

# **The Munro Review of Child Protection**

**Part One: A Systems Analysis**

Professor Eileen Munro



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# Preface



In June, the Secretary of State for Education, the Right Honourable Michael Gove MP, asked me to conduct an independent review of child protection in England. In this my first report, I set out my approach to this important review and the features of the child protection system that need exploring in detail and that will form the focus of subsequent stages of the review. My first aim is to understand why previous well-intentioned reforms have not resulted in the expected level of improvements. An interim report in January 2011 will provide an update on the review's further progress, beginning to set out potential solutions and areas for possible reform. It will be followed by my final report in April 2011 where I will set out my recommendations.

In this first stage, I have been listening to the views of children, young people, families, carers, social workers and other professionals, including for example those in health, education and police services, whose role in the protection of children and young people is of course significant. I have been supported by a personal reference group, drawing on the experience of service users, the Association of Directors of Children's Services (ADCS), the judiciary, the voluntary sector, the social work front line, and systems expertise. I have had the help and advice of a number of sub-groups that have been set up to examine specific issues in detail, and the support of an experienced team of civil servants.

There has been a great response from those in the field, both in reaction to the review's launch and to the subsequent call for evidence that sought innovative examples of good practice. At the time of writing, over 450 submissions have been received. Additionally, I have benefited from meetings with organisations such as the British Association of Social Workers, the National Society for the Prevention of Cruelty to Children, the Royal College of Paediatrics and Child Health, the Association of Chief Police Officers, and Ofsted. I have looked at models of child protection in use in other countries and my review team has visited ten local authorities and a Primary Care Trust where they have seen some innovative approaches to child protection. I am also drawing on the extensive evidence submitted to inform Lord Laming's 2009 progress report and the Social Work Task Force. This review also informs and is informed by the work of the Social Work Reform Board and the Family Justice Review.

The context of this review is one of financial constraint across public services, increasing demand for children's social care, and radical plans for the way government approaches public services. This review is timely, with the opportunity to advise Government, service leaders, and professionals across England where best to place our energies in order to meet the varied needs of vulnerable children and young people.

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# Introduction

Protecting children from abuse and neglect has been high on the political agenda for many decades. The reforms introduced by previous Governments have been designed by well-informed and well-intentioned people, so it is reasonable to ask why there should be yet another review leading to another set of reforms. The problem is that previous reforms have not led to the expected improvements in frontline practice. Moreover, there is a substantial body of evidence indicating that past reforms are creating new, unforeseen complications.

It is therefore important to think carefully before producing more recommendations for change. This report is purposely analytical. It sets out the systems approach I am taking to understand how reforms interact and the effect these interactions are having on practice. It is at the front line where they come together, at present creating an imbalance and distortion of practice priorities. There are unexpected consequences which arise and which are experienced by professionals as unhelpful, distracting from a clear focus on children's safety and wellbeing. A clear example of this is the introduction of prescriptive timescales for assessing the needs of children, introduced because there was a legitimate concern about 'drift' in cases where children may have been at risk of harm. Whilst clearly a reasonable aspect of practice to challenge, the combination of a new performance indicator to measure this, with a national performance and inspection system seeking better accountability, resulted in an over-preoccupation with meeting timescales for assessment relevant to concern about the quality of that assessment and its impact on the safety of children and young people.

Since beginning this review in June 2010, I have been learning a lot from people in the field about the real complexity of frontline work today – an invaluable lesson since it is many years since I have worked directly with families. I have also been impressed by the appetite for change, and the recognition and professional openness about the need for improvements in the quality of service provided to children, young people, and families. The submissions to the review outlining local innovations have demonstrated creative efforts to enhance practice and these show how it is possible to achieve high standards, even though many would say it was *despite* not *because of* the formal structures. The review as it progresses will continue to be a collaboration with professionals working with children and young people and there will be further opportunities for consultation and dialogue.

A dominant theme in the criticisms of current practice is the skew in priorities that has developed between the demands of the management and inspection processes and professionals' ability to exercise their professional judgment and act in the best interests of the child. This has led to an over-standardised system that cannot respond adequately to the varied range of children's needs.

Lord Laming's *The Protection of Children in England: A Progress Report* (March 2009) illustrated this well, reporting that:

*'Professional practice and judgment, as said by many who contributed evidence to this report, are being compromised by an over-complicated, lengthy and tick-box assessment and recording system. The direct interaction and engagement with children and their families, which is at the core of social work, is said to be at risk as the needs of a work management tool overtake those of evidence-based assessment, sound analysis and professional judgment about risk of harm.'*<sup>1</sup>

The Association of Directors of Children's Services (ADCS), in their position statement on inspection<sup>2</sup>, warn of the possible adverse effects:

*'The perceived punitive effects and the impact of judgments on services in terms of the local media and political response are in danger of creating a climate whereby the inspected manage for inspection rather than managing for quality and outcomes for children and young people.'*

**What elements of this description of child protection do you recognise in your organisation?**

Child protection work involves working with uncertainty: we cannot know for sure what is going on in families; we cannot be sure that improvements in family circumstances will last. Many of the problems in current practice seem to arise from the defensive ways in which professionals are expected to manage that uncertainty. For some, following rules and being compliant can appear less risky than carrying the personal responsibility for exercising judgment.

Social workers are only one of the many groups who work with children and all have a responsibility to protect them, to watch out for signs of difficulty and take responsibility for considering how those difficulties might be tackled. The problem is that the evidence of abuse and neglect is not clearly labelled as such. The causes of injuries are often hard to ascertain; children's distress and problematic behaviour can arise from myriad causes. Fear of missing a case is leading to too many referrals and too many families getting caught up in lengthy assessments that cause them distress but do not lead to the provision of any help. This is creating a skewed system that is paying so much attention to identifying cases of abuse and neglect that it is draining time and resource away from families.

547,000 children were referred to children's social care in 2008/09. There has been an 11 percent rise to 607,000 in 2009/10. Six percent in both years, became or continued to be the subject of child protection plans. The overwhelming majority of cases were not deemed to contain any actual or risk of significant harm. Many of the families, however, were likely to be struggling and would benefit from receiving some support and help. Children receiving social care support are described as 'children in need' and numbered 382,300 in 2009/10 (up 25 percent from 304,400 in 2008/09) according to provisional figures from the latest Children in Need census published by the Department for

1 The Lord Laming (March 2009), *The Protection of Children in England: a progress report*, p 33

2 Association of Directors of Children's Services November 2009 position on inspection (available online at <http://www.adcs.org.uk/download/position-statements/november-09/ADCS-position-on-inspection.pdf>)



Education on 30 September 2010.<sup>3</sup> Local authorities have a statutory responsibility under the Children Act 1989 to safeguard and promote the welfare of children within their area who are in need and, so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.

Earlier reforms have also contributed to the growing imbalances in that they have tended to focus on technical solutions – increasing rules, more detailed procedures, more use of ICT – while giving less attention to the skills to engage with families, the expertise to bring about enduring improvements in parenting behaviour, and the organisational support that enables social workers and others to manage the emotional dimensions of the work without it harming their judgment or their own well-being. A significant consequence of the practice and guidance imbalance has been the increasing alienation of the workforce in children's social care. Many local authorities are having trouble in recruiting and retaining staff, so that the most challenging social work tasks in frontline child protection work are increasingly being undertaken by the least experienced staff. The Social Work Task Force identified 'that social workers feel that their profession is under-valued, poorly understood and under continuous media attack. This is making it hard for them to do their jobs and hard to attract people into the profession.'<sup>4</sup>

The ones who lose out most are the very children the system is intended to protect. The reforms have driven compliance with regulation and rules over time, with social workers increasingly operating within an over-standardised framework that makes it difficult for them to prioritise time with children, to get to know them, and understand their feelings, wishes, and worries. It is then in turn difficult to provide the flexible and sensitive responses that match the wide variety of needs and circumstances that are presented. The Children's Commissioner has provided a wealth of evidence to this review that reveals the distress children feel at receiving an impersonal service where insufficient time is given to helping them understand what is happening to them. They want a social worker who forms an enduring relationship with them and listens to them.

A key question for this review is therefore to understand why these well-intentioned reforms have not produced the expected results and therefore to avoid making the same mistakes. The system needs to be more able to notice when imbalances are developing and to correct them more quickly. The review is working in collaboration with the Social Work Reform Board (SWRB) in taking forward the recommendations of the Social Work Task Force. The SWRB has set out its priorities for reform, agreed by Ministers, which include the development of a new set of standards for the profession and a single, nationally recognised career structure for social work, with clear progression routes and expectations at each stage of a social worker's career.

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3 DfE: Children Looked After by Local Authorities in England (including adoption and care leavers) – year ending 31 March 2010 (<http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000960/index.shtml>)

DCSF: Children Looked After in England (including adoption and care leavers) year ending 31 March 2009 (<http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000878/index.shtml>)

DfE: Referrals, assessments and children who were the subject of a child protection plan (2009-10 Children in Need census, Provisional) (<http://www.dcsf.gov.uk/rsgateway/DB/STR/d000959/index.shtml>)

DCSF: Referrals, assessment and children and young people who are the subject of a child protection plan, England – Year ending 31 March 2009 (<http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000873/index.shtml>)

4 Social Work Task Force (2009), *First Report of the Social Work Task Force*, (available online at [www.dcsf.gov.uk/swtf/downloads/FirstReport.pdf](http://www.dcsf.gov.uk/swtf/downloads/FirstReport.pdf))

The Reform Board will produce standards for employers of social workers, to include commitment to a culture of regular professional supervision and continuing professional development as the best ways of supporting social workers and improving practice. The Reform Board is working on measures to improve the quality and consistency of social work education and training, including the introduction of an assessed and supported first year in employment to bridge the gap between the award of the social work degree and becoming a fully autonomous social work professional. Good progress has been made in taking forward the Social Work Task Force recommendation to establish the College of Social Work, with the recent appointment of the College's joint interim chairs. The College will play a key role in improvement in standards and practice as the voice of the profession, as well as leading a programme of action to improve public understanding of social work.

In looking more deeply at the system for child protection in England as it currently operates, the review is making use of evidence that had previously been submitted to Lord Laming's 2009 progress report and to the Social Work Task Force. This allowed us to develop initial observations for the review team to test further. Many practitioners and leaders have said that these observations make sense in the context of child protection practice at this time. They are included here in order that readers of this report have access to the feedback that was already in the system prior to this review. They are grouped under the three main headings of our initial analysis: early intervention and prevention, frontline practice, and transparency and accountability.

*Early intervention and prevention:*

- Universal services, for example children's centres, do not currently offer comprehensive early specialist support to vulnerable children, young people and families because the professional and specialist family support capacity and expertise has not been developed in those services;
- There is evidence of inconsistency and uncertainty among professionals in respect of managing and responding to contacts and referrals about vulnerable children and young people.

*Frontline practice:*

- Compliance with regulation and rules often drives professional practice more than sound judgment drawn from the professional relationship and interaction with a child, young person and family;
- The assessment framework and process is inefficient and does not easily facilitate professional judgment about risk and safe next steps for a child, young person and their family; and
- ICT systems are experienced as unhelpful in two ways:
  - Social workers are required to spend too much time completing documentation; and
  - The Integrated Children's System (ICS) does not help enough in the creation of chronologies and the child's story.

*Transparency and accountability:*

- The performance and inspection systems in place do not adequately examine the quality of direct work with children and young people or its impact;
- A lot of data is collected (some required nationally and some developed locally) which is said to describe performance, but in many cases it does not describe what matters and it consumes a disproportionate amount of time and resource;
- Serious Case Reviews (SCRs) have not fostered a learning culture which supports improved practice; and
- Social workers are frequently blamed when children are harmed.

In undertaking this review, it is important to remember that there was no golden age. All the reforms have been a reaction to finding serious defects in practice. But it is also worth noting that, in recent years our knowledge of effective interventions, whilst still incomplete, has increased substantially. Recent reviews, including those undertaken as part of the Safeguarding Children Research Initiative, have identified such interventions for children who have been abused or neglected and also for families needing support in the early years of a child's life. There is much good practice and research for us to build on in our efforts to better protect children and young people.<sup>5</sup>

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5 Barlow, J. & Schrader McMillan, A. (2010), *Safeguarding children from emotional maltreatment: What works* (available online at [www.education.gov.uk/research](http://www.education.gov.uk/research)); Hicks, L. & Stein, M. (2010), *Neglect Matters: A multi agency guide for professionals working together on behalf of teenagers*; Littell, J.H. et al (2005), *Multisystemic Therapy for Social, Emotional, and Behavioural Problems in Youth aged 10-17*, Cochrane Review (available at [www2.cochrane.org/reviews](http://www2.cochrane.org/reviews)); Macmillan, H. et al (2009), 'Interventions to prevent child maltreatment and associated impairment', *The Lancet*, Volume 373, pp 250-266; MacMillan, H.L. (2010), *Interventions to Prevent Child Maltreatment*, PreVAiL: Preventing Violence Across the Lifespan Research Network (available online at [www.uwo.ca/fims/prevail/docs](http://www.uwo.ca/fims/prevail/docs)); Montgomery, P. et al (2009), *Systematic reviews of interventions following physical abuse: Helping practitioners and expert witnesses improve the outcomes of child abuse* (available online at [www.education.gov.uk/research](http://www.education.gov.uk/research)); Utting, D. et al (2007), *Interventions for children at risk of developing antisocial personality disorder*, Policy Research Bureau (available online at [www.communitycare.co.uk/Articles/2007/10/31/106309/research-children-with-antisocial-personality-disorders.htm](http://www.communitycare.co.uk/Articles/2007/10/31/106309/research-children-with-antisocial-personality-disorders.htm))

# Section 1

## A systems approach

- 1.1 A systems approach will help this review to avoid looking at parts of the child protection system in isolation, and to analyse how the system functions as a whole. Social workers and other professionals accept many previous reforms were well-intended but their interaction and cumulative effect on frontline practice have had unintended consequences. A systems approach will help to understand how and why previous reforms have had both beneficial and adverse consequences and how the review might improve how the system supports social workers and other professionals to protect children and young people better in the future.
- 1.2 The review will use systems theory in two ways. First, the review will look back at past reforms to explain what has happened, with systems theory providing a strong basis to build the review's understanding. Second, the intention is to use systems theory analysis to look forward – with systems theory helping the review design an improved approach. The first leads naturally to the second since what is needed is a stronger understanding of the system and analysis of how aspects of the system interact with each other before the review recommends any further changes.
- 1.3 In such a complex system as child protection, it is inevitable that any innovations this review recommends will themselves have unexpected consequences as they are put into operation. The review will keep this in mind before making recommendations, to Government in April 2011. Further, in designing recommendations, the review will be considering how the system can become better at monitoring how it is performing, learning about emerging difficulties, and responding creatively and adaptively to tackle them. The aim is a legacy where the system is better equipped to continuously learn and improve.

*'The aim is to make it harder for people to do something wrong and easier for them to do it right.'*<sup>6</sup>

- 1.4 Poor design of parts of the system, including the many examples submitted to this review, make it *less likely* not impossible for high quality service to be achieved. Similarly, other aspects of the system that are better designed can *promote* good practice but not *guarantee* it. Good social work practice thrives in children's social work across the country and this review is being informed by many successful local innovations in response to the review's call for evidence in July 2010. Farmer<sup>7</sup> illustrates this point well reporting that the highest success rate for reunifying children with their birth families was 64% while the lowest was 10%, with the key determinant being the skill and investment of the social work team. The review is

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6 US Institute of Medicine (1999), 'To Err is Human: Building a Safer Health System', Washington D.C., National Academic Press

7 Farmer, E. et al (2008), *Reunification of Looked-After Children with their Parents: Patterns, Interventions and Outcomes* (available online at [www.education.gov.uk/research](http://www.education.gov.uk/research))

concerned, though, whether previous reforms have, inadvertently, created a system which makes it harder for social workers and other professionals to achieve such good practice.

## The range of reform

- 1.5 There has been a remarkable degree of reform and change in the child protection system since the Local Authority Social Services Act 1970 which first introduced the requirement for local authorities to follow Government-issued statutory guidance. Over the last forty years, reform after reform has been intended to improve the quality of the protection provided to children and young people and compensate for failures in practice. Many such reforms responded to the cumulative evidence from inspections and high-profile reviews into children's deaths including: the 1974 Maria Colwell Inquiry (which led to the introduction of Area Review Committees), the 1988 Cleveland Inquiry (which informed the early versions of the statutory guidance *Working Together to Safeguard Children* and the introduction of SCRs), and the Victoria Climbié Inquiry Report (which contributed to the *Every Child Matters* Green Paper that set out policy proposals leading to the establishment of statutory Local Safeguarding Children Boards (LSCBs)). More recently, the circumstances around the death of Peter Connelly led to the previous administration commissioning Lord Laming's progress report. The Coalition Government has already endorsed the work of the SWRB has following the recommendations of the Social Work Task Force and within weeks of its formation the new Government has proceeded with further reforms including new statutory guidance on the publication of SCRs.
- 1.6 Over this same period there have been a number of re-organisations both at a national and local level. Children's social work was originally the responsibility of the Home Office, then the Department of Health and Social Security, then the Department of Health, moving in 2003 to the Department for Education and Skills which then became in 2007 the Department for Children, Schools and Families and is now named the Department for Education. At a local level, services have been organised in a range of ways, sometimes with generic responsibilities, sometimes in specialist teams, sometimes centralised, and sometimes based in locality teams.
- 1.7 The many changes have been most striking in relation to social work practice, an area where it can be argued there was most need for improvement. While in the 1970s there was relatively little guidance on dealing with child abuse and neglect, social workers now have a range of assessment and decision making tools, access to research evidence, and software programmes that shape, often in unintended ways, how a case is managed.
- 1.8 Professionals working with children and young people in social care, health, education, and police services have access to detailed guidance and procedures to inform the way they work together to safeguard children and young people. Parton<sup>8</sup> reports that the first formulation of Government guidance in 1974 was seven pages long, whilst the latest statutory guidance, published in 2010, has 390 pages and makes references to ten other pieces of supplementary guidance that provide a further 424 pages.

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8 Parton, N. (2010), *The Increasing Complexity of 'Working Together to Safeguard Children in England'*

- 1.9 The efforts to improve practice have not addressed all the weaknesses in practice and have tended to focus mainly on the process of case management, increasing regulation, and standardised assessment frameworks. Difficulties such as forming working relationships with families, asking challenging questions to really understand the family's history and current situation, keeping an objective view on what is happening, and coping with the emotional demands of the work have received less attention. The biennial reviews of SCRs report recurrent problems in practice, e.g. children being invisible to professionals because the focus is on the parents, inadequate assessment of the dangers of parental problems of substance misuse, domestic violence, and mental illness, and fixed judgments not being challenged and revised.
- 1.10 In addition, the impact of adopting New Public Management across public service reform in recent years has been to seek to improve practice in child protection through targets and performance indicators. This has led to a managerial focus on monitoring the processing of cases.<sup>9,10,11</sup> Inspection methodology has also changed from a professional review that was seen as insufficiently rigorous to assessment of more quantitative measures of process although, more recently, greater attention has been given to judging the quality of practice.
- 1.11 Each new reform, in isolation, has often been well designed, but the problem lies in the cumulative effect they have been having on practice. At the front line, where all these changes come together, the effect has been to produce the current unbalanced state of affairs. Social workers and other professionals have told the review that more managerial focus is being given to complying with top-down regulation, and often further locally designed procedures, than to providing a personalised service that matches the variety of needs of children and young people. The review will learn from innovations where local leaders and managers have supported social workers and other professionals to create less prescriptive working environments with more room for professional judgment.

*'Timescales can end up replacing professional judgment.'*

Social worker speaking to review field team

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9 Dunleavy, P. & Hood, C. (1993), *'From old public administration to new public management'*

10 Munro, E. (2004), *Public Money and Management*, 14, 9-16

11 Munro, E. (2004), *'The impact of audit and social work practice'*, *British Journal of Social Work*, 34, 1077-1097

## Thinking about the whole as well as the parts

1.12 The table below expands on the systems approach being taken. The review will consider whether previous reforms have tended to have more of the characteristics in the left hand column.

Table 1: Atomistic and Holistic Approaches to Child Protection

	Atomistic Approach To Child Protection	Holistic Approach To Child Protection
<i>Nature</i>	<ul style="list-style-type: none"> <li>● Narrow: tending to concentrate on individual parts or elements</li> </ul>	<ul style="list-style-type: none"> <li>● Broad: elements seen as standing in relation to each other</li> </ul>
<i>Perspective</i>	<ul style="list-style-type: none"> <li>● Isolated 'problems'</li> </ul>	<ul style="list-style-type: none"> <li>● Whole system</li> </ul>
<i>Cause and Effect</i>	<ul style="list-style-type: none"> <li>● Looking only at immediate and/or proximal effects</li> <li>● Short chains of causality</li> </ul>	<ul style="list-style-type: none"> <li>● Separated in space and time</li> <li>● Long chains of causality, ripple effects, unintended consequences, feedback effects</li> </ul>
<i>Style of Recommendations</i>	<ul style="list-style-type: none"> <li>● Regulation and compliance</li> <li>● Technocratic</li> </ul>	<ul style="list-style-type: none"> <li>● Strengthening professionalism</li> <li>● Socio-technical</li> </ul>
<i>Results (observed and sought)</i>	<ul style="list-style-type: none"> <li>● Narrow range of responses to children's and young people's needs</li> <li>● Defensive management of risk</li> <li>● Command and control management; frameworks and procedures; squeezing out professional discretion</li> <li>● Compliance culture</li> <li>● Focus on standardised processes, frameworks and procedures</li> </ul>	<ul style="list-style-type: none"> <li>● Requisite variety in responses to meeting children's and young people's needs</li> <li>● Acceptance of irreducible risk</li> <li>● Supportive and enabling management</li> <li>● Learning culture</li> <li>● Focus on children, their needs, appropriate pathways beneficial outcomes</li> </ul>

1.13 Since this review is looking at the whole of child protection, including the contribution of the police, health services, education and early years settings in order to see how aspects of each reform are interacting with the rest of the system, the review will be identifying the *ripple effects* from each reform and the *feedback loops* that are unintentionally reinforcing some aspects of practice whilst downplaying others. Appendix 2 contains an example of the use of the systems theory idea of ripple effects showing some of the unintended consequences of



previous reforms, because too narrow a view of the system was sometimes taken.<sup>12</sup> It also illustrates a second, powerful systems idea: 'requisite variety' in response to the varied needs of children and young people.<sup>13</sup>

- 1.14 The concept of 'feedback' as it relates to the way in which a system 'learns' is a third helpful systems theory idea. Feedback arises when a system is monitored to check whether it is behaving as required and corrective action is used as necessary. A thermostat is a simple example: it ensures that the heating system in a house runs higher or lower to produce a room temperature which is the same as the 'target' set by the occupier on the thermostat dial. This is a 'balancing loop' and it equilibrates out any divergence from the target. The feedback concept can usefully be drawn upon to propose possible explanations for the current state of the child protection system and help in recommending changes.

### Doing, thinking and learning

- 1.15 In broad terms, the difference between single and double loop learning can be characterised as:

*'A concern with doing things right versus a concern for doing the right thing.'*<sup>14</sup>

- 1.16 In child protection terms, single loop learning is a way of characterising the compliance approach underlying some reforms. As an example, has the set form on this case been completed and has this been done within the set deadline? In contrast, double loop learning leaves space for professional judgment and the questioning of set targets if a given situation does not conform to the technocratic model. As an example, is completing the Initial Assessment Form within a ten-day period the right measure of our success in helping this particular child? If not, can we change the target to reflect a more accurate measure?
- 1.17 Atomistic approaches to learning are characterised by single loop learning. As with the thermostat, the question that is asked is: *are we doing what is specified?* The situation is illustrated below. With single loop learning, targets are set for the child protection system and its performance is monitored to check (= 'learn') whether the performance matches the targets. If not, then action is taken to change what is going on in the system and put things right i.e. to hit the target. In feedback terms there is a balancing loop – B1 in the diagram – which acts to steer the performance measures closer and closer to the specified target.

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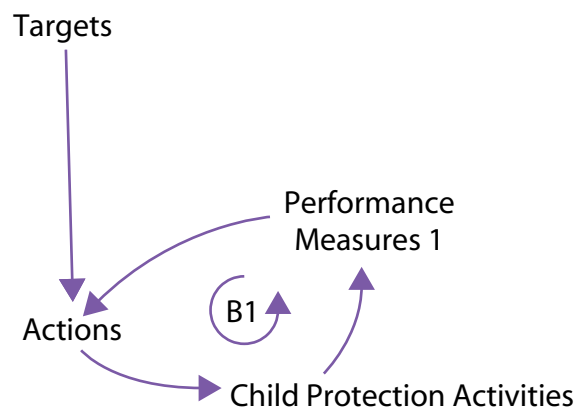
12 Forrester, F.N.J. (1961), *Industrial Dynamics*

13 Ashby, R. (1956), *An Introduction to Cybernetics*

14 Peter Drucker (1909-2005), writer, management consultant, and 'social ecologist'

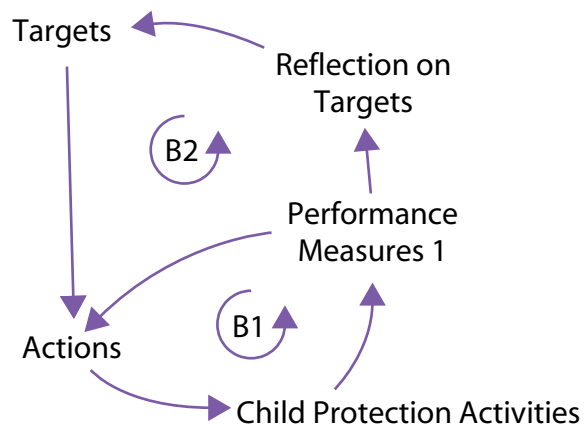


**Single loop: Child Protection System – Are we doing what is specified?**



- 1.18 This can be contrasted with the broader, more reflective learning approach that is a characteristic of holistic thinking. This is double loop learning, in which the question that is being asked is: *have we specified the right thing to do?*
- 1.19 With double loop learning a second loop uses the value of the performance measure to reflect on whether the correct target for the child protection system has been set. This new balancing loop – B2 – allows the target itself to be changed, or updated as the system ‘learns’ more about what a sensible target might be.

**Double loop: Reflective Child Protection System – have we specified the right thing to do?**



- 1.20 The review will question whether we have done too little double loop learning, i.e. standing back and reflecting on whether we have got the balance right in the demands made on social workers and other professionals and the resources provided to help them.

## The socio-technical approach

**1.21** The fourth systems theory idea that the review will draw on is that of the ‘socio-technical system’, contrasting the ‘technical’ approach to understanding child protection with a ‘socio-technical’ approach.<sup>15</sup> A ‘technocratic’ approach assumes that a given analytical problem is clear, with consensus about aims and that implementation of recommendations will be via hierarchical chains of command. In contrast, a ‘socio-technical’ approach assumes the individuals involved and how they work together are just as important as any analytical problem.<sup>16</sup> There is no presumption about consensus regarding the problem: aims might be hard to agree on, and implementing change may require support from a range of partners. This approach does not undermine the value of rigorous analytical thinking, but argues for a balance of abstract analysis and consideration of human relations. The nature of the child protection work has to mean that professional practice and policy makers are open to variety in both defining what help is being sought but also in any response to it. The most effective means of intervening in families is to try to provide the breadth of professional expertise that meets the breadth of their needs.<sup>17,18</sup>

*‘The technocratic view is faulty, not because it is incorrect, but because it is incomplete.’<sup>19</sup>*

**1.22** In shifting to a socio-technical approach, two issues come to the fore. First, greater attention is given to the impact that technical reforms have on professional practice and, second, there is a stronger focus on the fact that child protection work, at its heart, involves forming relationships with children, their family members and others working to support the child.

**1.23** To consider technical reforms first, there is a wealth of tools, frameworks, procedure manuals, and decision aids now provided to the workforce. They undoubtedly have much to offer that is beneficial but insufficient attention has been paid to how they influence what workers do, for good and ill. There has been a tendency to think of tools as making it easier for workers to perform a task but, in reality, they always change the task in some way.

*‘The electronic forms have altered child and family social work in an unhealthy way. The purpose of assessment is to safeguard and promote the welfare of the child this has been forgotten in favour of a primary purpose of filling in the forms.’*

Social worker in BASW submission to review

**1.24** One prominent example is ICS which is being experienced as unhelpful and distracting by social workers. For example, the micro-control of workflow and process in the ICS has had the unintended effect of increasing duplication and data

15 Rosenhead, J. (1989), ‘Introduction: old and new paradigms of analysis’, in *Rational Analysis for a Problematic World: problem structuring methods for complexity, uncertainty and conflict*, ed. Rosenhead J. & Mingers, J., pp 1-20

16 Pasmore, Y.W.A. & Sherwood, J.J. (1978), *Sociotechnical Systems: a sourcebook*

17 Pasmore, Y.W.A. & Sherwood, J.J. (1978), *Sociotechnical Systems: A sourcebook*

18 Rosenhead, J. (1989), ‘Introduction: old and new paradigms of analysis’, in *Rational Analysis for a Problematic World: problem structuring methods for complexity, uncertainty and conflict*, ed. Rosenhead J. & Mingers, J., pp 1-20

19 Tinker, A., & Lowe, A. (1984), ‘One-Dimensional Management Science: The making of a technocratic consciousness’, *Interfaces* 14(2) 40-49

entry at multiple stages, creating repetitive task that simply did not exist before its inception and now cannot be bypassed.

*'In design, we either hobble or support people's natural ability to express forms of expertise.'*<sup>20</sup>

- 1.25** Taking a socio-technical approach to child protection points to the work being essentially 'social' even though there is a place for technical aids; it deals with people not with objects. To paraphrase Chapman (2004), you can deliver a pizza but you cannot deliver a child protection service:

*'All public services require the 'customer' to be an active agent in the 'production' of the required outcomes. Education and health care initiatives simply fail if the intended recipients are unwilling or unable to engage in a constructive way; they are outcomes that are coproduced by citizens.'*<sup>21</sup>

- 1.26** In practice, the tasks of obtaining information, making sense of it, and deciding what action to take are all dependent on the relationship skills of the people involved, both workers and families. Some of the families social workers seek to help are very resistant and unwilling to engage. There are particular deficits in workers' ability to relate to men and to children, with serious adverse impacts on the quality of the data on which assessments and decisions are made. There is also strong evidence that workers, in seeking to engage with a family, can get pulled into relationships with one or more members that distort their overall perception of the family. A classic example is of being so focused on helping the mother that the child's needs are overlooked.
- 1.27** Efforts to think the best of families were found in the 2005-07 study<sup>22</sup> and echoed Dingwall's expression 'the rule of optimism'.<sup>23</sup> There was a reluctance among many practitioners to make negative professional judgments about a parent. Workers, including those in adult-led mental health services, domestic violence projects and substance misuse services were keen to acknowledge the successes of the often disadvantaged, socially excluded parents who were using their services, and reluctant to see them as parents and judge their behaviour as harmful to the child. In cases where adult-focused workers perceived their primary role as working within their own sector, failure to take account of children in the household could follow.<sup>24</sup>
- 1.28** The traditional solution to this problem has been reflective supervision where the supervisor helps the worker notice what is happening and revise their reasoning. Failure to give attention to these sources of error will increase the chances of erroneous assessments being made and kept.

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20 Woods, D. (2002), 'Steering the reverberations of technology change on fields of practice: Laws that govern cognitive work', in *Proceedings of the 24th Annual Meeting of the Cognitive Science Society, Atlanta, GA.* (available online at <http://cse1.eng.ohio-state.edu/laws>)

21 Chapman, J. (2004), *System Failure: Why Governments Must Learn to Think Differently*, Demos

22 Brandon, M. et al (2009), *Understanding serious case reviews and their impact: a biennial analysis of serious case reviews 2005-07*

23 Dingwall, R. et al (1983), *The Protection of Children: State Intervention and Family Life*

24 Brandon, M. et al (2009), *Understanding serious case reviews and their impact: a biennial analysis of serious case reviews 2005-07*

- 1.29 Building strong relationships with children and families with compassion is crucial to reducing maltreatment, but trust needs to be placed with care, and ‘respectful uncertainty’ towards families, and interest and curiosity in their narratives, needs to be part of the practice mindset. To work with families with compassion but retain an open and questioning mindset requires regular, challenging supervision.<sup>25</sup> The emotional and intellectual demands on social workers are substantial; this and their need for high quality supervision and support has been accepted by the Social Work Task Force.
- 1.30 In summary, the four systems ideas of ripple effects, requisite variety, feedback loops and socio-technical situations will all be used to illuminate the review’s understanding of how the child protection system is working and to ensure the review’s subsequent reports and their analysis of the child protection system are strengthened by the application of these and other systems theory ideas.

## Staying child-focused

- 1.31 It may seem self-evident that children and young people are the focus of child protection services but many of the criticisms of current practice suggest otherwise. In a system that has become over-bureaucratised and focused on meeting targets, which reduce the capacity of social workers to spend time with children and young people and develop meaningful relationship with them, there is a risk that they will be deprived of the care and respect that they deserve. The children and young people who have contributed so far to the review confirm that they do not feel as though they are centrally important and held in mind by their social worker:

*‘I was never asked about how I felt or what I wanted to happen. Asking me 10 minutes before the meeting is not the same.’*

Young person speaking to the review

- 1.32 Butler-Sloss in the Cleveland Report (1988) in which she examined the handling of a large number of cases of suspected child sexual abuse in Cleveland in 1987, was highly critical of the way that children had been treated, stressing that ‘a child is a person not an object of concern’. Treating children and young people as people not objects requires spending time with them to ascertain their views, helping them understand what is happening to them, and taking their wishes and opinions into account in making decisions about them. It requires us to hold anxious and difficult feelings on their behalf about what is happening to them, and involves working with carers and others who can help children and young people find their voice when they cannot communicate or are not able to state their own views. This is particularly important for some children and young people with disabilities whose needs are such that communication is more difficult for them.
- 1.33 Using empathy as a means of understanding (being for moments in the shoes of those who one is trying to help) is central to finding interventions that work. For children and young people who have been maltreated by their parents or carers, it is especially important that the professionals trying to help them do not add to the feelings of being powerless and vulnerable.

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25 Brandon, M. et al (2009), *Understanding serious case reviews and their impact: a biennial analysis of serious case reviews 2005-07*

*'I needed to be taken into care because of neglect as 'my parents were irresponsible'. I was placed in a home and then in a family who are lovely and I've been with them for 6 years. I felt very grateful to have a good life and it has made me appreciative. It's good being looked after because you get given the best for the best!'*

Young Person in evidence to the Review

- 1.34** Drift and delays in making forthcoming plans for children have serious adverse effects on their development.

*'2 months of delay in making decisions in the best interest of a child or young person equates to 1% of childhood that cannot be restored.'*<sup>26</sup>

Judge Crichton

- 1.35** This review will seek to keep the impact of any changes on children and young people in constant view. The desirable aspects of a child protection service from a child or young person's point of view is that their need for help is identified and met quickly, that they feel safer through the process, and they are reassured an adult will be looking out for them consistently.
- 1.36** The current performance management system provides detailed information about aspects of case management, such as time taken to complete an initial assessment, but it does not provide a clear picture of a child's journey from the identification of need to actually receiving help. The review will consider further innovative ways to understand and report the experiences of children and young people in need of protection, including delays in decision making about their futures. There is evidence from the children and young people who have contributed to the review that there is a limited amount of help available, making it more difficult for them to make sense of their painful experiences.
- 1.37** A young person is a member of the reference group supporting the review. The review team is working with Dr Roger Morgan, Children's Rights Director, to hear from children and young people with experience of social care. Additionally, seminars with children and young people that have experience of social care are designed to keep the review focused on their needs.

**How do we place the experiences of children and young people who need child protection services at the centre of actions, decisions or plans?**

## Uncertainty in child protection

- 1.38** Uncertainty pervades the work of child protection and trying to manage that uncertainty is central to the way the system has evolved since the 1970s. Many of the imbalances in the current system arise from efforts to deal with that uncertainty by assessing and managing risk. Risk management cannot eradicate risk; it can only try to reduce the probability of harm. The big problem for society (and consequently for professionals) is working out a realistic expectation of

<sup>26</sup> Judge Crichton (1 July 2010), Family Drug and Alcohol Court, Wells Street, London W1

professionals' ability to predict the future and manage risk of harm to children and young people.

- 1.39** Children and young people's safety and well-being arouse strong protective feelings in most adults as is evidenced by the intensity of the public reaction when a child or young person dies. These protective feelings strengthen society's motivation to provide a good child protection service so that children and young people get the help they need. However, people also react strongly when they see families being broken up by what they see as over-zealous professionals. The media carry two perennial forms of stories about child protection: cases where the danger has been under-estimated and cases where the danger has been over-estimated. Professionals, in particular social workers, face the possibility of censure whatever they do: they are 'damned if they do and damned if they don't.'
- 1.40** Prior to the 1970s, this uncertainty about which children were in danger and in need of state protection was accepted as a problematic feature of child care work and there was no public outcry holding professionals to account when parents killed a child. The concept of risk did not appear in professional literature of the time. The death of Maria Colwell in 1973 marked a change in society's attitude with a growing expectation that the professionals who work with children and young people should be able to predict which ones were at high risk of serious harm and to protect them. Managing risk of harm to children and young people from abusive parents or carers began to assume an ever greater priority through the 1970s and 1980s when a series of high profile child deaths aroused increasing public concern.
- 1.41** Uncertainty is a feature in all aspects of child protection work. Even defining what counts as acceptable parenting and what is abusive or neglectful is problematic. Identifying cases of abuse and neglect is an uncertain process since much of the worrying behaviour (both actions and omissions) goes on in the privacy of the home. There can be uncertainty about the facts of the case (was the child injured?) and the interpretation of the facts (was the injury due to deliberate assault?). Adults may give convincing but false accounts of how the injuries were due to an accident; children and young people may lie from fear or to protect their parents; professionals may think the parents are lying when they are in fact telling the truth and the injuries are indeed accidental. Throughout the process of working with a family, professionals need to have a degree of caution in their judgments, to maintain what Lord Laming called 'respectful uncertainty' and 'healthy scepticism.'<sup>27</sup>
- 1.42** The review will consider how social workers and all those involved in child protection can be better helped to handle uncertainty – how they can be assisted in making appropriate evidence-based assessments and interventions that will be more likely to protect vulnerable children. But the review will also consider how the media and the public can be supported in understanding that tragedies will often not be the result of unprofessional practice but rather will occur in the context of uncertainty about unpredictable families in unpredictable circumstances.



## Low probability events happen

- 1.43** Professionals can make two types of error: they can over-estimate or under-estimate the dangers facing a child or young person. Error cannot be eradicated and this review is conscious of how trying to reduce one type of error increases the other.
- 1.44** The public tend to learn of cases of abuse after a child or young person has died or suffered serious harm and then, with the benefit of hindsight, make judgments on how it was easy to see that the child or young person was in danger and would have been safer if removed. This is of course not the way the issue looks for the professionals who only have foresight. Removing a child or young person can protect them from immediate risk of significant harm, but is understandably traumatic for them. Maltreated children or young people who come into care often benefit in the long term,<sup>28</sup> but although the outcomes achieved by looked after children have improved, in too many cases, the potential of the care system to compensate for early harm is unrealised for reasons which are well documented.<sup>29</sup> Our society rightly values the birth family as the primary source of care for children and young people and disrupting that bond is seen as a serious step to take, requiring close scrutiny before the courts will grant the legal authority to do so. The birth family equally presents a mixture of benefits and dangers. A good assessment involves weighing up these relative risks and benefits and deciding which option, on balance, carries the highest probability of the best outcomes for the child. Neither option carries zero risk of harm.
- 1.45** In assessing the value of leaving the child in the same situation, professionals have to consider a balance of possibilities: to estimate how harmful it will be, to consider whether it might escalate and cause very serious harm or death. They also need to consider whether resources are locally available so that families can be helped to provide safer care and estimate how effective such interventions are likely to be.
- 1.46** All of these areas of uncertainty make decisions about children and young people's safety and well-being very challenging. A well thought out decision may conclude that the probability of significant harm in the birth family is low. However, low probability events happen and sometimes the child left in the birth family is a victim of extreme violence and dies or is seriously injured is therefore very important. Public understanding that the death of a child may follow even when the quality of professional practice is high is therefore very important.<sup>30</sup>
- 1.47** The Taylor-Russell diagram<sup>31</sup> helps to illustrate how trying to reduce false positives (over-estimating risk) inevitably increases the rate of false negatives (under-estimating risk) other things being equal. The two axes measure the degree of

28 Forrester, D. (2008), *Is the Care System Failing Children?*

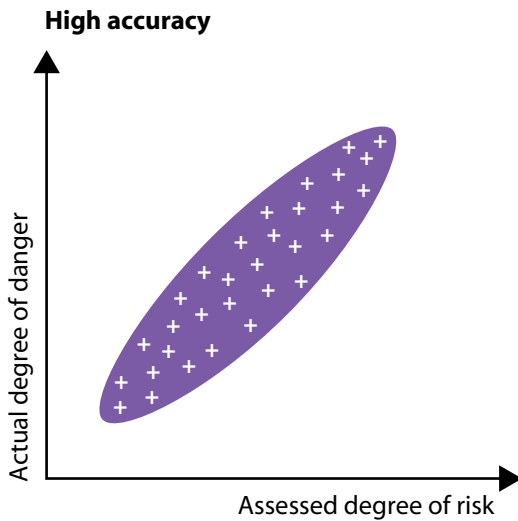
29 Sinclair, I. et al (2007), *The Pursuit of Permanence: a Study of the English Care System*; Ward, H. (2009), *Separating Families: how the origins of the current child welfare policy and practice can be traced to the nineteenth-century child rescue movement*; Skuse, T. & Ward, H. (2003), *Outcomes for Looked-After Children: children's views, the importance of listening. An interim report to the Department of Health*; Stein, M. (2008), 'Transitions from care to adulthood: messages from research for policy and practice', in *Young People's Transitions from Care to Adulthood*, ed, Stein, M. & Munro, E.

30 Brandon, M. et al (2010), *Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009*

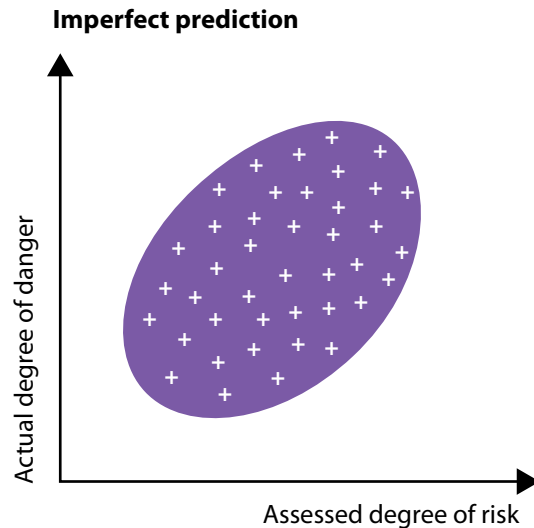
31 Taylor, H. & Russell, J. (1939), 'The relationship of validity coefficients to the practical applications of tests of selection', *Journal of Applied Psychology*, 23, 565-578

actual abuse and the assessment of risk. If we had a perfect way of identifying high-risk situations, we would expect cases to follow a straight line with real and identified risk being the same. However, since we can have only fallible measures, cases will fall within an ellipse; the less accurate the diagnostic system, the bigger the scatter. Hence, a good diagnostic system would produce a graph like Figure I below, while a less accurate one would look like Figure II.

**Figure I**

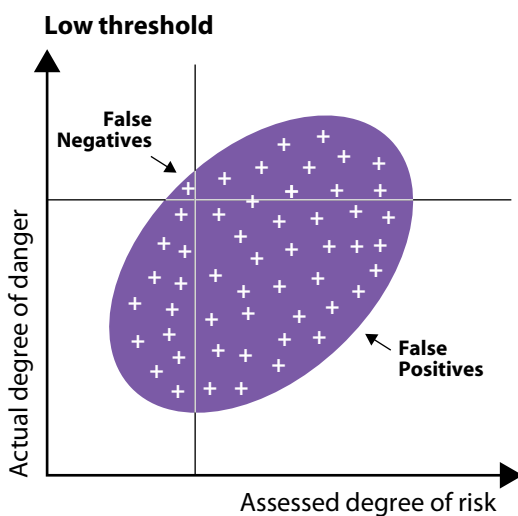


**Figure II**

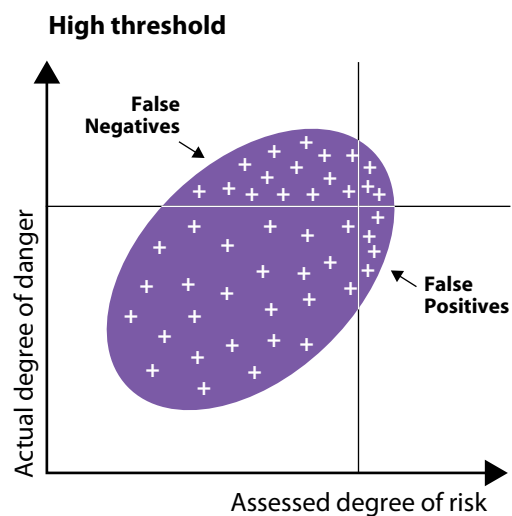


1.48 Professionals assessing risk need to make decisions about the threshold for intervention. Once these are added to the picture, the rate of false positives and negatives becomes apparent. A low threshold for intervention produces a high rate of false positives (Figure III) while, conversely, a high threshold leads to a high number of false negatives, missed cases of serious abuse (Figure IV).

**Figure III**



**Figure IV**





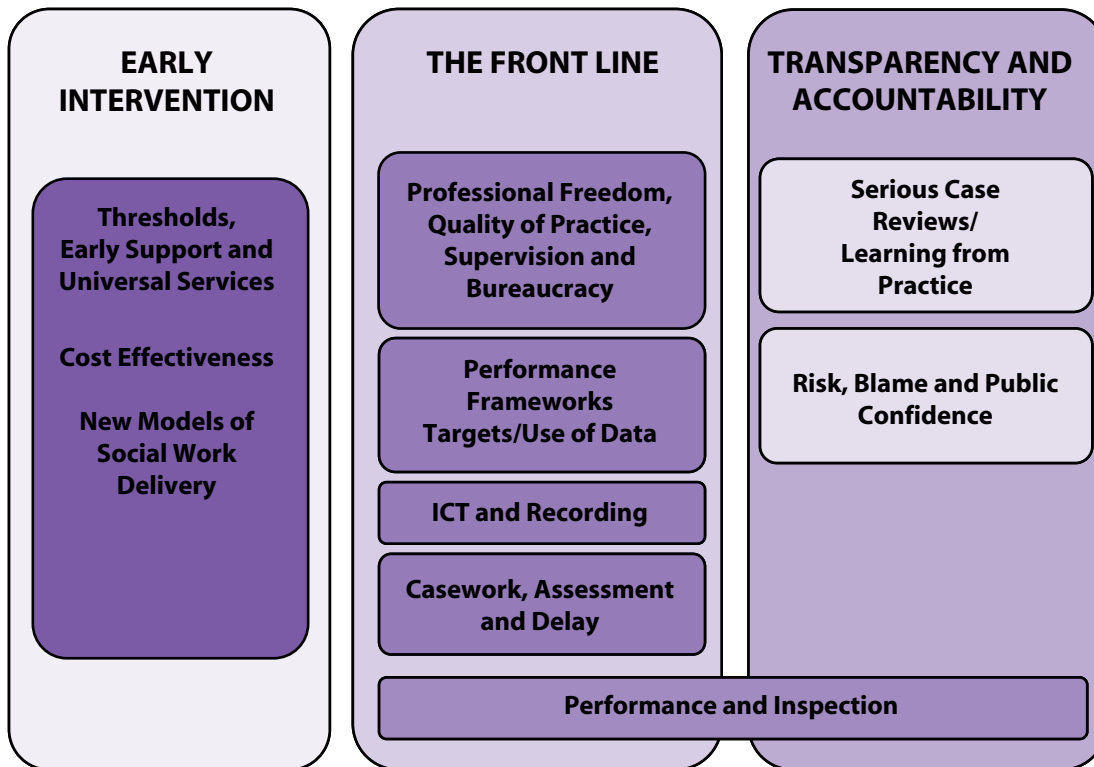
- 1.49 Researchers may help professionals make more accurate identifications of high-risk situations, but they will not determine the point or threshold at which professionals should act. This is a value judgment made by policy makers and practitioners and, in recent years, strongly influenced by media coverage of mistakes and the public's response. As these diagrams illustrate, given the same level of accuracy in the diagnostic process, moving the threshold to reduce one type of error *automatically increases the other type*. When society was outraged by the death of Maria Colwell and the series of high profile cases through the 1970s and 1980s, professionals responded by gradually lowering the threshold for intervention to minimise the chances of missing another child in such extreme danger. This necessarily led to more families with low actual levels of abuse being caught up in the net. The cases of Cleveland and Orkney were unsurprising consequences: on these occasions, professionals were criticised for intervening inappropriately and removing large numbers of children from their homes unnecessarily.
- 1.50 After Cleveland, there was strong pressure to avoid false positives but, there was no public acceptance of the logical consequence that this would lead to more false negatives and so increase the chances of another tragedy like that of Maria Colwell, Jasmine Beckford or Kimberley Carlile. Faced with this dilemma, professionals took the only rational course open to them of trying to increase the accuracy of identifying high-risk families (illustrated in the Taylor-Russell diagram when the ellipse becomes smaller) and in doing so reducing both false positives and false negatives. Investigations therefore became the central task of child protection agencies, with a more thorough and single-minded focus on the risk of abuse to the detriment of assessing the family's other needs, resourcing effective interventions, with little attention paid to the costs either to the agency in terms of resources or to families in terms of pain and trauma.

**Does the exploration of the concept of uncertainty strike a chord in your understanding of frontline child protection work?**

- 1.51 The problems created by the uncertainty about what has happened or will happen to children and young people permeate every aspect of the work. In the following sections which deal with the key areas the review has been asked to focus on, it will become clear that anxiety about managing the uncertainty is shaping practice often in adverse ways.

# Section 2

## The scope of the review



### Early intervention and prevention

2.1 In our society, families are rightly seen as the best place for raising children and young people.

*'The Act (Children Act 1989) rests on the belief that children are generally best looked after within the family with both parents playing a full part and without resort to legal proceedings. That belief is reflected in: the new concept of parental responsibility; ... the local authorities duty to give support for children and their families; ... the local authorities' duty to return a child looked after by them to his family unless this is against his interests.'*<sup>32</sup>

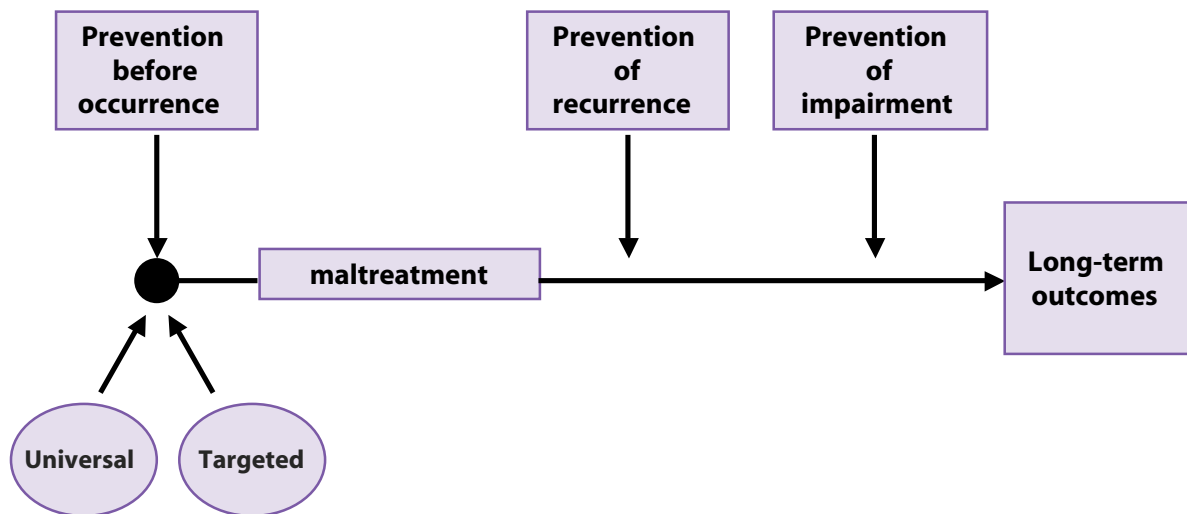
2.2 There is a spectrum of support for families, for some this is one of increasing involvement of state agencies in their lives, starting with wholly voluntary co-operation, moving through some degree of challenge and persistent efforts to engage, and culminating in coercive intervention when the child is considered to be suffering, or likely to suffer significant harm.

32 Department of Health (1989), *An Introduction to the Children Act 1989*, London, HMSO, p 1

*'In reality, many children move across and back again. The term 'case closed' needs to disappear. We need to think of a continuum of support.'*<sup>33</sup>

- 2.3** Preventative services can operate at different points in the development of a social problem. Primary prevention seeks to ameliorate the conditions that create the problem in the first place. Secondary prevention aims to respond quickly when low level problems arise and prevent them getting worse. Tertiary prevention involves responding when the problem has become serious. Quarternary prevention is providing therapy to victims so that they do not suffer long term harm.

#### Framework for Intervention<sup>34</sup>



- 2.4** The State provides a range of services to help parents take good care of their children. The universal services of health, education, housing and income support provide sufficient assistance for most families but some need additional help, for example caring for a disabled child, offering additional help when a parent is seriously ill, or helping parents cope with separation and loss. This help can, generally, be provided on a co-operative basis. Often, parents complain that insufficient help is available.

### The two types of early intervention

- 2.5** The 'early' in early intervention is ambiguous because it refers to intervening early in a child's life and early in the genesis of problems, which may emerge at any point in childhood or adolescence.
- 2.6** The first form of early intervention seeks to counter the adverse effects of socio-economic disadvantage by providing a rich and stimulating environment to children and easy access for parents to advice and support. This is a key priority for the Coalition Government, influenced by the growing research evidence on effective forms of help. Graham Allen MP was commissioned by the Government in July 2010 to undertake an independent review looking at how children at greatest risk of multiple disadvantage get the best start in life and the best models for early intervention.

<sup>33</sup> Evidence given to the review's reference group

<sup>34</sup> Adapted from: Barlow, J. & Schrader MacMillan, A. (2010), *Safeguarding Children from Emotional Maltreatment: What works*

- 2.7 The second form of early intervention is embodied in the *Every Child Matters* reforms introduced by the last Government in 2003.<sup>35</sup> These reforms sought to increase the involvement of all those working with children, young people, and families in observing and responding to low level signs of difficulty. An explicit aim of the policy was to motivate the contribution of several different services in helping children, young people, and their families.

## Universal services

- 2.8 Professionals in universal services cannot and should not replace the function of social work, but they do need to be able to understand, engage and think professionally about the children, young people and families they are working with. That necessarily entails trying to understand the presenting circumstances of families and children at the point they seek help, or when they are identified as needing help, whilst using a service (such as education services, urgent care settings such as accident and emergency departments, pre-and post-birth health visiting, police visits to investigate a violent incident, or drug and alcohol support). It also entails an understanding of what services social workers can be expected to provide.

### How can we develop a greater range of expertise in early years settings and other universal services in support of vulnerable children, young people and families?

- 2.9 Families should be referred on to social workers either because they need support services that the local authority can provide (for example respite care for a disabled child) or because there are concerns about abuse or neglect. The problem is in determining what level of concern warrants a referral for a child protection investigation. There is always the risk that a sign that is fairly benign might occasionally be the surface appearance of serious harm. There is also the risk, for example, that parents who are neglectful may become more harmful. Professionals need the ability to make an expert judgment about which cases should be referred. The judgment is necessarily fallible. Violence in families can suddenly escalate without any visible warning signs; a minor injury can, with hindsight and fuller knowledge, be seen to have been visible evidence of serious abuse. Managing this fallible judgment is significantly affected by anxiety and defensiveness, both of which lead to increasing and indiscriminate referrals to social workers. Some referrers, for example, automatically refer all cases of domestic violence without any indication of priority. This avoids the referrer making any judgment but increases risk to children and young people because it is difficult for the social work team to respond to so many referrals and the child who is in serious danger might be missed.

*There is still a reluctance from some other agencies to share the safeguarding responsibility. This clogs the system with inappropriate referrals.*<sup>36</sup>

BASW member's evidence to the review

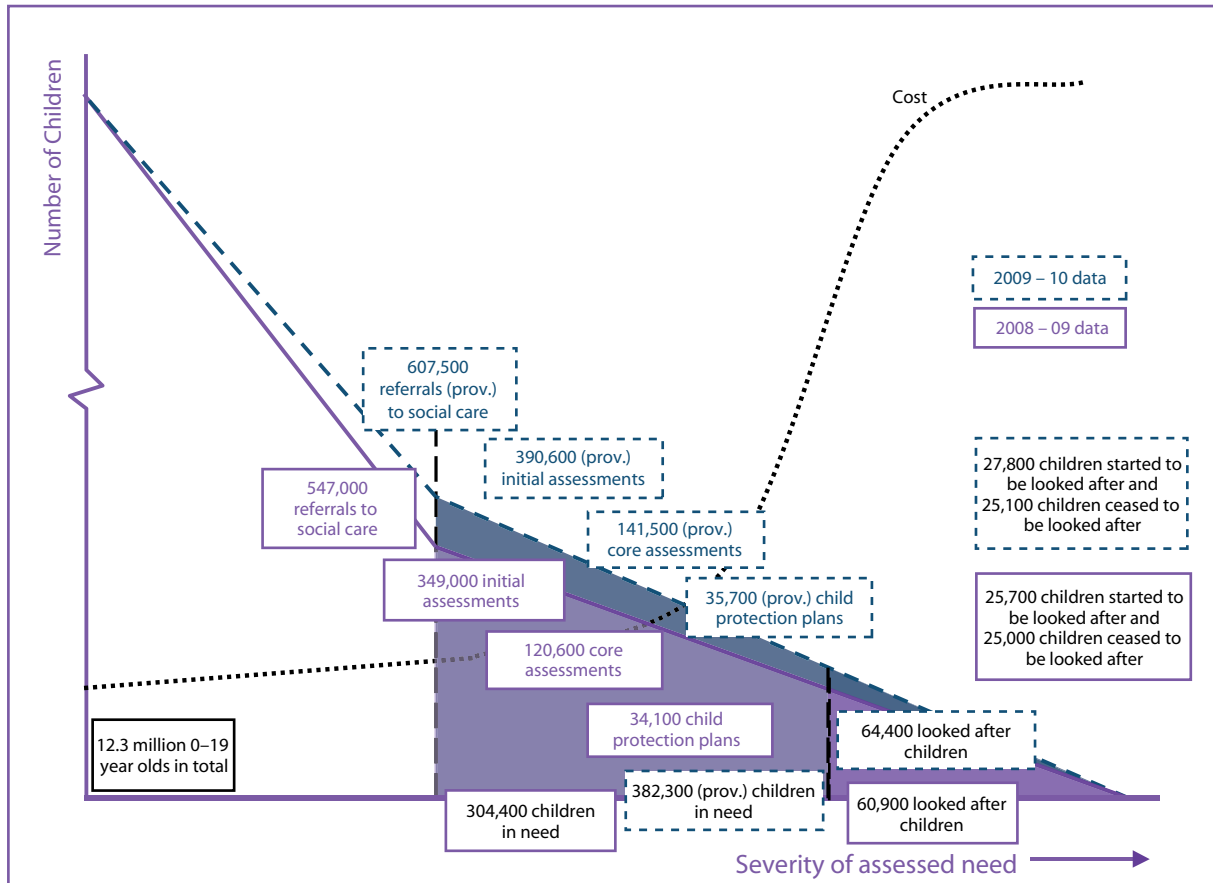
### What type of change is required in the universal services to tackle the rise in referrals to children's social work services?

<sup>35</sup> HM Government (2003), *Every Child Matters*, Green Paper

<sup>36</sup> Submission by British Association of Social Workers member to the review

**2.10** There has been a steady escalation of numbers referred to social workers over the decades but there has been a perceptible steep rise in referrals (11 percent in the 2009/10 year) since the publicity around the tragic death of Peter Connelly as shown in this diagram.<sup>37</sup>

### Numbers of Children



**2.11** Managing this high rate of referrals has become so problematic that it is seriously affecting all other aspects of social work. The majority of referrals to social workers are not deemed to warrant a full child protection investigation. In the graph above, the statistics for 2008/09 and 2009/10, show that around 22–23 percent receive a core assessment and 6 percent became or continued to be the subject of a child protection plan. There appears, therefore, to be scope for managing this judgment stage better and keeping more families out of the child protection system. This would not only reduce cost but reduce the distress families experience in being investigated.

<sup>37</sup> DfE: Children Looked After by Local Authorities in England (including adoption and care leavers) – year ending 31 March 2010 (<http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000960/index.shtml>)

DCSF: Children Looked After in England (including adoption and care leavers) year ending 31 March 2009 (<http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000878/index.shtml>)

DfE: Referrals, assessments and children who were the subject of a child protection plan (2009-10 Children in Need census, Provisional) (<http://www.dcsf.gov.uk/rsgateway/DB/STR/d000959/index.shtml>)

DCSF: Referrals, assessment and children and young people who are the subject of a child protection plan, England – Year ending 31 March 2009 (<http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000873/index.shtml>)

- 2.12 In evidence submitted to the review, examples were given of local innovations, for example, exploring whether it is more constructive for experienced social workers to have conversations about the best action to take and even form integrated teams with potential referrers instead of having a single process of completing a standardised form for the full variety of needs and concerns.

## Identifying and helping children and young people in need

### Case Study 1:

'We developed a Partnership Triage Unit which would accept and investigate all Police reports. A co-located team of forensic researchers was available to interrogate their own IT systems to identify other members of the family, determine who was already working with them, make a preliminary assessment of risk and need and determine who was best placed to offer support.

In its first year, the Unit has had a number of soft and hard outcomes. Some of the key outcomes include:

- Reduced inappropriate referrals to Children's Social Care and ensured that any new referrals were clearly Child Protection cases. In Year 1, only 15.4% of incidents required a new referral to CSC;
- Promoted increased transparency, better understanding and dialogue about thresholds and agency roles. The hierarchical relationship between CSC and other agencies has been challenged. In the Partnership Triage Unit, all agencies contribute to the discussion and all agencies receive referrals; and
- Led to the development of a borough wide panel involving senior managers that (among other things) reviews the plan and actions arising from incidents, determines effectiveness and, where appropriate, suggests alternative strategies. This 'back to the front' approach has promoted more effective and thoughtful practice.'

- 2.13 In the next phase, the review will be working with a small number of partner local authorities assessing whether innovative strategies are better at meeting children's and young people's needs in a timely way. It will also consider the role that evidence-based interventions in children's centres and other universal services can play in supporting families before they reach formal intervention thresholds.

## Identifying and helping children and young people in need

### Case Study 2:

#### Integrated Pathways and Support Team (IPST) (Front door team)

The IPST is a new multidisciplinary team in Children's Social Care which aims to provide a holistic approach to increasing protection for vulnerable children and families.

The IPST has three main functions:

**Screening** – To receive all contacts (referrals) of concern about children and families a Child Protection Advice Line for schools and children's centres is part of the service. Child Protection and high level Child in Need contacts go to Advice and Assessment; others are signposted to other agencies where possible.

**Advice service** – Each team member has a specialism with time given for liaison with appropriate agencies. This informs the screening function of the team, enabling referrals to be made to a wide range of services for children and families. In addition, team members are available to give advice referrers and fieldwork social workers.

**Exit strategy** – Support is provided to children and families who do not require allocated social work support both pre or post Children's Social Care involvement. IPST workers support and facilitate Team Around the Child.

#### Outcomes

- Cases are being more holistically and systematically screened than previously;
- Interface with the Police Public Protection Desk is well developed;
- Evidence of a reduction in cases progressing from contact to referral and statutory assessment since the team went live (down from approximately 33% to 16%);
- The work passed through to the Advice and Assessment teams has a clearer Children's Social Care (CSC) remit;
- Clear interface between the IPST and the Advice and Assessment teams has been embedded; and
- The presentation of the issues dictates the need for involvement from CSC at an early stage.

## Frontline practice

*'Helping children, families and adults who are in crisis or in difficult or dangerous situations to be safe, to cope and take control of their lives again requires exceptional professional judgment. Social workers have to be highly skilled in their interactions and must draw on a sound professional understanding of social work. They have to be able to do all of this while sustaining strong partnerships with the children or adults they are working with and their families: sometimes they will be the only people offering the stability and consistency that is badly needed.'*<sup>38</sup>

- 2.14** This statement in the final report of the Social Work Task Force, highlights a number of important aspects connected with the social work role in protecting children and young people – the importance of professional judgment being critical.
- 2.15** The Coalition Government has confirmed the continued priority of the reform of social work, and the strengthening of social work training because of the critical importance of improving the skills and capacity of the profession. The Social Work Reform Board has the vital role of taking forward the recommendations of the Social Work Task Force. The SWRB has set out its priorities for reform, agreed by Ministers, which include the establishment of the College of Social Work and the key role it will have in giving a stronger voice to the profession.
- 2.16** During this first phase of the review, there has been emerging evidence of the unintended consequences of restrictive rules and guidance with reference in particular to social workers needing 'judgment space'. Some social workers tell the review that their professional judgment is not seen as a significant aspect of the social work task; it is no longer an activity which is valued, developed, rewarded or motivated in the system of child protection. It is as though the confluence of the search for certainty in detecting and eradicating abuse and neglect, combined with the belief (and management oversight) that following rules will further reduce the risk of missing a case, has replaced the space for reflection on professional judgments which actually protect children and young people.

*'Child protection professionals are constantly making judgments that impinge on the rights of parents to be with and relate to their children and the parallel right of children to their parents. The stakes are high and child protection decision-making needs to be as explicit as possible and be available for review and scrutiny.'*<sup>39</sup>

- 2.17** These factors interwoven with an all pervading sense in society that social workers and the system in which they operate can prevent child abuse has, it seems, led to a defensive professional culture which in some instances results in a drive to follow rules where instead judgment is required.

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38 Social Work Task Force (2010), *Building a safe and confident future: implementing the recommendations of the Social Work Task Force* (available online at [www.education.gov.uk/swrb/documents.shtml](http://www.education.gov.uk/swrb/documents.shtml))

39 Turnell, A. (forthcoming), *Building Safety in Child Protection Practice: Working with a strengths and solution focus in an environment of risk*



*'The role of social workers has been insidiously eroded so that the concept of 'case management' whereby social workers assess and refer on rather than doing work themselves is creeping into child and family work.'*<sup>40</sup>

Evidence submitted to the Social Work Task Force

- 2.18** As the review progresses, further consideration will be given to ways in which professional dependence on prescriptive rules can be replaced by a mixture of 'best professional principles' and 'guided judgment'. Social workers tell the review that guidance can be useful but that the burden of guidance is preventing independent thinking and that social workers want to be given more space to use their professional judgment. In some authorities local procedures also require hierarchical approval that de-skill and contribute to ineffective and delayed decision making.
- 2.19** This work will necessarily involve the review team working in collaboration with a team of frontline social workers and the SWRB to identify the principles of good social work connected with safeguarding practice. Appendix 3 of this report has a helpful summary provided by the London Assistant Directors of Children's Services as evidence to this review of the range of skills and knowledge needed for good practice.
- 2.20** In the next phase there will also be further consideration given to the need for a practice and policy framework which acknowledges the complexity of the social work task, the emotional and intellectual demands on individuals making highly complex and emotionally charged decisions concerning the lives of children and young people, and the need for this work to be housed within an explicit space for critical reflection.

## Assessing the needs of children, young people and families

- 2.21** Assessment should provide the practitioner with the information they need to make a judgment about helpful and safe next steps.
- 2.22** The call for evidence for this review has revealed a significant concern among social workers, non-social work professionals working with children, and leaders of children's services about what is said to be over-prescribed guidance on assessment, the restrictions placed upon practitioners by the associated timescales, and the perceived ambiguities concerning the purposes of the Common Assessment Framework (CAF), the electronic version of that framework (eCAF) and the initial/core assessment processes. In many cases, this is said to be inefficient because the tasks require unnecessary duplication, but more importantly many practitioners, both in evidence and during fieldwork visits, said that in their view the needs of children and young people were obscured by the dominance of the standardised process. Further they suggest in some instances that delayed responses to children and young people are also 'built' into the system as it tries to navigate such complex assessment procedures.

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<sup>40</sup> Evidence submitted to the Social Work Task Force and The Lord Laming progress report e.g. Unison (2008), 'Lord Laming Progress Report on Safeguarding: Summary of Unison Memorandum'. (available online at [www.unison.org.uk](http://www.unison.org.uk))

*'Large child protection systems, with their bureaucratic tendencies can often get means and ends confused and the completion of assessment frameworks can become a highly prized, over valued key performance indicator. While consistency of assessment is a critical factor in good outcomes in child protection casework, it does not of itself equate to on-the-ground child safety.'*<sup>41</sup>

- 2.23 In the next phase, the review will examine further the statutory framework for assessment and the associated processes and guidance. It will work closely with the SWRB in order to ensure that the training and development aspects of assessment, that is the skills to assess well, are central to any future advice about how to improve this critical and fundamental part of work to protect children and young people.

**What do you think about the view that assessment frameworks need to be remodelled to something more dynamic and flexible?**

## Information and communication technology

- 2.24 ICS, locally procured IT systems to support case management, has been a major cause for complaint from social workers and although mandatory requirements have recently been removed, most systems currently in use have been developed on the basis of previous requirements and will take some time to change. The group set up by the Department for Education to consider how ICS suppliers can be reformed has produced the following three principles for ICT use:

*Principle 1: Future ICT systems for children's social work should rebalance functionality to take account of the importance of maintaining a narrative which describes all the events associated with the interaction between a social worker, others such as a paediatric department at a local hospital, and the child and their family.*

*Principle 2: Future ICT systems for children's social work should be developed in such a way that it should be relatively easy to cope with both changes in requirements, and, equally important, take account of local circumstances extant in children's departments.*

*Principle 3: The analysis of requirements for future ICT-based systems for children's social work should primarily be based on a human-centred analysis of what is required by frontline workers; any clashes between the functional requirements that have been identified by this process and those associated with management information reporting should normally be resolved in terms of the former.*

- 2.25 Evidence gathering in this early stage of the review has focused on assessing the current situation in local authorities which are trying to make changes to ICS systems. The current situation can be summarised as follows:

<sup>41</sup> Government of Western Australia (June 2008), *Adoption of the signs of safety as the Department for child protection's practice framework: Background paper* (available online at [www.community.wa.gov.au/NR/rdonlyres/24035200-210C-4EE2-A7C3-19C66DA450A2/0/SignsofSafetyBackgroundpaper.pdf](http://www.community.wa.gov.au/NR/rdonlyres/24035200-210C-4EE2-A7C3-19C66DA450A2/0/SignsofSafetyBackgroundpaper.pdf))

- The hardware in local authorities is of variable quality; some systems will run well in some settings but not in others. There is also something of a digital divide in that some authorities equip their social workers better for a computer-based system than others;
- The software of the various suppliers differs in terms of its stability and flexibility. Some can be relatively easily changed, with workflows relaxed and forms simplified;
- The forms embedded within ICS systems were experienced as unhelpful by practitioners, often being described as repetitive and poor in helping risk assessment and case analysis. They actively disrupted the social workers' ability to tell the story.<sup>42</sup>

**2.26** Thus far, constrained by the existence of the statutory requirement to collect data for central Government and to conform to the current performance management regime, progress has tended to focus on modifying the forms embedded in ICS systems. IT suppliers who have 'designed in' flexibility have obviously had greater success with this, and many are working closely with their customers to make significant improvements. Others are unable to do this easily because their systems are relatively inflexible. There are also significant financial costs to some local authorities in seeking help from their suppliers to modify the system.

**2.27** For those authorities which have procured a flexible system there is currently some progress in redesigning the system to support recording and analysis in a lean and efficient manner, and to enable a more effective approach to case management. Problems remain with some systems which are inherently poorly suited to the task. Tailored local solutions, outside the current procurement contracts, may need to be sought for these, and examples have been observed in some authorities. A range of possibilities exists, but to deliver real benefits, a change is needed in the regulatory regime. The review will continue to examine how the changes to ICS systems are impacting on frontline practice and what advice may be given to those authorities struggling to make helpful changes.

**2.28** In the next phase, this review will also be looking beyond ICS systems to consider whether ICT might play a useful role in supporting aspects of social work. For example, ICT *may* have the potential to support social work decision-making. There are examples of 'expert systems' being used to support complex professional tasks, e.g. in the airline industry and medicine, and there is also a substantial body of research on the design of safe systems and organisations. In any future development, the principles outlined above for a cautious, human-centred approach to design is essential. Towards the future, supporting 'responsible autonomy' should be the overarching principle guiding design. The move to any electronic system carries with it certain effects and consequences, for example, the research literature on reading electronic documents must be taken into account.<sup>43</sup> Thus, the design of electronic systems must take account of the consequences of

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42 See also: White, S., Wastell, D., Broadhurst, K. & Hall, C. (2010), 'When policy o'erleaps itself: the tragic tale of the Integrated Children's System', *Critical Social Policy* 30, 405-429; Shaw, I., Bell, M., Sinclair, I., Sloper, P., Mitchell, W., Dyson, P., Clayden, J. & Rafferty, J. (2009), 'An exemplary scheme? An evaluation of the integrated children's system', *British Journal of Social Work*

43 Dillon, A. (2004), *Designing Usable Electronic Text*

moving away from paper, and seek to give additional features (beyond simple free text searching) which paper cannot deliver.

- 2.29 There is a need in the medium term to undertake further research within organisations to design IT which will support practice and promote safety. It will be particularly important to draw on the steadily accumulating evidence base on patient safety and the design of safe systems within the healthcare domain<sup>44</sup> and on emerging literature in social care.<sup>45</sup>

## Care Proceedings

- 2.30 During the initial phase of the review, there has been a considerable weight of evidence expressing concern about the effect on children, young people and families of the delays which are now an enduring aspect of the court and care proceedings system.
- 2.31 In public law, cases take on average 55.7 weeks to conclude (reported in the second quarter of 2010/11) in the county courts. Case duration has been rising steadily in recent years: for the same quarter in 2009 it was 54.41 weeks and in 2008 was 53.02 weeks.<sup>46</sup>
- 2.32 The reasons cited for delay are many and varied, but there is merit in considering the causal connections for those delays which so directly affect children and young people. Social workers, first line and middle managers, Directors of Children's Services and their deputies have provided evidence to the review about the rise in caseloads over the past year. The National Audit Office report of July 2010 observes:
- 'since the major increases in new care cases, the number of cases closed by courts each month has fallen. In June 2010, nearly five new care cases arrived for every one closing.'*<sup>47</sup>
- 2.33 The caseloads of social workers and local authority lawyers are undoubtedly higher. Cases being brought before the courts are higher by the same ratio. The Children and Family Court Advisory Service (Cafcass) report a 30% rise in applications for care proceedings during the course of the past year.<sup>48</sup>
- 2.34 The Family Justice Review commissioned by the Ministry of Justice, the Department for Education and the Welsh Assembly Government is conducting a whole system analysis of the problems facing the family justice system. Both review teams are working closely together in pursuit of good analysis and solutions which improve the system, focusing any reforms on the interests of children and young people.

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44 See, for instance, the seminal book by Vincent, C. (2010), *Patient Safety*

45 See: Fish, S., Munro, E., & Bairstow, S. (2008), *Learning Together to Safeguard Children: Developing a Multi-Agency Systems Approach for Case Reviews*, Report 9, SCIE; Munro, E. (2005) 'A systems approach to investigating child abuse deaths', *British Journal of Social Work*, 25, pp 531–46

46 Ministry of Justice, Judicial and Court Statistics 2009 (available online at [www.justice.gov.uk/publications/judicialandcourtstatistics.htm](http://www.justice.gov.uk/publications/judicialandcourtstatistics.htm))

47 The National Audit Office (July 2010), *Cafcass's response to increased demand for its services* (available online at [www.cafcass.gov.uk/publications/care-demand-statistics.aspx](http://www.cafcass.gov.uk/publications/care-demand-statistics.aspx))

48 The National Audit Office (July 2010), *Cafcass's response to increased demand for its services* (available online at [www.cafcass.gov.uk/publications/care-demand-statistics.aspx](http://www.cafcass.gov.uk/publications/care-demand-statistics.aspx))

**2.35** Evidence to this review has suggested that there are major issues to address concerning case delay (on the part of both courts and local authorities) and the impact this has on children. Other issues identified by the review for further analysis include:

- The paramouncy principle of the Children Act 1989 (confirming the fundamental importance of a child's welfare, their wishes and feelings and their right to be protected from harm) and the balancing of this principle with Human Rights legislation;
- The cycle of commissioning of multiple assessments in proceedings and the associated cost and delay that results;
- Parallel planning occurs where there is a decision to pursue a particular long term plan would result in unacceptable delays for the child in achieving an alternative such as adoption. In such cases, the requisite actions to realise the plan for adoption are being undertaken in parallel with efforts to enable the child to live with birth parents. This is necessary in order to ensure that a child's need for an attachment to a responsible long term carer is met at the earliest possible stage of their life;
- The presentation of cases to courts and the need in each case to provide a detailed and clear assessment, chronology and care plan for the child or young person.

**2.36** The Magistrates Association (family courts committee) reported to the review that:

*'Once in court proceedings, the court must set a timetable for the child. It would be helpful for tight timetables to be set by the social workers outside of proceedings and action taken if agreements by parents/carers are broken or not complied with. If there are any concurrent criminal and care proceedings, social workers need to be able to share the evidence gathered by the police and held by the Crown Prosecution Service.'*

## Family Drug and Alcohol Court

### Case Study 3:

Findings from a small-scale exploratory evaluation of the pilot Family Drug and Alcohol Court<sup>49</sup> (FDAC), indicate that the approach of the specialist team attached to the court, combined with regular reviews by the court, is more successful than ordinary court and service delivery in engaging parents with lengthy substance misuse histories, many of whom had been known to children's services for many years and had multiple psychosocial problems. The specialist multi-disciplinary team includes adult substance misuse workers, child and family social workers and adult and child psychiatrists. Team members use a variety of methods, including motivational interviewing to engage parents. Reflective practice is used to promote objectivity. The team work closely with the network around the family and co-ordinate all the various elements of the plan. Regular planning meetings with parents, social workers and other professionals help promote a clear division of responsibilities and thereby avoid duplication.

The evaluation found that parents within FDAC received substance misuse services more quickly than parents in the comparison sample and received a wider range of services for their other problems. Fewer parents were misusing at the end of care proceedings by engaging with services for longer and as a result more children went home than in the comparison group. However there is currently no follow-up data on the longer term outcomes of those children who went home.

Consideration will be given to exploring the value of introducing one component of FDAC, the FDAC multidisciplinary team, at an earlier stage in the child protection process. Families subject to a child protection plan and pre-birth conferences where parental substance misuse is an issue could benefit from the skilled assessment and support provided by a specialist family drug and alcohol team, as well as its links to community resources. This could enable a larger number of vulnerable children and substance misusing parents to be reached and supported through wrap-around services. It could also help provide a better evidence base to make decisions about timely removal from parental care.

- 2.37** Both this review and the Family Justice Review are fully committed to improving the experiences of children and young people involved in child protection services. This must mean that their journeys through proceedings do not further damage them. This will be a central preoccupation of work going forward.
- 2.38** In the coming months we will be working with the Family Justice Review to consider these and other issues identified through their evidence gathering phase (which is just concluding). This will lead to a programme of reform to be implemented over both the short and longer term.

<sup>49</sup> Professor Judith Harwin on behalf of the FDAC Research Team Family Drug and Alcohol Court (FDAC) Evaluation Project, Brunel University, funded by the Nuffield Foundation and Home Office



## Transparency and accountability

### Performance and inspection

**2.39** This review has considered a range of academic and research evidence which suggests that the focus of performance indicators and targets on specific aspects of process as opposed to practice, has skewed and misdirected local priorities. This has obscured attention from whether or not children, young people and their families are receiving the help they need and that makes a difference. The Broadhurst research<sup>50</sup> supports evidence submitted to the review and concludes that:

*'the demands of timescales and performance management appeared to dominate and were not always seen as conducive to good practice with families.'*

**2.40** This view was supported by the ADCS in their response to the 2009 national consultation on revised indicators for child protection<sup>51</sup> and also by Unison in their submission to Lord Laming's 2009 progress report.<sup>52</sup>

**2.41** It seems plausible at this stage of the review to conclude that the anxiety about managing uncertainty has supported the creation of a performance culture and regulatory regime which searches for compliance with process, finds the scrutiny of practice difficult, and is ultimately distanced from learning and reflective practice.

**2.42** Performance indicators alone are of course only one aspect of what must be available and considered when trying to ascertain the effectiveness and impact of a service to protect children and young people. ADCS, in the same consultation referenced earlier, make the point that:

*'indicators need to be used to ask intelligent questions about what is happening in service performance. They do not provide measures of quality or outcome that can be relied on without other information which gets much closer to the experience of those receiving services.'*<sup>53</sup>

**2.43** It is also important to note that measures about how good a service is are very different to indicators about how well outcomes for children and young people are improving or about their experiences of child protection. Whilst the former clearly influences the latter, they are often unhelpfully conflated or confused, meaning in consequence that there is confusion about why and how services can be judged to be good, yet outcomes for children and young people in those areas continue to

50 Broadhurst, K., Wastell, D., White, S., Hall, C., Peckover, S., Thompson, K., Pithouse, A. & Davey, D. (2009), 'Performing 'Initial Assessment': Identifying the Latent Conditions for Error at the Front-Door of Local Authority Children's Services', in *British Journal of Social Work* (available online at [www.publicservices.ac.uk/wp-content/uploads/broadhurst-et-al\\_2009-performing-initial-assessment\\_.pdf](http://www.publicservices.ac.uk/wp-content/uploads/broadhurst-et-al_2009-performing-initial-assessment_.pdf))

51 Association of Directors of Children's Services response to the 2009 national consultation on revised indicators for child protection (available online at [www.adcs.org.uk/download/position-statements/november-09/ADCS-position-on-inspection.pdf](http://www.adcs.org.uk/download/position-statements/november-09/ADCS-position-on-inspection.pdf))

52 Unison's submission to The Lord Laming's progress report (March 2009)

53 The Association of Directors of Children's Services response to the 2009 national consultation on revised indicators for child protection (available online at [www.adcs.org.uk/download/position-statements/november-09/ADCS-position-on-inspection.pdf](http://www.adcs.org.uk/download/position-statements/november-09/ADCS-position-on-inspection.pdf))

be poor. The confusion between performance measures and outcome indicators is something that the review will also want to consider as it progresses.

**2.44** The inspection system too has been criticised for being too focused on adherence to processes, although more recently, inspection has paid greater attention to judging the quality of practice. ADCS stated in their 2009 position paper on inspections<sup>54</sup> that they have been ‘consistently critical of Ofsted inspection frameworks as being process-driven and methodology flawed’, further stating that ‘process has its place but grade descriptors which largely measure conformity to process should not be used as a proxy to measuring the quality of practice or outcomes’. ADCS’s position statement on inspection further reflected service leader’s perception that ‘all too often a reductionist approach is taken to the inspection, moderation and judgements of services, particularly local safeguarding services where risk-averse approaches on the part of inspectors are leading to perverse judgements and unintended consequences.’

**2.45** Professionals echo service leaders’ sentiments: ‘Inspection systems need to be fundamentally reformed so that local authorities are not stigmatised for acknowledging problems but instead are helped and supported and praised for recognising when more work needs to be done.’<sup>55</sup> The review will work with Ofsted, service leaders and professionals to consider what inspection would be helpful and how to create a system characterised by good local management information, focused and meaningful national data, combined with regular feedback from children, young people, families, staff and partners.

## Learning

**2.46** This review will consider why previous reforms to the performance and accountability framework have not secured a culture within the child protection system that sufficiently promotes learning and development and why, instead, a culture of fear and blame is reported by many as undermining both the quality of practice and public confidence in the child protection system.

**2.47** The review will examine how local systems can become more reflective and adaptive learning organisations which instill a fair culture of transparency and accountability and how such an approach could secure the levels of improvement in practice that have not followed previous reforms. The second phase of the review will look in particular at how the performance and accountability framework is contributing to the standardised and compliance-driven system described above. It is worrying that this is manifested in the same issues recurring in SCRs, Ofsted reporting that ‘the failures and deficiencies which too often lay behind the sad events that triggered the reviews evaluated in 2008/09 were very little different than those that emerged in the evaluations complete in 2007/08.’<sup>56</sup>

**2.48** Lessons from professional practice ‘need to be repeatedly learned and deeper learning is needed to look at the systems issues that may underlie the repeated

54 The Association of Directors of Children’s Services position paper on inspection, 20 November 2009 (available online at [www.adcs.org.uk/download/position-statements/november-09/ADCS-position-on-inspection.pdf](http://www.adcs.org.uk/download/position-statements/november-09/ADCS-position-on-inspection.pdf))

55 Submission by the British Association of Social Workers to the review

56 Ofsted (2009), *Learning lessons from serious case reviews: year 2. Ofsted’s second year of evaluating serious case reviews: a progress report*



failure to learn simple lessons.<sup>57</sup> The review therefore takes very seriously Ofsted's observation that SCRs 'are generally successful at identifying what had happened to the child concerned, but were less effective at addressing why' and that 'there is an overwhelming sense that there is too much emphasis on getting the process right, rather than on improving outcomes for children, of the process being driven by fear of getting it wrong, of practitioners and managers feeling more criticised than supported by the process, and that the Ofsted evaluations do not support learning.'<sup>58</sup>

- 2.49** The review will therefore consider how a model of reviewing serious cases could be part of a wider context of learning that reviews practice at every stage of a child's journey through the child protection system. Different methodologies for learning, which were submitted in response to the review's call for evidence, will be considered. The development of opportunities for practitioners to learn from practice will be a high priority in the next phase.
- 2.50** Practitioners must be held accountable when malpractice is proven but this is a matter for employer-led disciplinary processes and must not be confused with acknowledging the mistakes that inevitably arise because of the inherent uncertainty in the work. Children and young people will be safer if workers can revise assessments or change decisions because they develop a different understanding of the problems without fear of being criticised for not getting it right first time. Any alternative model of learning must continue to focus on learning and improving professional practice. This will need to include how such reviews are evaluated by the inspection process. The review will also be considering how reports can be written, and published, so that there is a clear focus on professional practice that allows learning but with minimal details of the child's story being included.

**How can we create a system for learning from practice which counteracts blame and allows for critical professional reflection?**

## Local Safeguarding Children Boards

- 2.51** Local Safeguarding Children Boards (LSCBs) are the current statutory mechanism through which the partners (some prescribed in statutory guidance) in local areas agree on ways to co-ordinate their safeguarding services.
- 2.52** Their statutory functions include: developing and agreeing local safeguarding policies and procedures; providing training; making assessments about the impact and effectiveness of local safeguarding arrangements; and undertaking serious case and child death reviews.

<sup>57</sup> Sidebotham, P. (2010), *Report of a research study on the methods of learning lessons nationally from SCRs* (available online at [www.education.gov.uk/research](http://www.education.gov.uk/research))

<sup>58</sup> Sidebotham, P. (2010), *Report of a research study on the methods of learning lessons nationally from SCRs* (available online at [www.education.gov.uk/research](http://www.education.gov.uk/research))

- 2.53 Research undertaken by the Centre for Research in Social Policy and Centre for Child and Family Research in 2009<sup>59</sup>, provides evidence concerning the effectiveness of LSCBs. The report identifies ambiguity over the role and function of LSCBs, in particular with regard to the lines of accountability between the chair of the LSCB and the Director of Children’s Services (DCS). This, according to the research manifests in further ambiguity between the Boards’ operational and strategic functions.
- 2.54 The research further finds that those LSCBs focused carefully on protecting vulnerable children and young people, resisting the pull to a broader safeguarding role, have been more effective. There is also evidence that the practice of an integrated professional group being accountable for local child protection is preferable to confining that responsibility to children’s social care.
- 2.55 SCR evidence over the several years of the biennial review process, provides a compelling case for inter-professional learning and thinking about improving child protection systems. The ambiguity about where this responsibility for learning should be located, further makes it everybody’s but nobody’s business.
- 2.56 Through the course of this review, the team intends to work alongside some LSCBs to establish how they can become more effective in their role as a strategic leadership group, supporting and leading local and national learning from practice.

**Is there scope for LSCBs to assume a strengthened leadership role in multi-agency learning about child protection?**

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59 France, A. & Munro, E. (2009), *Effectiveness of the new local safeguarding children boards in England: Interim report*, Centre for Research in Social Policy and Centre for Child and Family Research

# Section 3

## Next steps

- 3.1** In the work of this review so far, the professionalism, capability and dedication of those leading and working with and for children, young people and families has been impressive. The commitment, passion and search for continuous improvement in the protection of children and young people goes unquestioned in this report.
- 3.2** There is frustration that an imbalance has developed between the demands of the management and inspection process and professionals' ability to exercise judgment, arising from efforts to deal with uncertainty and often shaping practice in adverse ways. Furthermore, previous reforms have tended to address single aspects of the child protection system without anticipating the effect that these will have on other parts of the system, unintentionally reinforcing some aspects of practice, while downplaying others.
- 3.3** Professionals in universal services cannot and should not replace the function of social work, but they do need to be able to understand, engage, and think professionally about the children, young people and families they are working with, despite an unavoidable element of uncertainty. They also need the confidence and ability to make sound judgments about which cases should be referred to children's social care.
- 3.4** This review will continue to consider how a local system for protecting children and young people manages the identification and assessment of risk so that demand for children's social care services is both reasonable and appropriately targeted. There appears to be scope for managing these concerns more appropriately whilst developing the expertise of universal services to support vulnerable families.
- 3.5** When investigations become the central task of the system it is at the expense of resourcing effective interventions. In the next phase, the review will be working with a small number of partner local authorities assessing innovative strategies to manage the 'front door' of children's social care.
- 3.6** An over-standardised framework makes it difficult for professionals to prioritise time with children and young people and to meet their wide variety of needs and circumstances. Moreover, drift and delay in making permanent plans for children have serious adverse effects on their development. As the review progresses further consideration will be given to ways in which professionals' dependence on prescriptive rules can be replaced with a mixture of best professional principles and guided judgment informed by a strong professional body.

3.7 In its future work, the review will consider:

- the need for a practice and policy framework which acknowledges the complexity of the social work task, the emotional and intellectual demands on individuals and the central importance of critical reflection;
- the assessment framework and process and the potential for a more flexible child-centred approach;
- how practice expertise is deployed and how decision aids and ICT software might play a more useful role in supporting aspects of the social work task;
- how the focus on performance indicators and targets could be modified so that a focus on outcomes for children is the central point of accountability in children's services;
- how local children's services can become more reflective and adaptive learning organisations, instilling a culture which holds professionals to account in a clear and fair way;
- what inspection would be helpful and how to create a system characterised by good local management information, with focused and meaningful national data, combined with regular feedback from children, young people, families, staff and partners;
- how a model for reviewing serious incidents could be part of a wider context of learning that reviews practice at every stage of a child's journey through the child protection system;
- the role of Local Safeguarding Children Boards, their strengthened contribution to multi-agency learning and development and their strategic leadership locally in relation to the quality and impact of child protection services; and
- how the media and public are helped to have a better understanding of the complexity of decisions, and the uncertainty that professionals live with each day.

3.8 Some good practice thrives in parts of the country despite the design of the system. The review is concerned how previous reforms have, inadvertently, created a system which makes such practice harder to achieve. So this review will also consider how the system can become better at monitoring what is happening, learning about emerging difficulties and responding creatively and adaptively to tackle them.

3.9 There are questions and observations throughout this initial report that it is hoped will stimulate local professional discussion as well as national debate. The review will engage in regular feedback and discussion events. Keep referring to the website for the review to stay informed: [www.education.gov.uk/munroreview](http://www.education.gov.uk/munroreview)

3.10 Thank you for taking the time to read the initial report. Please do get in touch via [munro.review@education.gsi.gov.uk](mailto:munro.review@education.gsi.gov.uk) should you require help or further information about how to give feedback.

# Appendix 1:

Letter of 10 June 2010 from  
Rt Hon Michael Gove MP,  
Secretary of State for Education,  
to Professor Eileen Munro



**Rt Hon Michael Gove MP**  
Secretary of State

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10/11/10

*Dr Eileen*

**MUNRO REVIEW OF CHILD PROTECTION  
BETTER FRONTLINE SERVICES TO PROTECT CHILDREN**

I am announcing today that I have asked you to conduct an independent review to improve child protection. You are extremely well placed to lead this review, given your extensive research experience in child protection, and I am very grateful to you for agreeing to take forward this work.

The reforms led by the previous administration were well-intentioned. The immense dedication and hard work of frontline professionals is an inspiration. But the system of child protection in our country is not working as well as it should. We need fundamentally to review the system. My first principle is always to ask what helps professionals make the best judgment they can to protect a vulnerable child?

I firmly believe we need reform to frontline social work practice. I want to strengthen the profession so social workers are in a better position to make well-informed judgments, based on up to date evidence, in the best interests of children, free from unnecessary bureaucracy and regulation. I want social workers to be clear about their responsibilities and to be accountable in the way they protect children. I particularly want social workers to have the confidence they need to challenge parents when they have concerns about the circumstances in which children are growing up, and to know they will be supported by the system in doing so.

I would like the review to set out the obstacles preventing improvements and the steps required to improve child protection. This should include considering how effectively children's social workers and professionals in other agencies work



together. I should be grateful if you would work closely with those leading related reviews such as the Family Justice Review. I also want any review to be informed by the strongest systems of child protection in other countries.

This is complex territory and necessarily wide-ranging. I intend this review to be broad in scope and want you to feel free to consider a wide range of issues. Three principles will underpin the Government's approach to reform of child protection: early intervention; trusting professionals and removing bureaucracy so they can spend more of their time on the frontline; and greater transparency and accountability.

You will want to identify and develop priority areas for improvement in practice by listening to what social workers and others working with children are saying, and build on the work of the Social Work Task Force, though the review may refine the future direction of this work. Examples of issues you might like to address are:

#### **Early Intervention**

- How can interaction between social work teams and universal services for children and families be improved?
- In particular, how can Sure Start Children's Centres and Health Visitors make sure that the families who need the specialist input of Social Workers are identified effectively?
- What are the barriers to consistent good social work practice? How can other agencies help social workers undertake more effective practice?

#### **Trusting frontline social workers**

- How could regulation be simplified and bureaucracy be reduced so social workers can spend more time with vulnerable children and their families?
- How have targets got in the way of good practice? What are better ways of using data to improve social work practice?
- How can recording of cases contribute to supporting the work of professionals and improving the service experienced by children? How can ICT contribute to strengthening good practice?
- How could social workers be given greater professional freedom and how could support for social workers be improved? How can social workers be supported to have the confidence to challenge difficult families when that is what is needed to protect children? What role might Social Work Practices, new models of social work delivery and volunteer social workers play? What can be learnt by what happens in other countries?



- How could poor performing areas come up to the standard of the best? How could councils most effectively share best practice with each other, including sharing information about how good outcomes can be achieved in a cost-effective way?

#### **Transparency and accountability**

- How can greater transparency in the system be achieved in a way which commands public confidence and protects the privacy and welfare of vulnerable children and their families?
- It is the Government's intention to publish anonymised full Serious Case Reviews. How could reviews be strengthened? Are there alternative ways of learning from experience that could be more effective? What might be learnt from other sectors?
- How can risk be managed so that agencies do not develop a blame culture and their focus remains on protecting children?
- What approaches to inspection would better capture the quality of frontline practice and lead to better services for children?
- How could the system champion the profession, raising its status? Is there a role for a Chief Social Worker?

You have already identified a number of experts to act as a reference group for your review, and I know you plan to talk to people working in the voluntary and statutory sectors on specific issues. The Department will provide you with the necessary support to complete your review.

I look forward to receiving by the end of September a first report on the evidence you have gathered and the problems you have identified. This should be followed by an interim report in January 2011 setting out your further analysis of these problems and a final report by April with solutions.

Yours,



MICHAEL GOVE

# Appendix 2:

## Applying systems thinking ideas to child protection

Developed in collaboration with Dr David Lane, London School of Economics and Political Science.

- 1 The purpose of this appendix is to give an indication of the sort of tools and thinking that the review team will be applying to the child protection system. The aim is not to offer definitive conclusions on the phenomena discussed but rather to illustrate how systems ideas offer a way of thinking about complex situations and of representing formal theories about how they work and why they produce a certain behaviour over time.
- 2 The illustration uses a number of ideas from the paper 'Learning to Reduce Risk in Child Protection' by Munro<sup>60</sup>, as amended by comments from the review team.

The systems ideas that are used are:

- Single and double loop learning: derived from the Organizational Development field, specifically the work of Argyris and Schön.<sup>61</sup>
  - Ripple Effects (unintended consequences and feedback loops): this concept derives from the System Dynamics field, specifically the work of Forrester.<sup>62</sup>
  - Requisite Variety: derived from the Cybernetics field, specifically the work of Ashby.<sup>63</sup>
- 3 What follows is a series of 'causal loop diagrams' (CLDs) which use elements of the child protection system to illustrate these ideas. CLDs are a system dynamics tool which normally aims, first, to represent the causal mechanisms believed to be in operation in a social system and, second, to give an idea of how the variables in the system will behave over time. In this illustration the concentration is on the first aim.

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60 Munro, E. (2010), 'Learning to reduce risk in child protection', *British Journal of Social Work*, 40, 1135 – 1151

61 Argyris, C. & Schön, D. (1978), *Organizational Learning: A theory of action perspective*

62 Forrester, J.W. (1961), *Industrial Dynamics*; idem (1968), *Principles of Systems*

63 Ashby, W. R. (1956) *An Introduction to Cybernetics*

## A note on the system diagrams<sup>64</sup>

- 4 An arrow linking variable A to variable B should be read as ‘a change in the value of A produces a change in the value of B’. The qualitative nature of the link is indicated by a ‘link polarity’. These should be read as:
  - 5 ‘S’: the variables move in the same direction *ceteris paribus*, so a change in variable A produces a change in variable B in the same direction: if A goes up, B goes up.
  - 6 ‘O’: the variables move in the opposite direction *ceteris paribus*, so a change in variable A produces a change in variable B in the opposite direction: if A goes up, B goes down.
- 7 Note that the link polarity says nothing about the size, or quantity of the change. The indication of the effect is qualitative only. Moreover, there is no presumption of a linear relationship between the two variables.

### Feedback loops arise in two types:

- 8 ‘R’: in isolation, reinforcing loops operate so as to amplify any changes to variables within the loop. Over time, the values of variables will ‘snowball’, becoming greater or accelerating downwards. If the result is desirable then we speak of this as a ‘virtuous circle’. If the result is unwanted then it is a ‘vicious circle’.
- 9 ‘B’: in isolation, balancing loops operate so as to equilibrate out any changes to variables within the loop. In time, the variables normally settle down, the values possibly being in line with explicitly set goals for the loop or in line with resource restrictions which create an implicit ‘goal’, or limit.
- 10 N.B. The descriptions of behaviour over time given here are true only for isolated loops. In a system with many interacting loops the behaviour over time can be very complex, to the point of defeating normal human intuition about what should happen and why.<sup>65</sup>
- 11 Applying this diagramming convention to a hypothetical understanding of systemic factors in child protection, in the following five sections an increasingly complex CLD is developed which illustrates the use of systems thinking ideas.

## Single loop learning: Are we doing what is specified?

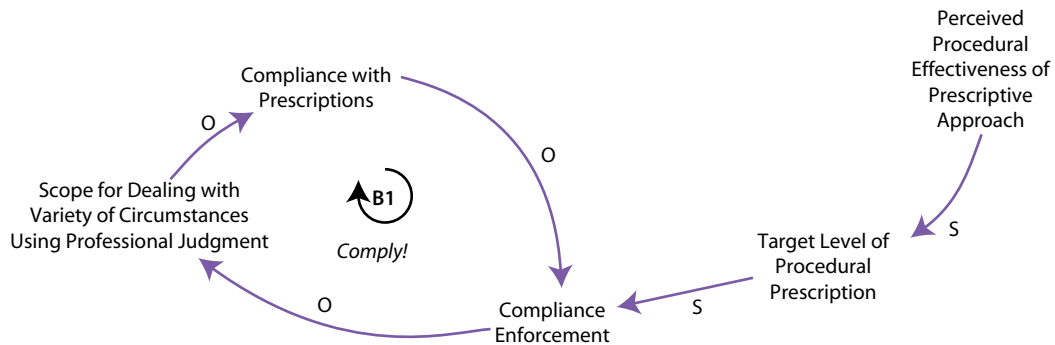
- 12 The system adopts the perception that a prescriptive approach is needed. So, in the CLD below, the variable on the upper right ‘Perceived Procedural Effectiveness of Prescriptive Approach’ increases. This increases the level of prescription that is targeted in child protection and compliance to this target is enforced – both variables move in the same direction. Via a range of means, some mentioned in the main body of this report, this causes the scope that child protection staff have in their work to move in the opposite direction – that is, reduce. Increased

64 Further information on the historical provenance, structure and use of CLDs can be found in: Lane, D. C. (2008), ‘The Emergence and Use of Diagramming in System Dynamics: a critical account’, *Systems Research and Behavioral Science* 25(1) 3-23

65 Forrester, J.W. (1975), ‘Counterintuitive behaviour of social systems’, in *Collected Papers of Jay W. Forrester*, pp 211-244

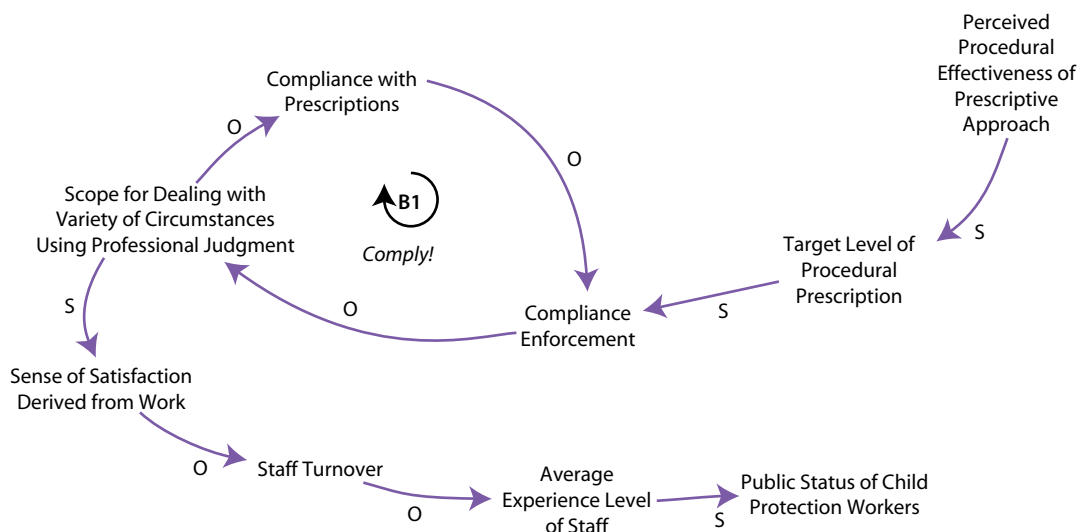
'Compliance with Prescriptions' is then the proximal effect of that reduction in scope. However, that variable is a key performance measure, and bringing its value closer to the target level is what is sought in this system.

- 13 What is created is a single feedback loop – balancing loop B1 – which, in aggregated terms, monitors what is going on and ensures that this single loop learning effect runs so as to check that the specified level of compliance is taking place.



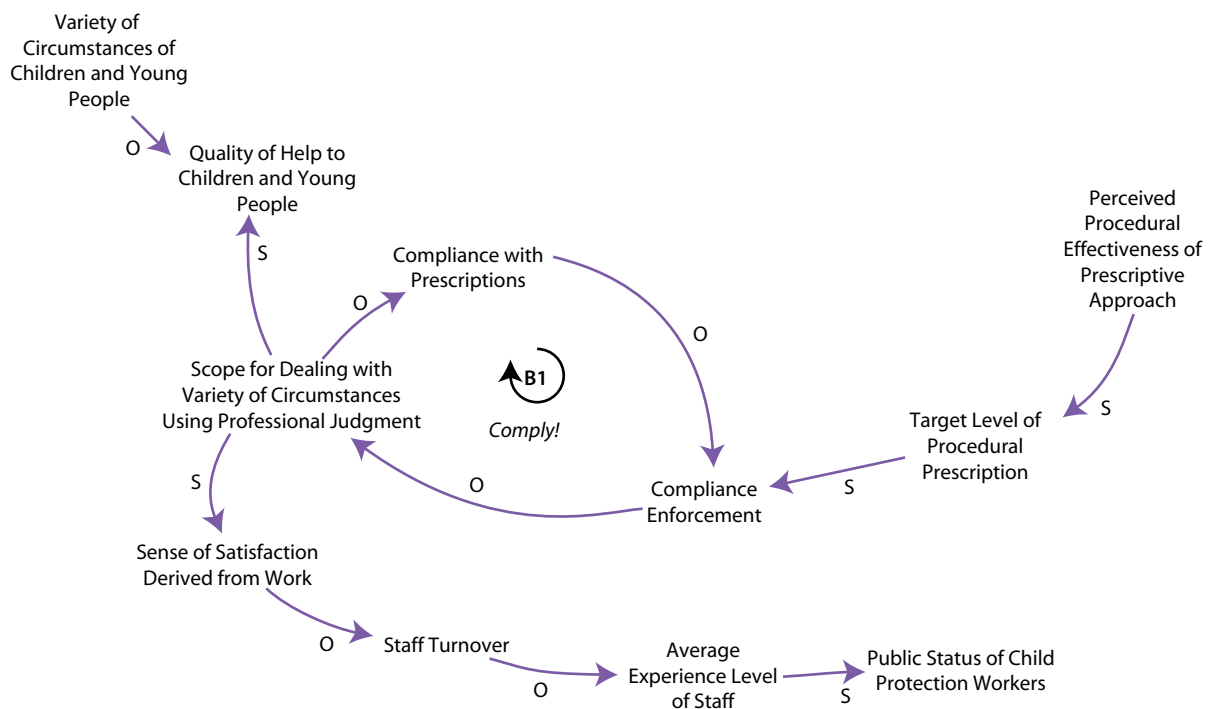
### Ripple Effect 1: an unintended consequence

- 14 In the previous CLD reducing the scope that social workers have in dealing with young people has a proximal effect that is desirable. However, it also has an effect that ripples out through the system along a chain of causality, ultimately producing effects which were not intended. In the illustration there is also an effect on the 'Sense of Satisfaction Derived from Work'. As this is reduced staff turnover rises, so the experience level of staff reduces and finally the status of child protection workers suffers.
- 15 Ripple effects such as this are not 'side effects', in that they are no less 'effects' than those originally intended. What they are is effects that the changes were not meant to produce but which do result from the complex connections in the system. They are unintended consequences.



## Requisite Variety

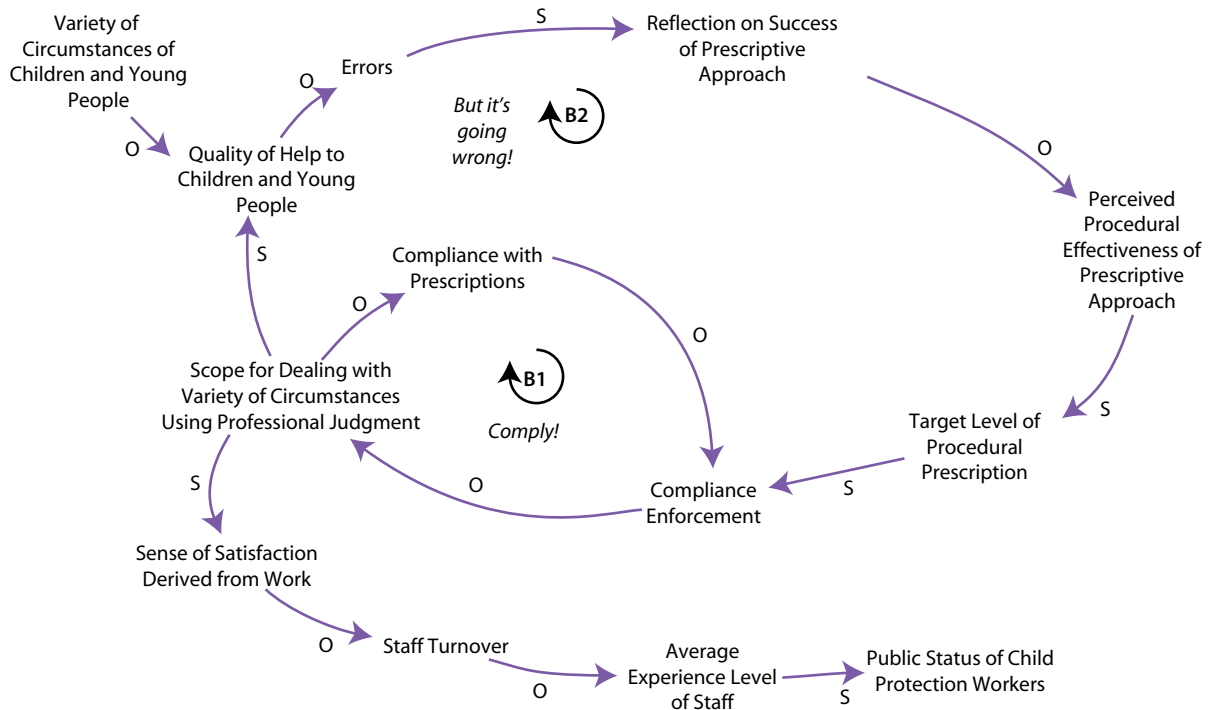
16 In general terms, the idea of ‘Requisite Variety’ is that a policy in a controlling system must have available a variety of responses that is at least as great as the variety of circumstances it seeks to control. In simple terms, a controller must be flexible enough to cope effectively with the full range of circumstances it will encounter. In the illustration here, as social workers’ ‘Scope for Dealing with Variety of Circumstances of Children & Young People Using Professional Judgment’ increases, then the quality of help that their interventions provides is increased. (Note that this is always judged in terms of the wide variety of circumstances that children and young people are found in.) However, if that scope is reduced by the enforcement of compliance standards then social workers have less flexibility to deal with children and young people whose circumstances do not fit well into the procedures. Dealing with them using the set procedures therefore produces a lower quality of intervention and they receive less help. A ‘one size fits all’ approach cannot exhibit the flexibility required to supply the help that is needed.



## Double loop: Have we specified the right thing to do?

17 Loop B1, the compliance loop, may view a reduction in the scope that social workers have as a desirable thing. However, as the requisite variety idea suggests, such scope reduction has consequences for the quality of help given to children and young people. There are sometimes ‘errors’, sometimes tragic and high profile ones. Now, if these lead to reflections as to whether the prescriptive approach is the wrong target then a second loop – B2 – is created. Via this loop the system is able to learn whether, in the light of the errors, it is correct to sustain a belief in the effectiveness of a given level of prescription or whether this should change.

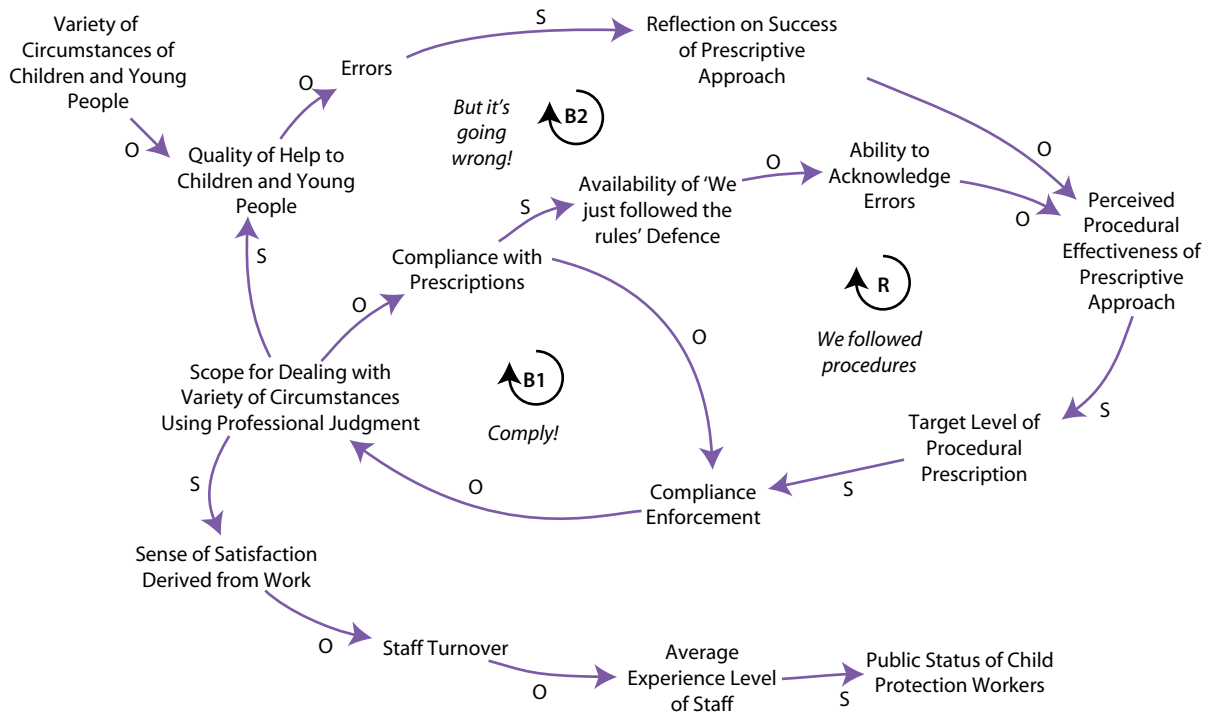
- 18 This is an example of double loop learning. The second loop signals back into the organisation and makes it question whether the prescriptive approach is effective, whether the target for compliance is the correct thing for it to try to achieve or whether that target should be questioned. However, this error detecting mechanism might be undermined because of the next ripple effect.



## Ripple Effect 2: a feedback loop

- 19 Here we consider a further effect that ripples out when social workers' scope is reduced. With the increased use of a prescriptive approach the child protection sector finds that it is able to defend itself against allegations of failure by showing that its internal rules on procedure were followed. This reduces its ability to acknowledge errors which in turn means that it cannot do double loop learning and so examine the possible deficiencies of an over-prescriptive approach. This escalates the commitment to a prescriptive approach making it increasingly possible to show that extensive compliance has occurred and so strengthening the 'we just followed the rules' defence. The unintended consequence creates a reinforcing loop – R – which causes the child protection sector to become addicted to prescription.

- 20 In a vicious circle of organisational addiction, the organisation creates a self-defence mechanism which 'hides' the perceived errors. Its ability to show that there was compliance allows it to argue that there was due diligence in terms of the procedures used and that, hence, the errors in actual child protection cannot be perceived to be errors in terms of the approach used. As a result, the double loop learning of the 'But it's going wrong!' loop does not take place.





# Appendix 3:

## Description of social work expertise, submitted by London Assistant Directors of Children's Services

Good social workers possess a range of knowledge, skills and abilities which they utilise to undertake purposeful intervention in the following way:

**Assessment** as the first stage in developing an understanding of what is happening in a family, and the impact on the children within that family. Relying on practice wisdom and underlying social work theory, the skilled practitioner uses interview and observation to acquire information in order to describe the social history of the family, the relationships between family members, and crucially, the needs of the child in a number of different dimensions (physical, emotional, social etc) and how these needs are being met or not met. Social workers work closely with children and parents, and talk to other professionals in order to understand a child and family's needs, resources and resilience, showing understanding of patterns and dynamics within the family, as well as the impact of wider environmental factors.

**Analysis**, i.e. the ability to break down the different elements within the family situation and the wider community, in order to understand the relationship between the various factors that are impacting on the child, the weight to give to each factor and how they might be changed or influenced. Using information intelligently and constructing a narrative and hypotheses which can be tested and re-tested are a daily part of the competent social worker's task.

**Risk assessment** and the ability to predict future behaviours of parents, weigh up protective and risk factors, and assess the potential for change in a family or with parents is an essential element of the continuing assessment of the family. These are difficult judgments made in complex situations and demand a combination of reasoning skills and practice wisdom. This is a core skill of children's social workers.

**Working alongside families**, understanding family dynamics and contributing environmental factors to help families gain insight, build on strengths and change established patterns of behaviour / relationships – use of systemic family therapy and family group conferences. In this same context, social workers are able to use the legislative framework in an authoritative way when required.

**Problem solving** as a key part of social work intervention with families who have complex and difficult lives. Competent social workers spend time with children and families looking for solutions to their difficulties as defined by the family, and use creativity to ensure the least intrusive intervention is provided.

**Decision making and planning** based on identified needs, set within the legal and policy framework and which rest firmly on the involvement and wishes and feelings of children – and families when their view is not contrary to the child’s needs. Good plans are clear, relate closely to outcomes, are accessible to children and families, and able to make effective use of services. Competent social workers are able (when permitted) to use their professional judgment in decision making and planning to promote positive outcomes for children. Care planning for children subject to a child protection plan and looked after children is a fundamental aspect of the children’s social worker role and has to be based on a holistic view of the child not always available to other professionals.

Building strong **relationships** between the social worker and the child and his/her family. Social workers build relationships with children, young people and parents in extraordinarily difficult circumstances, and within a context that would appear from the outset to be counter to any chance of creating a positive dialogue. The situations in which social workers build positive relationships, and go on to use the relationship to create change, include those in which: children are being removed from their family; in adversarial legal processes; with parents who may be aggressive, intimidating or violent; with parents who are dishonest, but often plausible or at least where the evidence to prove their dishonesty doesn’t exist; with parents who have substance misuse difficulties and erratic behaviour; and in cases where the social work intervention is actively resisted. Equally the children may display some or many of these features. The children’s social worker is frequently required to work with both parent and child in an extremely complex mix of hostility and psychological disorder.

**Partnership** with other agencies in every area of work undertaken by children’s social workers, including effective safeguarding, information sharing, use of the lead professional role and co-ordination of multiple plans to keep children safe. This usually requires the social worker to have at least a working knowledge of how systems operate in education (primary and secondary schools, SEN, inclusion), health (acute, community and CAMHS), housing (homelessness as well as a range of providers who will have different policies and procedures), adult services (mental health, substance misuse, adult social care, etc) and the voluntary sector ranging from small local projects to large national charities. Invariably the social worker has to work with a range of these other agencies to construct a care package for each child or family, which requires skills in negotiating, persuading and influencing as well as in monitoring and reviewing the care plan and actions of those partners.

**Relationships with looked after children** which sustain those children through periods of loss, transition and turmoil. When the same social worker is able to work with a child over a long period, they assist in building resilience and developing positive outcomes for children as they grow up, providing emotional and practical support and helping young people move on to independence. Social workers demonstrate a sophisticated understanding of the need to enable children to stay with their families in situations which are far from perfect, and to remove them if absolutely necessary and on the basis of good evidence. Social workers engage in detailed planning to allow children to return safely home after periods in care, or permanency planning when they cannot return – recognising the urgency required for young children and securing permanent placements in the shortest time possible.

Underlying all the work that social workers do is a **value base** which incorporates an approach where empathy and warmth are central, where respectful scepticism is a priority and which is based on an holistic view of the child and family. Social workers act as advocates and at the core is the preservation of human rights for children, and their families, when these are not in conflict.







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