strategy meeting was convened. The way the case was presented at this meeting diminished its seriousness; the family had been 'on the books' for a long time and their problems were essentially old ones that resurfaced every now and again. On the basis of this, police involvement in any child protection investigation was deemed unnecessary.
- 16 This coincided with a period of unprecedented media attention on Haringey in general and children's social care in particular. The review team heard very graphically about the challenges that this presented from both Case Group and Review Team members; it is understandable that a family hitting the system at this point, who were known and already had a professional mythology attached to them – 'difficult'; 'unremarkable'; - would have received a less urgent response than other referrals. This does not make it excusable – statutory processes did not work well enough.
- 17 By April 2009, when the children were taken into police protection, it is the view of the Review Team that they had been allowed to live in appalling home conditions for at least 5 months too long. The appropriate action of the police came too late for these children and, while removal into police protection was necessary in April 2009, separation of the children from their mother and each other is likely to have profound and long-lasting consequences for them. It is the view of the Review Team that, during the period covered by this review (January 2006 –April 2009) when a co-ordinated, multi-agency response was required, more effective intervention, particularly by Children's Social Care, may have resulted in better outcomes for the children.
- 18 This, then, was not a family unknown to professionals. The nature of the vulnerabilities and challenges the parents faced were not hidden nor were they of an unusual kind such that they might have proved difficult to recognise. Nevertheless, the multi-agency network proved unable to adequately safeguard and protect the children. In many ways this is perplexing yet this is not unusual and not particular to Haringey. The creeping and cumulative nature of chronic neglect does make it difficult to detect if you are not really looking for it. There is much research about the difficulties faced by professionals in

supporting families and safeguarding children in cases where change is not easily achievable, and support needs continue over a long period. Yet it has also been argued<sup>1</sup> that there has been little informed debate about the possible implications for the way in which services are organised.

- 19 The strength of applying the systems model is that the Review Team does not limit itself to highlighting areas of problematic practice. This is rather the starting point for a thorough investigation as to 'why' any problematic areas were handled in the way they were. From the review of this case it became very clear that these problems are not in most instances essentially about the calibre or motivation of the individual staff involved. Indeed, the review team formed the view that, in this location and at this time, if there had been different staff involved it is highly likely that the trajectory of the case would have remained the same. There are critical underlying issues here and the review team recognise that many are known not to be unique to this location but to be widespread issues.

## **Analysis and Identification of Underlying Issues**

- 20 The review team have prioritised eight findings for the LSCB to consider. These are:

### **Management systems**

1. The absence of a coherence between family support services and emergency response
2. Autocratic management style creates fear, paralyses thinking and prevents constructive case work challenge

### **Long term work**

3. Inadequate understanding of the causation and impact of neglect across agencies leaves professional efforts misdirected
4. No shared culture of authoritative challenge amongst professionals allowing for the exploration of disagreements

### **Tools**

5. Design of work processes and procedures makes it difficult to respond *as effectively* to neglect as to incidents/injuries
6. Computer systems can make it difficult

### **Cognitive and emotional biases**

7. Absence of systems to promote review of professional judgements

### **Family-professional interaction**

8. No effective challenge to, or ability to work with, non-engaging families

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<sup>1</sup> Olive Stevenson's chapter on Child Neglect in Taylor & Daniel: Child Neglect – Practice Issues for Health & Social Care (2005)

## Management Systems

### **FINDING 1: Absence of a coherence between family support services and emergency responses**

- 21 Overall the review team were unable to identify the presence of an agreed strategic approach to safeguarding (and particularly neglect), which was compounded by, or perhaps led to, the absence throughout the period under review, of robust family support provision. This reflects the relative low priority given to children in need cases and was formalised in the structures in Children's Social Care in relation to the higher level of resources allocated to short term compared to longer term work.
- 22 Professional safeguarding practice involves a balancing act, with professionals treading the line between needing to accommodate a child and trying to support the parents/carers in such a way as to ensure the child's safety and welfare within the family home. Good practice involves charting a course between two adverse outcomes – removing a child or children prematurely and leaving them in danger. Without any clear philosophy to underpin the commitment to, and nature of efforts used to understand and support whole families, there is a systemic vulnerability that inaction or nothing effective will take place. This case provides a stark illustration of that consequence.
- 23 The lack of a clear 'whole-system' approach to safeguarding children also makes services very vulnerable. If the organisation does not grasp the relationship between one form of service provision and another it will treat them as distinct. Treating them as distinct, particularly in an environment in which the need to make financial savings is a constant, risks making one service more vulnerable to cuts than another. By the same token, it is easier for organisations to perceive one as more important than another. What should be a fluid and flexible service response to different levels of assessed need becomes more jagged; effectively, the flow stops.
- 24 The very particular Haringey context is relevant here. Since the death of Victoria Climbié in 2000 the focus in Haringey and nationally had been on what was perceived as the failure of a 'child protection' service. Additional funds were injected and service provision at the child protection end improved, confirmed by a joint inspection of child protection services in 2003. The additional monies were then gradually withdrawn as the need for them was no longer seen as acute.
- 25 According to a number of case group members we spoke to, the impact of this on the interconnected family support-focussed services being provided at lower threshold levels was hardly considered.
- 26 Less importance was given at the time to non-Child Protection cases – which is possibly still the case. The Review Team were told that Child in Need plans would have routinely been put in place when a Child Protection Plan ended but there was rarely any discussion/agreement about what a Child in Need plan involved. In practice this meant that cases were held open but with no planned work or review and then closed after a

certain time if no concerns were raised to social care. Child in Need meetings did sometimes take place, chaired by a Social Worker, but there were generally no minutes. Child in Need cases – at a ‘lower’ level of statutory intervention, had little organisational status. When the children in this family were taken off the Child Protection Register at the end of 2006 and the step down plan was to carry on working with them as ‘children in need’, this was ultimately meaningless.

- 27 Critically, nothing was noted on the Conference minutes of November 2006 in respect of “step down plans” to ensure that change was sustained. A Child in Need Plan should have been put in place that should have identified potential trigger points which would prompt a re-assessment. This case went into a void.
- 28 According to case group members as of Spring 2011, when interviews for this review were held, an effective balance between support for a child who was ‘In Need’ and a child assessed at a higher level of risk is still to be achieved. The link in terms of service provision between these and lower levels of support provided by non-social work professionals is also unclear. Family support services too had no real status at the time covered by this review. Organisationally, responsibility for statutory and non-statutory support services is kept separate although a family on a shifting trajectory of need may need to move smoothly between the two.
- 29 An opportunity to change strategic direction had been provided by the 2004 Children Act and the introduction of ‘safeguarding’ as a notion with a far wider reach than child protection alone. *Every Child Matters* provided a framework on which to hang an organisational way of working with families that acknowledged the relationship between the different kinds of services provided to families but it required a mindset shift on the part of organisations to recognise and implement this. In Haringey the focus on child protection services persisted, driven in no small part by the need to comply with national performance indicators and the potential consequences of not doing well enough against the Ofsted inspection regime for a Council only recently the other side of ‘special measures’. The pressure upon managers and staff to do better against performance indicators such as those measuring the speed with which assessments are undertaken became much more intense following the Ofsted inspection of 2006, which returned a judgement of ‘adequate’ against safeguarding. The consequence of this was to skew the focus away from reflection on the quality of practice and the impact of this upon practice on the ground is considered in Finding 2 below.

**Absence of a coherence allows disconnect between family support services and emergency responses**

**Issue that the Board needs to consider:**

Professor Eileen Munro in her recent Review of Child Protection, places early help services squarely within rather than outside a child protection system. She advocates and gives examples of a number of theoretical models for service delivery that support the fluid relationship between early help and emergency intervention, with the emphasis on early help as most significant in terms of outcomes for children. The fourth of her eight

Principles of an Effective Child Protection System is unequivocal: “Early help is better for children”.

Children do better in the majority of cases in their home environment; effective early help services support them to stay there. The child protection system that tips the balance in favour of this while at the same time adopting a holistic approach that acknowledges the relationship between the different kinds of intervention is therefore more child-centred.

A consequence of this holistic approach should be an organisational structure and strategic plan that connects child protection and early help services. The Board can take a lead for Haringey in posing a challenge for the multi-agency partnership, taking current financial constraints into account. The questions to ask are these:

- How can we collectively work to best effect to support families to stay together while responding appropriately to risk?
- Does the way that services are organised, funded and prioritised facilitate an integrated approach to support and protection – is there an effective balance of investment?
- Do existing management structures support such a rebalancing or work against it?

It is vital to look before and beyond the frontline child protection response and see all interventions beyond the universal as part of a joined up whole. The Hackney model of ‘reclaiming social work’, referenced in the recent Munro Review, is perhaps currently the most well-known approach that explicitly aims to do this. Whether you agree with it or not, it has strength in the fact that it is a philosophical foundation for an organisational approach. More importantly still, it sits within a range of family support services that allow for emergency response and longer term intervention. As a theoretical model, it makes sense.

## **FINDING 2: Autocratic management culture creates fear, paralyses thinking and prevents constructive case work challenge**

30 The Director of Children’s Services (DCS) and the Lead Member for Children and Young People are key decision-makers in relation to the strategic direction that local services take. The government revised and reissued statutory guidance in July 2009 that clarified both roles and their accountability for the well-being of children in their local areas. The LSCB and in particular the person of the independent Chair, provides an additional challenge at leadership level that should be built into the organisational fabric; if the LSCB Chair and DCS are one and the same person, that challenge risks not being there to the same degree or at all. The fact that statutory guidance is now much clearer in relation to the desirability for checks and balances embodied in all three posts means that governance arrangements both locally and across the country are stronger now.

- 31 During the course of this case review, participants from children’s social care gave the review team a distressing picture of the management culture prevalent at the time. The management culture in the Tottenham social work office in 2005/06 was described as overbearing; one which mitigated against any reasonable discussion about casework decisions let alone an appropriate professional challenge and provides the context for why practitioners acted as they did. In the view of the Review Team it sounded wholly dysfunctional. It’s easy to underestimate the impact of what a member of the case group described as a ‘shouty’ culture on professional decision making. When practitioners are told to accept management direction or leave, they inevitably become de-motivated and their capacity for taking the initiative and challenging decisions that concern them is severely undermined. When faced with hostility or avoidance from service users, dealt with in Finding 7 below, the opportunity to reflect, learn and constructively challenge was either abdicated or lost in the absence of responsible management.
- 32 These managers did not operate in a strategic or organisational vacuum – which is where findings one and two link. All those we spoke to recalled the ‘integration’ of education and social work services following the 2004 Children Act as an environment within which school improvement and pupil attainment was prioritised and social work was both misunderstood and marginalised. This was compounded by the strategic response to the Ofsted-led JAR inspection of 2006 which explicitly required, in respect of key safeguarding standards, the move from “adequate” to “good” in 6 months and, in particular, that the number of children on the child protection register should be significantly reduced (as indeed they were: from a total of 204 in March 2006 to 130 in December 2006). The focus again was entirely on child protection services and against a background of acute year on year financial pressures.
- 33 All of those we spoke to in the course of this review from children’s social care were explicit in stating that these key strategic organisational drivers had a direct and negative impact on front-line practice and decision-making. The anxiety levels of managers were high, driven up by the pressure to achieve against largely quantitative indicators – in the Tottenham office in particular this manifested as a blinkered focus on assessments being completed within statutory timescales. It is significant in this context that this was the same office in which Victoria Climbié’s case had been held. Anxiety bred a culture of harassment and bullying and an increasingly autocratic style of management.
- 34 Positively, the Review Team also heard from participants in the case review to suggest that this culture has been transformed and is no longer felt to exist. Yet creating a safe system requires knowing what that looks like, how it impacts on staff and on service users and being alert to the possibility of it re-establishing itself. The review team’s view is that the current financial pressures and associated cuts create significant pressures, making vulnerable the more constructive management style that has been cultivated recently.

### **Autocratic management culture creates fear, paralyses thinking and prevents constructive case work challenge**

#### **Issue that the Board needs to consider:**

The Munro review has brought to the fore the limitations of a target driven strategy to supporting and managing professional efforts to safeguard and protect children. The balance is refocused in terms of quality of work and outcomes for families, with services delivered in a way that supports both those on the receiving end and those doing the delivering. However, the opportunity for radical cultural shift opened up by the Munro review, runs significant risks due to the current financial pressures and associated cuts. Resources are retracting while the pressures of work remain the same, creating inevitable tensions for managers to negotiate with potentially negative impact on organisational culture.

- Is the possible negative impact of local management cultures an integral part of the risk management strategy of the LSCB and partner agencies?
- In what ways have the roles and influences of the DCS, lead member, CEO and LSCB chair changed since this time and are they likely to be more effective now?
- How do the DCS, lead member, CEO and LSCB Chair measure their own impact?
- Are there reliable ways in which the emergence of problematic cultures would be brought to the attention of the Board?
- More broadly, is the Board able to track the impact on frontline practice, of decisions around organisational change, including the impact of decisions made in response to the need for financial restraint?

## Long-term work with families

### **FINDING 3: Lack of an adequate understanding of the causation and impact of neglect across agencies leaves professional efforts misdirected**

35 Alongside the other issues that influenced the poor professional response to the experience of the children in this family and dealt with in other findings, it is the view of the Review Team that there was also a fundamental misunderstanding about neglect which persisted across all agencies throughout the period under review. This included a lack of understanding about the nature and causation of neglect, as well as how neglect impacted on each child and what it meant for them in terms of their emotional and physical development. This is a crucial underlying issue because without an understanding of the causation, manifestation and cumulative impact of chronic neglect, responses in the future will inevitably, be generally wanting.

36 Neither the written assessments nor the conference minutes that we looked at over the period of the review showed an understanding of the nature and causation of chronic neglect and how it manifests itself over time. One social worker, in a core assessment outside the review period, had managed to engage Mrs Z and get detail of her background history but she, and others after her who would have read the same assessment, missed the implications of what was said. There was almost no attempt to

get at the underlying latent conditions – parental childhood history, parenting capacity, relationship stressors - and no attempt to work with either the children or parents on their experiences. Consequently the multi-agency response was to symptoms – children looking cleaner – and missed the sustained nature of change required as evidence of progress and assurance that children were better protected. Even when possible incidents of non-accidental injury or self-harm to three of the children presented themselves, the response focused narrowly on the events in isolation, and on individual children, with no attempt to place them in the broader narrative of this family’s presentation to statutory services – see Findings 5 and 6 below.

37 The review team heard how the LSCB’s multi-agency training programme does include courses on Child Neglect and on Attachment Theory & Child Development. But, while undeniably important, the questions then remain as to how much coverage a training course has and the degree to which attendance at it has impact on daily practice.

**Lack of an adequate understanding of the causation and impact of neglect across agencies leaves professional efforts misdirected**  
**Issue that the Board needs to consider:**

Assessing family situations, parenting capacity and how children experience these are tasks that are complex, time consuming and dependent on practitioners being sufficiently knowledgeable, skilled and experienced. Neglect raises particular challenges to effective assessment. Addressing absence of adequate professional understanding of child neglect is therefore of fundamental importance and links to the findings of other case reviews.

- Is professional understanding of neglect, its nature, causation and impact any better now than it was in 2006 or 2009?
- How is this being supported across different agencies?
- Are mechanisms such as supervision being effectively used to help professionals to be alert to whether they are tending to focus on tangible indicators of neglect such as the physical condition of the family’s house as opposed to children’s holistic needs?
- Parental compliance tends to be misleading as a proxy for success in cases of neglect. How might it be possible to measure sustained progress?

**FINDING 4. No shared culture of authoritative challenge amongst professionals, allowing for the exploration of disagreements**

38 A safe system is predicated on the fact that professionals from any agency working within it are empowered to constructively challenge where they feel a decision or behaviour of another is mistaken or wrong. That way lies learning and child protection procedures support it, for example in permitting a professional from any agency to call a strategy meeting if they feel one is warranted. Where there is fearfulness for any reason, an organisation risks collusive behaviour on the part of its staff and those who are willing to raise concerns may be treated as nuisances or ignored completely. If this

attitude prevails it undermines the challenger and the correct challenge is not reacted to in a timely fashion or at all.

- 39 One specific example of this, linked to a lack of understanding of neglect on the part of children's social care was that truanting was not seen as a potential symptom. The potential significance of children being absent from school was missed by all but the school itself and the education welfare service. Records give the impression that as a consequence the latter were treated as number crunchers by the social work manager in December 2008 and then almost as an irritation going into January 2009. It is to the credit of the Education Welfare Service (EWS) manager that she persisted over the course of two months to argue the case for a child protection investigation.
- 40 In response, when they felt that they were not being heard by children's social care, the primary school switched their monthly 'cause for concern' meetings to weekly review meetings on the children concerning them so that they could track concerns in a more timely way and be better equipped for making effective use of multi-agency meetings. This was good practice.
- 41 From one perspective, this represents an incident of the school creating safety in the face of resistance from the key statutory agency. However, if we look at it in terms of the resilience of multi-agency networks of professionals to handle conflict and challenge decisions, it appears more concerning. It does not suggest a shared culture in which it is acceptable and even desirable for professionals to query each other's assessments. Resolving disagreements by majority rule or on the grounds of disparaging personal comments about the dissenter, inhibits good critical thinking about the management of a case. An alternative approach is an attempt to explore openly *why* the parties have reached such different judgements. In this case, this might have served to reveal that social care had not understood the significance of the truancy.

**No shared culture of authoritative challenge amongst professionals, allowing for the exploration of disagreements**

**Issue that the Board needs to consider:**

By the nature of their different roles, professionals often have different information about any particular child and or family and different perspectives on the sense to make of what is known. Differences of opinion are therefore to be expected. A safe system requires a culture in which it is usual and accepted to question and challenge differences in judgement and the requirement to explore openly what lies behind disagreements.

- Does the Board have means of ascertaining the 'health' of norms of multi-agency working?
- What might be done to support and develop critical thinking?
- How might professionals be supported to explain better to each other the significance of the information they are sharing – why it is a safeguarding concern?

Safe multi-agency systems require mechanisms to manage professional disagreements and conflicts. Often these mechanisms take the form of some kind of brokerage, such as the role of the Designated Doctor or Nurse in Health. There is not the same legislative requirement on schools, which are becoming separated more from the workings of Local Authorities. The challenge to the Board is to consider:

- Is there now a clear procedure for escalation of child protection concerns for schools?
- What might a local practice model look like for schools that parallels the operational and strategic functions that exist in health?

It might help to put such considerations in the context of the 'education economy' rather than thinking about individual schools.

## Tools: Effectiveness of the tools available to staff to support safe decision –making

- 42 Professional practice is being increasingly influenced by the introduction of tools. Frameworks for the assessment of need and associated electronic and paper forms, such as those for the Initial and Core Assessment and the Common Assessment Framework (CAF), and processes such as the Integrated Children's System, are all examples of such tools. Traditionally, people have tended to see tools as passive objects that help professionals do the same tasks as before, but do them better or faster. Consequently, research, evaluation and SCRs in child welfare services have tended to focus only on whether or not practitioners are using prescribed tools; for example, whether all the sections of a Core Assessment Form were completed.
- 43 The experience from other fields, however, emphasises how tools become active agents in shaping practice and, in the process, alter the nature of the practitioner's task. An assessment framework, for example, is more than a neutral format for organising data but offers a mechanism for organising the assessment that influences the way the family is conceptualised and hence alters the final picture of them that is acquired. The structure of forms with their differently headed boxes, similarly, can affect both the sense-making process of the form filler and the 'interpretive demands' (White et al, 2008: 12) it places on subsequent readers. It is important, therefore, to consider how people and tools 'interact with each other and, over a period, change each other in complex and often unforeseen ways' (Hood and Jones, 1996: 35), and to examine whether these changes are leading to improvements in practice. Clarity about the purpose of any tool is also fundamental to any evaluation of its usefulness.

## **FINDING 5: Design of work processes and procedures makes it difficult to respond *as effectively* to neglect as to incidents/injuries**

44 In Finding 1 we discussed the absence of a coherent philosophy to tie together early help and responses to emergencies. This makes it difficult to see them as mutually necessary and supportive and leads to the prioritisation of emergencies over early help. Here we show how this tendency is reinforced by the working processes, procedures and associated tools that workers are required to use and give examples of three processes, as evidenced from this review, that highlight the inadequacy of their use in the context of neglect cases. These, while supportive of good practice in response to incidents, actively create barriers to effective understanding of, and responses to, neglect.

### **Prioritisation of referrals**

45 Referrals are prioritised according to professional assessment of current and immediate levels of risk. As neglect is often chronic and by its nature builds gradually, the levels of risk in neglect cases are often lower *at any given point in time* than cases of physical abuse. Compared to physical abuse, one is less likely to see sudden ‘spikes’ in the level of risk to the children. Instead, the damage caused by neglect is cumulative over longer periods of time (Daniel et al. 2009). The way that decisions within the First Response team are made on whether to accept referrals is often based on current risk or a precipitating incident. This means that cases may have more difficulty getting through the ‘front door’ of children’s services unless the level of neglect is extreme. In this case, where strategy meetings were called it was mainly in response to an incident or injury to one of the children. Only two in a seven year period were prompted by concerns about neglect.

46 If this is the case it is necessary to build into the system alternative triggers for concern that are possible indicators of risk in neglect cases. Doing so relies on a professional understanding of neglect that goes beyond the typical (nits, cleanliness, weight and odour) and reacts to the more atypical. The fact that this is difficult was shown in Finding 4 above and in the lack of understanding of the significance of truanting.

47 Another possible trigger might be a birth, especially where there is a history of a lack of antenatal care or late bookings. A mid-wife in this case did make an appropriate referral, concerned about an unplanned, late home delivery and her good practice should be embedded in guidance to the midwifery service so that previous inconsistent access to ante-natal care is potentially, in itself, grounds for referral. This is particularly important where a family is either not registered with, or as in this case, not accessing a GP. Services such as health visiting and midwifery are critical to the network of services routinely coming into contact with families and it is essential that they act pro-actively as the “eyes and ears” of the protecting agencies. The fact that the referral did not result in an effective assessment goes to the tendency of social care practitioners to focus only on the child that was the subject of the referral – picked up further in Finding 6 below.

## **Strategy meetings better suited to respond to incidents and not effective as the only and routine response to cases of chronic neglect**

- 48 Current child protection procedures require that strategy meetings (or discussions) take place to determine whether or not a referral proceeds to a child protection investigation. Although statutory guidance states that these should be multi-agency meetings, the norm over the review period was for the strategy meeting to be a conversation between children's social care and the police. Guidance is also conflicting, as it directs that a child protection investigation cannot be initiated without a strategy discussion with the police. The police interest, determining their involvement in a joint investigation with children's social care, is in whether or not a crime has been committed. With cases of chronic neglect the evidence base grows over time and is likely not to reach a level to trigger police involvement until severe damage has been done. Complicating matters still further, police investigations are conducted in the legal context of having to show beyond all reasonable doubt that neglect is 'wilful' and according to the representative from the Police Service it was only in 2008 that an appeal held that this could include apathy to a child's wellbeing.
- 49 The strategy meeting that triggers a child protection investigation is still the default response to a referral. It is designed to produce an effective response to information that is perceived as urgent but it is not necessarily the best way to respond to information that is important – or, at least, not while it is the only process that triggers a child protection investigation and not while the fact of it in turn triggers tight timescales linked to other work processes (picked up further in Finding 6). How might a more appropriate response, that is allowed to take longer, be facilitated in cases of neglect? Would this be appropriate too for physical abuse? A bruise might be more urgent but the neglect more important; the pressure to prioritise the urgent does not easily allow for such nuance.
- 50 There is a link between this point and Finding 1 in which we advocate for an integrated child protection system. Where there is a robust early help provision, might a response to cases of chronic neglect be signposted directly to this, bypassing the statutory mechanisms for child protection, for re-assessment and planning? If the answer to this is yes the onus returns to Finding 3 and the need to improve professional understanding of the nature and causation of neglect.

## **Categorisation requirements for child protection plans**

- 51 Once a case has been categorised as 'neglect', there can be a tendency to rule out other forms of abuse, for example sexual abuse. This is sometimes known as the 'neglect mindset' (Brandon et al. 2010). It is encouraged by the tendency to 'register' children on child protection plans under only one category of abuse rather than being able to indicate multiple forms of abuse, and by the associated need to easily interrogate management information. Neglect is the only form of abuse that does not have the word 'abuse' in its name. Speculation – does this cause workers to take it less seriously or not 'see' other forms that may coexist?

**Design of work processes and procedures makes it difficult to respond *as effectively* to neglect as to incidents/injuries**

**Issues that the Board needs to consider:**

Child protection systems and the LSCB that has the remit to monitor and evaluate their effectiveness need to think about what work processes, procedures and tools would need to look like to be able to respond as effectively to neglect as to incidents/injuries.

- How might referrals be prioritised to enable cumulative risk over longer time spans to have equal weight with short-term 'spikes' in risk, such as seen in physical abuse cases?
- What would be involved in moving beyond the use of strategy meetings as the default response to cases of neglect, to adopting an approach that better facilitates planning and analysis? What might a more effective response to neglect look like at assessment stage and how do you ensure that its effectiveness is measured?
- Would it be possible to allow multiple categories of abuse for any care plan, or abolish use of categories altogether?

**FINDING 6: Computer systems can make it difficult**

52 It is vital to any child protection system that it is able to measure how effective it is being. Currently, there is a growing emphasis on the need to measure impact and outcomes rather than numbers and timescales but the computer systems that organisations rely on to store data are not yet sophisticated enough to produce reports that support this, nor has the statutory guidance quite caught up. Going back to the strategy meeting point in Finding 5 above: the strategy meeting at which the decision to conduct a child protection investigation is made triggers a timescale within which a first child protection conference must be held. In theory it is possible to hold any number of strategy meetings before the trigger one, which would make it more likely that they would be appropriately multi-agency in nature and offer an opportunity for greater intelligence gathering over a period of time. In practice, as soon as the fact of a strategy meeting is entered on the computer system the trigger is released and the clock starts ticking – in the interests of the production of management information that shows whether or not child protection conferences are held within the statutory timescale. Revising the computer system is not straightforward; it is more often than not either expensive to change or outside the possibilities of the software package.

53 Computer systems can facilitate good practice or exacerbate the likelihood of blinkered vision. We have shown how an appropriate referral from a midwife came to no consequence as professionals dealt with it in isolation from the child's family context. Before the introduction of individual electronic data records a paper file would include a

file for the family, making it relatively straightforward to locate a particular child within their family context and thus be alert to risk indicators elsewhere in the family network. New systems were designed to respond to the need for professionals to identify and assess the needs of the individual child rather than assume that the need of one in a family was common for all. The family file ceased to exist.

- 54 The introduction of an electronic data system (Framework I in Haringey) in the summer of 2005 featured heavily in professionals' commentary about the challenges children's social care faced throughout the review period and training logs for the period show how many struggled to use the new processes. This was perceived as being general and widespread but the impact of a large and/or complex family network on staff trying to learn and implement a new process was not only described as – "overwhelming" but was responded to by some with feelings of "dread". The absence of a family file within the system meant that common information had to be manually copied across to another record if there was more than one child and information across files was not transferable - a laborious requirement. In relation to the complex family of this case review, the Review Team experienced the difficulties graphically for itself when we had access to the children's social care electronic record (Framework i) in one of our half-day meetings. Documents of relevance to each child, such as assessments and/or meeting minutes, were filed in the records of one (and not always a logical one – we had to explore) and were not copied across to another. How time consuming this is and the level of frustration it engenders should not be underestimated. It acts as a strong disincentive to getting a picture of the whole family.
- 55 The implementation and use of ICT systems is critical both to effective information gathering and to supporting good assessments and safe decisions in relation to vulnerable children. The effective introduction of any new system presents a challenge to such functions. The perception was, and to a significant degree remains, that changes to systems did not always realise the intended benefits and in some areas had an adverse impact. While we have heard that the current systems available to staff have improved significantly since the period under review, gathering and making sense of information about families with a number of children remains an issue.

**Computer systems can make it difficult  
Issues that the Board needs to consider:**

Designing useful technology requires a good understanding of the nature of the tasks that the user needs to accomplish. It is far from unusual for children's social care staff to work with families who have more than one child. Knowing the history of the family and previous involvement of services is vital to making correct sense of the current situation.

A critical question for the Board to consider is:

- Are recent and planned improvements to Children's Social Care IT systems sufficient to support safe practice and decision-making, particularly in respect of complex families?
- Do they make it easy to create and access family histories and chronologies? Is

there some way of displaying and recording whole family history to ensure a whole family perspective is taken?

- If not, what more needs to be done?

The quality of the work that staff are able to accomplish is significantly affected by the appropriateness of the tools that we give them to use. What this case review has highlighted is a particular way in which the ICT tools that we require social workers to use not only fail to support them, but actively create a further barrier to their accessing the information on siblings that is necessary to getting a picture of the whole family. Unless this issue is addressed, seeing the whole family will continue to require heroic efforts of social care staff. This may be possible for families with one or two children, but in cases involving complex families, it does not seem a realistic, or indeed fair, expectation. Achieving good practice cannot rely on heroes; we need well designed systems that enable all staff to produce quality work.

## Cognitive and emotional biases

### **FINDING 7: Absence of systems to promote review of professional judgements**

- 56 While the whole-systems approach to reviewing critical incidents requires an understanding of the role of the individual practitioner in why things go wrong, it is also fundamental to the systems methodology that any individual will have certain limitations – cognitive, psychological - on their capacity to make safe decisions and avoid errors. Designing a safe child protection system means taking into account these limitations and requires an understanding and recognition of the main human errors of reasoning, and building in strategies for detecting and correcting them.
- 57 Many of the innovations in children’s services in recent years have attempted to provide defences against these human vulnerabilities, for example, the emphasis given to recording, to timely decision making, strict performance indicators and the prescribed arenas for serious case reviews. The important question however, in any case review, including this one, is whether or not these mechanisms worked and why and what impact they had on individual decision-making.
- 58 According to the human performance literature, a persistent problematic tendency in cognition is our human slowness in revising our view of a situation or problem. It is one repeatedly found in child abuse inquiries (Munro, 1999). Once practitioners have formed a view on what is going on, there is a surprising tendency for them to fail to notice, or to dismiss, evidence that challenges that picture. In the opinion of the Review Team, this was a significant contributing factor to the failure of statutory agencies to provide an appropriate and consistent response to this family. In this case an early assumption was made by key social care professionals that the main issue for the family was one of overcrowded housing with related issues of poor physical presentation and attendance

of the children in school. The view was held, and persisted throughout changes in personnel, that addressing these “symptoms” would resolve matters.

- 59 An example of where this went wrong is the culture of the ‘six month rule’. The Review Team learned that it was accepted practice within children’s social care at the time to operate a ‘six month rule’ in relation to Child in Need cases. Should a case be re-referred within 6 months of its closure it would automatically be transferred back to the Child in Need Team, by-passing the usual front door and the formal re-opening of the case. The theory was understandable: this would give families consistency, as cases were re-allocated to the same social worker that had been involved before. The practice was very different due to the turnover of staff at the time – and simply to do this without any robust management oversight was risky; an opportunity for directed reassessment missed.
- 60 It is also very unclear whether this cultural practice was ever made clear to any other agency or if it was explained to families. A family that was already hostile, who had been told that social work involvement with them was to cease, stood to become even more so if they discovered this not to be the case, with no explanation. The primary school Head Teacher, trying to make a new referral when one of the children came to school with an unexplained injury, spoke of her frustration when told that she couldn’t as the case was being held in a particular team. As far as she was concerned the case had been previously closed, so a call to the Duty Service was entirely reasonable.
- 61 The most important challenge and support mechanism that most organisations have at their disposal is supervision. This is particularly so if knowledge and expertise of staff are limited, as we have argued in Finding 3. Had this been operating effectively at the time, it may have brought about a step change in the direction of case management.
- 62 It was not effective for a variety of reasons, some to do with the turnover of both social work staff and first line management, combined with the evident lack of an organisational investment in professional development that was linked to improving social work practice. There were measures in place to monitor the fact of supervision but not its quality. Supervision – or its frequency - was another performance measure to be met; we heard how it was common practice in the Tottenham office to count a manager answering a question as ‘on the spot’ supervision in order to meet the performance measure.

**Absence of a system to promote review of professional judgements**

**Issue that the Board needs to consider:**

Psychological research has shown that it is impossible to police one’s own cognitive biases, so not addressing the quality of supervision brings with it a risk that failures to revise judgements about particular cases will not be picked up. The LSCB has already agreed a Best Practice Standard in relation to supervision and there are indications that the significance of supervision is more recognised within current practice but it is not

embedded consistently across the partnership. The challenge for the LSCB is:

- how to ensure that its constituent partners have appropriate supervisory and checks/balance arrangements in place to provide effective challenge to practitioners – both in general and particularly around the management of cases of chronic neglect? Such arrangements need not always be provided directly by a particular agency for its staff but must be accessible to those who work directly with children.
- And how to hold agencies accountable for this? The use of the Section 11 audit process will assist in establishing a base-line of practice across the partnership.
- Are there extra safeguards that could be put in place for cases that that are worked with over a longer time period e.g. chronic neglect? What would the cost-benefit of this be to the partner agencies in terms of the amelioration of risk?

## Family-professional interaction

### **FINDING 8: No effective challenge to non-engaging families prevents accurate understanding of what is going on**

- 63 It is a key finding of this review that practitioners from children's social care had no effective challenge to the barriers to effective intervention that the family put up. The parents were difficult and became mythologised as such in a way that diminished their obstructiveness. Their behaviour was explained away – as if being difficult made it less rather than more significant. Front line social care staff were not equipped or supported to engage with challenging or non –engaging parents.
- 64 Research has shown that some families shut themselves away from contact with the outside world and with members of the professional network by refusing to open their front door to them, failing to keep appointments and keeping the children away from school or nursery. In this case while the family did not disappear from view, parents resisted attempts to engage with them and professionals appeared unable to challenge this effectively or to assert their professional authority with the family. One striking example, was professionals accepting uncritically what they called the “family's policy” whereby agencies were prohibited from going beyond the downstairs area of the home. The lack of the appropriate use of professional authority was compounded by an absence of curiosity about the children and their experiences and uncertain awareness of the extent, and limits, of what it is reasonable to expect families to comply with. The result was that at no time did representatives of the statutory agencies have the opportunity to develop any more than a superficial understanding of the circumstances in which this family was living and why.
- 65 This was compounded by what Reder et al (1993) called ‘disguised compliance’, where parents defuse professionals’ attempts to take a more authoritative stance by making pre-emptive shows of cooperation. In the period immediately prior to the child protection conference in November 2006 at which professionals agreed to remove the

children's names from the Child Protection Register, Mr Z displayed a tolerance towards social work involvement for the first time. Previously his response to social workers' attempts to engage with him had been met with aggression and threatening behaviour, behaviour which had also been in evidence at previous formal meetings with him. Mr Z also attended the last child protection conference itself and clearly presented in a way which was reassuring to those professionals who had attended. Problematically, this change was taken at face value by professionals. At no point was this change of approach questioned or set alongside how he had presented previously.

- 66 It takes confidence for a worker to come across to others as authoritative. The public response to high profile child deaths locally saw a marked decline in the public standing of social workers, manifest in part in increased abuse from the parents on the doorstep of the home. This has continued to-date, albeit with less intensity. It has not made it easier for social workers to feel the confidence that is necessary to deal constructively and with authority, with families who seek to control the manner in which professionals gain access to them. It raises questions for the review team about whether current workers are likely to be any better equipped than during the time under review.
- 67 Professional confidence that can be gained from feeling secure in what your organisation permits you to do and offer in your role. This is the last of the review findings but in a way it brings us back to the first: it is easier to do this when armed with a clear understanding, not just of law and procedures, but of the resources at your disposal within your organisation's approach to safeguarding families.

**No effective challenge to non-engaging families prevents accurate understanding of what is going on**

**Issue that the Board needs to consider:**

The need for a greater level of authoritative practice has been highlighted in previous reviews.

- Does the Board feel adequately assured that statutory agencies have tackled this deficit?
- How might partners be supported to develop a culture and management approach which supports and encourages the use of professional authority with families who are controlling or reluctant to engage?

In situations where access to the home is denied, what range of strategies are available to professionals? Is there clarity about what should be done if none of these strategies work? The Munro review has again brought the importance of the relationship that professionals, particularly social workers, have with families back into the spotlight. To paraphrase consultant Jake Chapman you simply cannot 'deliver' safeguarding and child protection services in the way that you can deliver a pizza, because they require that the children, young people and family member engage with professionals and professionals to engage with them. Lord Laming previously highlighted the 'high ask' involved in cultivating relationships while simultaneously maintaining a respectful uncertainty about

what is actually going on. Adequate skills and competencies to exert professional authority when appropriate are therefore crucial to the workforce. To send them out without these, is to deny them a critical tool of their trade.

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