Piloting the SCIE 'systems' model for case reviews: learning from the North West

Supplement A – illustrative final report

Foreword

This report is a supplement to the SCIE publication titled 'Piloting the SCIE 'systems' model for case reviews: learning from the North West' (Fish, Munro and Bairstow 2010). People interested in the development of this approach often ask 'what does the final report look like?'. This supplement provides an illustrative example of a final case review report using the SCIE systems model. It is the final report of one of the pilot case reviews. As such it is part of a research and development process and therefore inevitably not without scope for improvement. Any reflections on the content and structure of it will be gratefully received. These should be sent to sheila.fish@scie.org.uk

Piloting the systems approach for case reviews in Site A.

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Pilot case review

1. Introduction

The case

This case review was prompted by the second death of a child of the same mother. The first child had died four years earlier of natural causes aged seven months, but the mother had been found guilty of neglect in relation the circumstances around the death and sentenced to a three year community order. Following the death of the second child, the SCR panel met on a number of occasions to consider whether the criteria for a SCR had been met. However the coroner found no suspicious circumstances. In light of the previous death of mother's first child and her related charge for neglect, the SCR Panel put the case forward for a critical incident review and it became part of the SCIE pilot of using the systems model for case reviews.

Family Composition

Mother, born 1987
Child, born 2008
Previous child, born 2004, died April 2005

Other significant people

The Maternal grandmother (and grandfather)
Maternal Great Aunt
Father
Paternal grandmother

Methodology

This case review has used the 'systems' model to analyse this case. The systems approach provides a theory and method for understanding why good and poor practice occurs, in order to identify effective supports and solutions. It originated as a method for conducting accident investigations in other high risk areas of work, such as aviation, and has subsequently taken up in health. It has been used and promoted, for example, by the National Patient Safety Agency (NPSA). A SCIE-led project adapted the approach for use in conducting case reviews of multi-agency safeguarding and child protection work. The new model is presented in *Learning together to safeguard children: developing a systems approach to case reviews* (Fish et al. 2008).

Distinctive about this approach is that it endeavours to understand professional practice in context, identifying all the factors in the system that influence the nature and quality of work with families, making it more or less likely that the quality of practice will be good or poor. Solutions then focus on redesigning the system to minimise adverse contributory factors. In this way the aim is to strive to make it harder for professionals to do safeguard poorly and easier to do so well (cf. Institute of Medicine 1999).

Understanding such influences on practice requires reviewers to engage those people who were directly involved in the case in a collaborative process of dialogue. As well as

drawing on the formal documentation as a source of data, input is gathered from all key people involved in the case through individual conversations. Individually and jointly in group meetings these key people are also given the opportunity to discuss, correct, amplify and challenge the factual accuracy and interpretations of the sense that the reviewers make of the case.

The review team

The review team was led by three members of the SCIE team:

1. xxxx
2. xxxx
3. xxxx

This SCIE team worked together with members of the SCR Panel including:

1. Head of Safeguarding, Children & Young People's Department.
2. Principal Manager, CAMH's & Treatment Fostering, Children & Young People's Department.
3. Assistant Chief Officer, Probation
4. Named Nurse for Safeguarding
5. Designated Nurse for Safeguarding
6. Designated Doctor (Paediatrician)

Together they formed the 'review team'.

The scope and Terms of Reference

The Review Team determined that the time span that the case review should focus on was from the mother's second pregnancy becoming known to professionals, till the death of the child. The death of the first child was not subject of this case review, though would form a crucial part of the family history and history of involvement of services.

Statutory guidance for SCRs requires that the Terms of Reference identify: "What appear to be the most important issues to address in identifying the learning from this specific case? How can the relevant information best be obtained and analysed ...?". However, the danger with attempting to specify the key issues in a case before the review has begun, is that you pre-empt what you might find. Consequently, taking a systems approach, encourages you to begin with a more open enquiry in order that you can be led by the data as to the key issues to be explored. The aim of a systems review is to make a particular case act as a window on the system: What can we learn about the strengths and weaknesses of our current single and multi-agency systems through reviewing this particular case?

What sources of data have we drawn on so far?

Who have we spoken to?

We have held individual conversations with the following people.

PROBATION

1. Probation Service Officer / Offender Manager (PSO OM)
2. Probation Service Officer's Manager
3. Probation Officer / Offender Manager (PO OM)
4. Probation Officer's Manager
5. Community Services Officer / Offender Manager (father) (CSO OM)
6. Community Services Officer's Manager (father)

Children & Young People's Department (CYPD) – SOCIAL CARE

1. Social Worker (Assessment Team)
7. Social Worker (Case Management Team)
8. Social Work Manager (Case Management Team)

Children & Young People's Department (CYPD) – FAMILY SUPPORT

9. Family Support Worker (mother)
10. Family Support Worker (father)

HEALTH - HEALTH VISITING

11. Health Visitor
12. Health Visitor's Safeguarding Supervisor / Named Nurse for Safeguarding Children

HEALTH - GP PRACTICE

13. GP

These professionals made up the 'case group' for the review.

What documentation have we accessed?

We have also looked at the following documentation:

- Probation. OASsys assessment
- Health Visiting files.
- CYPD files

What discussion meetings have we held?

Using the SCIE model, gathering and making sense of information about the case is a cumulative and iterative process. The review team has various 'analysis' meetings. The emerging analysis resulting from these are presented to the case group at what are called 'follow-on meetings' – following on from the data collection and analysis. In the course of the case review, two follow-on discussion meetings were held with the case group – the first two hour, the second three hours. The review team met on six occasions, usually for three hour sessions.

Limitations

Despite initial intentions, the review team did not engage any members of the family in this review process. This means that crucial perspectives are missing.

Reviewing any particular case opens the possibility of exploring in more detail a potentially huge range of practice issues within single and multi-agency child welfare systems. However, it is not feasible to investigate all of them within useful timescales and available resources. The review team have therefore and, in our view legitimately, made judgements

in the course of the analysis process about what issues to prioritise. This inevitably means that others have not been dealt with. For example, there has been no detailed exploration here of GP services and Health Visitor/GP interface and arrangements where by GPs get information about vulnerable families.

Structure of the report

This report has four main sections. This introduction is followed by:

2. Pulling the story together
3. Analysis of key practice episodes
4. Identification of underlying patterns and linked recommendations

2. Pulling the "story" together

Key dates

	2005	Death of first child
	2006	Mother sentenced to 3 year Community Order for neglect
	2006	Trainee probation officer worked with mother under supervision of practice supervisor
	October 2006	Mother reassessed by probation as low risk. Case transferred to Probation Service Officer who worked with her for next two years
	May 2008	Anonymous referral to social care about mother being pregnant
KPE 1	**July 2008**	Probation case held by PSO, transferred formally to qualified PO OM after birth (**KPE 1**) but PSO continued day-to-day work
	20 August	Pre-birth assessment completed
KPE 2	**August 2008**	Pre-birth CP conference; child subject to CP Plan (**KPE 2**)
	2 September 2008	Case transferred to CYPD Case Management Team
	September	Planning meeting with Senior Pract SW, HV, Probation Service Officer, Midwife & mother
KPE 3	**8 December 08**	Risk assessment by SW of father completed – no concerns
	Mid-December 2008	Birth of the child, two weeks early
KPE 3	**5 January 2009**	Core assessment completed (started 2 September 08)
	8 January 2009:	Child Protection Plan
	9 January 2009	Post-birth conference
KPE 3	**11 Jan– 10 march**	Parenting assessment of mother by family support worker
KPE 4	**28 January 2009**	Mother moves out of her grandparents to her own accommodation (**KPE 4**)
	February 2009	End of Mother's Community Order; end of Probation involvement
	2 March 2009	Core group meeting (SW, HV, mother)
	5 March 2009	Mediation appointment for mother and father re. contact; mother failed to attend
KPE 5	**March 2009**	Review Meeting; child no longer subject of CP Plan (**KPE 5**)
	20 March 2009	Referral via paternal grandmother
KPE 6	**17 April 2009** -	CIN Plan (**KPE 6)**
	18 May 2009	Mother moved back to her grandparents
	May 2009	Private court hearing re. contact
KPE 7	**May 2009**	HV refers family to Sure Start Children's Centre (**KPE 7**)
	June 2009	DNA test results confirm paternity of father
	June 2009	Anonymous referral
	18 June 2009	Unannounced SW visit & legal gatekeeping meeting
	22 June 2009	Strategy Meeting
	June 2009	Court hearing re. Father's contact
	24 June 2009	Sure Start Family Support Worker allocated but initial meeting put on hold
KPE 8	**6 July 2009**	CP Conference; the child re-subject to CP Plan (**KPE 8**)
KPE 9	**14 July 2009**	Core Group Meeting to draw up CP Plan (**KPE 9**)
	July 2009 –	Unannounced Statutory visit by SW / no answer
	July 2009	Pre-arranged Statutory visit by Duty Worker
	July 2009	Statutory visit by SW cancelled because mother came to office with child and maternal grandmother
		Father's contact session with child
	July 2009	Child's death

Narrative chronology - synopsis of the case and professional involvement

Background context

Social history of mother

Mother was born in 1987. Her parents separated when she was young. In the pre-birth assessment [20.08.2008] she was described as having good relationships with both newly formed parental couples. However, problems between mother and her step-father were commented on by the Probation Officer in the case review conversation. There is no note of this in the social care files and the review team have not been able to find out more information on this. The GP records note that she had been treated for depression since 2002 [SCR Panel minutes 10.09.2009] and started medication when 15 years old. The review team have not ascertained whether any specific cause was attributed to this at the time.

More generally, there is a lot of social history in the documentation of the probation service that does not appear in the social care files. This conveys a picture of a young woman who has had a troubled early adulthood. Her first child was born in September 2004 when she was 18 years old. Just before the birth they were referred to Sure Start (unclear by whom) in relation to domestic violence and housing issues. Sure Start referred this to then social services and received a response that they could not help. Sure Start assisted mother in taking out an injunction against the father, preventing him from having contact with her or the child. They also helped her to move into a women's refuge on being discharged after birth until suitable accommodation was found. This they also helped her find [Strategy Meeting notes 26.04.2005]. She was first prescribed medication for depression shortly before the birth and ceased using this once contact with the father of the child ended and she was settled in a new home. [From 'psychiatric history section' of pre-birth assessment 20.08.2008]. It was against this background that her first child then died aged 8 months (details below).

The files give a picture of someone who had never managed to live independently but instead always ended up returning to her own parents or finding other people either to stay with or have stay with her, who ended up causing problems.

Summary of circumstances leading to death of first child in 2005

The final conclusion of the Post Mortem on Mother's first child was that the child had died from natural causes, specifically bronchopneumonia, aged 8 months. However, the circumstances surrounding her death led to the prosecution of the mother for neglect, for which she received a three year Community Order.

The child had not been well in the few weeks prior to her death. Mother had taken the baby to the doctor on three separate occasions over the previous six weeks, the last being 12 days before her death. She had been diagnosed with bronchitis and prescribed antibiotics/steroids and given an inhaler. On the w/end of her death, mother and child were staying with friends of mother, a couple older than mother, with four children of their own aged: 12, 10, 4 and 3 years old. Mother and child had been staying with these friends since Friday and the child was found dead on Monday morning. During this time, mother had put the child to sleep strapped in to the buggy, on the landing between the bedrooms

where the couple and mother slept. This, she later explained, was because the child could climb out of the cot that was available, so mother felt it was safer that she be strapped in to the buggy.

On the evening prior to the first child's death, Sunday, mother and the couple had been out for the evening, leaving the 12 year old to look after his three younger siblings and the child, then aged 8 months. The couple arrived back home around midnight and mother later, about 2am. Mother said that she fed the child around 4am. The child was found dead at 9am. The police described the house as in appalling condition, with no appropriate beds or bedding available and unhygienic conditions throughout, including human faeces on the bedroom floor. [Summarised from Social Worker's report for Child Protection Conference 27th August 2008, based on information provided by the police and safeguarding department].

Prior to this incident there had been no social care involvement and The Health Visitor records show that there had been no concerns. The first child had always appeared well cared for, home conditions were good and the child was up-to-date with all health appointments.

Summary of probation's involvement prior to mother's second pregnancy

Mother was sentenced in 2006 and received a three year Community Order. Within the probation service, initially her case was allocated to an offender manager, and then delegated to a trainee probation officer, under the supervision of a practice supervisor. The trainee probation officer's supervision of mother focused primarily on getting her to understand and accept responsibility for her offence and on lifestyle issues and healthy relationships. During this time mother was living with her maternal grandmother as there were problems with her stepfather. She was getting a lot of abuse from the co-accused as well as people in the local community who saw her as having murdered her child [conversation].

In October 2006, the case was reassessed from medium risk of reoffending to low risk as she had no children and was not in contact with any. This led to the case being transferred to a Probation Service Officer (PSO), a role that requires no formal qualifications and only supervises cases assessed as low risk. The PSO the held the case, meeting her every 2-4 weeks in accordance with national standards for the management of cases assessed as low risk.

After a year, the PSO made a request to her manager that they apply for an early revocation – going to court to ask for a termination of the supervision order – but the manager did not think this appropriate given the nature of the offence. Mother was found compliant and cooperative; it was not a case that stood out for any reason within the probation service.

Narrative chronology of the period under review

When mother became pregnant with her second child, she was serving the last year of the three year community order, for her conviction for neglect relating to the death of her first child, in **2005**. She was reporting monthly to the PSO. Social Care Children and Young People's department (CYPD) were alerted to the fact that she was pregnant by an anonymous referral, on **May 2008**, from someone who knew a lot of detail about the death of her first child, and said that due to her conviction and erratic behaviour, they were concerned for the safety of the unborn child.

This information triggered an initial assessment by CYPD and the arrangement of a pre-birth Child Protection Conference for **August 2008**. Within probation, the PSO informed her manager. It was agreed that the PSO keep the case and review whether it should be allocated to a more qualified worker once the child was born.

The CYPD initial assessment highlighted the good parenting that mother had displayed in relation to her first child apart from the evening of her death, and that she accepted the irresponsibility of her actions at that time. The report stressed ongoing trauma and loss linked to the death of her first child, and her fears and anxieties that something similar might happen to her second. The SW stressed that it was difficult to foresee how this trauma and anxiety might impact on her parenting ability.

The pre-birth conference was attended by the IRO, Senior Practitioner SW, Named midwife and named nurse for safeguarding, HV, PSO, FCIU mother, maternal grandmother, great aunt, It was agreed that the child be subject to a CP Plan at birth under the category of neglect. A planning meeting **in September** clarified the support roles of the midwifery team including visiting, a Cona system for monitoring the baby, and parenting classes; the HV and Probation Officer.

The child was born early, in mid-December 2008.

A child protection Plan was drawn up on 8 January 2009.

On 14th **January 2009**, case responsibility in probation was formally transferred to Probation Officer Offender Manager (PO OM). However, because the PSO had been working with her for two years, and the Order was coming to the end of the Order, it was decided that she should continue to be centrally involved, doing all the monthly visits. The PO OM completed two OASys risk assessment reports: one was completed on the **14th January**, to assess the risk of reoffending due to the change in circumstances of mother being pregnant. This increased her risk from low to medium. The second, **27th February**, was the end of term risk assessment, which also concluded medium. This followed the termination of her Order on **23 February 2009** and with it probation's involvement.

At the first review meeting, 3 months later, **March 2009**, it was recommended that the CP plan was no longer necessary. This decision drew on the findings of:

a) a risk assessment conducted by the social worker on father (linked to mother's describing him as very controlling with what she saw as potential to become violent), and
b) a Core Assessment also conducted by the social worker, which included
c) a parenting assessment by a family support worker, done on mother.

Mother had moved out of the maternal great-grandparents house into a home of her own. She continued to receive a lot of support from the maternal grandmother and none of the professionals had any concerns about her ability to love and care for the baby, who was thriving. The Review recommended that CYPD support be in place if needed for a further 3-6 months.

Continued involvement from CYPD did prove necessary. A CIN Plan was drawn up on **17 April 2009** to include fortnightly visits by the social worker to monitor that mother was meeting of all the child's basic care needs and monitoring of his development by the Health Visitor through visits as necessary. This development was initiated after the SW investigated allegations that the paternal grandmother had drawn to her attention on **20 March 2009**. They involved mother's alleged recklessness in organising babysitting arrangements when she had wanted to go out, following a funeral – circumstances similar to those that led to her conviction for neglect in the death of her first child – and that when the child had been returned home, mother was drunk and claiming to have taken cocaine. A second such example was also given which involved mother not waking up in the night despite the child crying relentlessly to be fed. All these details were refuted by mother.

It was during discussions of this incident with the social worker that mother had queried father's paternity for the first time. Informal contact arrangements had broken down soon after birth and father had sought legal advice. This had led initially to attempted mediation sessions in February but these failed due to non-attendance of mother. Father had then initiated a private Court hearing to apply for contact. The first court date was set for **May 2009**. By **June 2009** mother had received DNA test results that confirmed paternity of father. The next Court hearing was scheduled for **June**.

Scheduled fortnightly visits by the social worker followed the March 2009 referral – three taking place after the CIN Plan was completed. Mother called the social worker as necessary to inform of changes to her circumstances (e.g. new mobile number; moving in with great-grandparents) or if there was a change to the plan e.g. meeting at maternal grandmothers, or need reschedule (twice she was in Wales).

Mid-May 2009 mother moved back to the great- grandparents, explaining to the Health Visitor that she felt harassed by friends in the locality of her home, reporting threats of physical injury by text. This followed her telling the social worker that her 'friend' had given her mobile number to the co-accused in the neglect case linked to the death of her first child. At this point the Health Visitor also referred mother to Sure Start Children's Centre, who in June informed the Health Visitor that they were in the process of allocating a family support worker for mother.

Mid-June 2009, CYPD received an anonymous referral alleging that mother was drinking lots of alcohol and leaving the child alone in the flat when she was out in the street drinking. The referrer suspected possible drug use due to mother's appearance. A home visit by the social worker the next day was inadvertently the first ever unannounced home visit because mother had changed her mobile so had not received the social worker's message. This meeting raised serious concerns for the social worker as mother took some time to open the front door, and smelt of alcohol when she did. Mother explained that the child was in the bedroom with her new partner, and another friend was asleep in the living room. She brought the child for the social worker to see as requested. The same day, CYPD received another referral expressing concerns about the child and excessive drinking that had gone on in the flat the night before till the early hours. The same day, the social worker requested initial legal advice through a 'legal gate keeping' meeting that she

was already scheduled to attend that afternoon, due to the circumstances being similar to those linked to the death of mother's first child.

The agreement from the legal gate keeping meeting was that the SW would add an addendum to her report for the father's next private Court hearing, which was only 5 days away, outlining recent events and concerns and asking the Court to invite CYPD to complete a Section.37 Report. The Legal team would arrange for a solicitor to be in attendance at the court hearing. She would also book another Child Protection Conference. There was discussion about offering accommodation for the child under Section 20 so that the child would be looked after until the assessments were completed but this course of action was not agreed as appropriate. It was noted that "the maternal grandmother will minimise any inappropriate action carried out by her daughter". On a home visit by the Social Worker the following day, this position was explained to mother.

The outcome of the private Court Hearing on **June** was that the Local Authority was to conduct a Section 37 report, organise contact with the father for two hours a week at the Family Centre supervised by a Family Support Worker and prepare a report on that contact. The mother and father were ordered to have hair strand tests for both alcohol and drugs, to be filed by end July.

The Child Protection Conference on **6 July** was attended by the social worker, health visitor, named nurse for safeguarding and police officer from the Family Crime Investigation Unit (FCIU). Family members present included mother, father and maternal grandmother. Summary of causes of concern included 'similar issues and concerns to those in the past have re-emerged, and they are highly concerning'. Agencies agreed with the social worker that the child required a formal Child Protection Plan and recommendations included statutory visits, both announced and unannounced, to be weekly until the first review and fortnightly thereafter.

Following the CP Conference, the social worker started the S.37 Report, and finalized checks on father's contact arrangements (completing an SPA). The First Core Group meeting was held on **14 July** to draw up CP Plan. This was attended only by the social worker and health visitor and father turned up right at the end, having just come from a contact session. Information from father was that mother had said she knew nothing of this meeting, though details had been given at the CP Conference.

Three statutory visits took place over the subsequent three weeks, one unannounced, as per the CP Plan. Father had x number of contact sessions with the child. On the last but one day of the child's life, he was seen by the family support worker at a contact session with the father and by the social worker, when mother came to the CYPD office with the child and maternal grandmother. Neither had had any concerns about his health, well-being or quality of care mother was providing.

In July, mother called an ambulance. She had been up drinking with her neighbour friend until 3am, when she said she had fed the child before putting him back to sleep. When she went to him at 9am she found him lifeless. The child was pronounced dead on arrival at hospital. The cause of death was determined as unascertained.

3. Identifying and analysing Key Practice Episodes and their contributory factors

A key part of organising and analysing the data using a systems approach is to identify what we call 'key practice episodes'. These are a selection of practice episodes that were 'key' in that they were significant to the way the case developed and/or was handled. Some of these are identified by professionals in the individual conversations, others are identified by the review team with the benefit of the overview perspective that they hold. They are not restricted to incidents and can cover any time period. Analysing them requires the review team to do three things:

1. clarifying the way in which we think they were significant
2. describe how we are judging the quality of practice they contain
3. identifying contributory factors that explain why the practice contained seemed sensible at the time

Eight episodes have been selected for analysis. They are:

- Probation's response when informed that mother was pregnant.
- Pre-birth conference
- Core Assessment including parenting assessment
- Mother's moving out of her grandparents to her own accommodation.
- March review meeting.
- CIN Plan April 17th
- HV referring to Sure Start for family support
- July re-registration and CP Plan

They are analysed with reference to this list of contributory factors:

- Aspects of the family
- Aspects of your role
- Conditions of work / work environment
- Personal aspects
- Your own team factors agency factors (including supervision;
- Inter-agency /inter-professional team factors (assessments by the courts; relativity of agency judgments;
- Organisational culture and management
- Wider political context
- Other

Key Practice Episode 1.

Description of episode and its significance
Probation's response when informed that mother was pregnant.

In May 2008, social care informed the PSO that mother was pregnant and they were doing an assessment. When the PSO informed her manager of this it was agreed that the PSO keep the case and review whether it should be allocated to a more qualified worker only once the child was born. After the birth of the child After the birth of the child, it was agreed between managers that management of the Order would be transferred to the PO OM, who would update the OASys risk assessment, but that direct day-to-day contact would continue to be with the PSO in order to preserve Offender Manager continuity.

This was an important and first opportunity for probation services to revisit the work they had done with the mother at the beginning of her Community Order for neglect in relation to the death of her first child, and to test the extent to which she accepted responsibility for the consequences of her actions then, and the extent of awareness and change on her part in regard to the forthcoming baby.

Judgement of practice	**Identification of contributory factors & related questions**
The opportunity that the information about mother's pregnancy provided was not adequately utilized. There was no return to earlier work to refresh with mother the past issues and relate them to new pregnancy and potential future risks, either before or after the birth. There does not seem to have been any consideration of risk to the unborn child – there was no formal change of worker to one more qualified till after the birth on the basis that there was no evidence of risk to the child during her previous pregnancy. After the birth of the child, where there was formal transfer or case responsibility to a qualified PO OM, the management rationale for not transferring day-to-day contact was that the PSO already new mother well and it would allow continuity and would be more efficient than someone else starting from scratch. The PO OM therefore relied primarily on input from the PSO to inform the formal risk assessment. However, at this point it might have been preferable to have the original PO back in as Offender supervisor (doing day-to-day) as well as Offender Manager because, as a trainee, she had done a lot of work with mother originally to address her offending behaviour and on getting her to understand the impact of her decision making on the w/end of the initial death and this could have been revisited. This is particularly so because the PSO who had been working with her other for over two years seems to have had something of a motherly relationship with her so was not disposed to challenging her. The documentation shows examples of input from the mother being taken at face value and sometimes overinterpreted as evidence of her ability to make suitable judgments in regard to relationships and the unborn child. Yet input from the conversations and documentation	**Agency culture (probation).** The probation service does not seem well designed to deal with pregnancy compared to children's workers. Input from probation staff at the follow-on meeting suggested that the need to assess and address risk to the unborn child hard to grasp: "what would we have done with her?". **Role (3 year order).** • Input from probation suggests that in a three year order it is difficult to sustain work with the client, and that this was particularly so in this case because until this point there had been no child most of the time. Therefore it had been difficult for staff to test the results of any of the work they were doing with mother. The purpose of probation involvement toward the end of the order had become somewhat unclear. • The fact that the first death had happened three years ago also made it easier to put it from mind. • Furthermore, dealing with the part a mother has played in the death of her own child is clearly a deeply sensitive and emotional subject. If the mother did not want to acknowledge the issues, then it would have been a hard task for even the most qualified staff to persevere. **Agency culture (probation).** Compounding the lack of opportunities to test the extent to which mother had changed, she was also highly compliant and this was judged positively by probation and other agencies. Mother's level of compliance would be somewhat unusual in the probation service. Her willingness to engage would therefore have been interpreted as part of the 'maturing' process, which was understood as minimising risks to the new child. **Supervision.** Input from conversations described how managers rely on staff to bring cases where they have 'concerns' to their attention. This leaves staff to police their own biases – such as the benign view of mother in this case - which research demonstrates is impossible.

suggest that in fact both probation workers involved with mother saw her more as a victim than as an offender. This was the predominant mindset within probation. So even if a different worker had been allocated, it might not have made any different. There was a strongly held view that mother had matured significantly over the time of the order, however, this does not ever seem to have been tested.	

Key Practice Episode 2

Description of episode and its significance
Pre-birth conference

Mother, maternal grandmother and Great Aunt attended, as well as the Social worker, named midwife and named nurse for safeguarding, HV, probation officer, police. It was chaired by the IRO.

At this conference we see the prevailing picture beginning to be set where by mother's conviction related to the death of her first child is disregarded in its significance. Protective factors are seen to far out way the risk factors. Grounds for reassurance were set at this meeting – her maturity; her extended family as protective factors and her compliance with professionals as evidenced through Probation.

Judgement of practice	**Identification of contributory factors & related questions**
There was insufficient discussion to ensure clarity about why this conference was taking place – what was the background? Procedures state that this is required if the parent is a risk to children. Given her history, the potential risk she posed was insufficiently explored. At the pre-conference briefing, the maternal grandmother had challenged information that mother had already given and agreed with the police, that featured in the social worker's report, about having stayed the whole w/end at her friends prior to the death of her first child. The Chair repeated this correction at the opening of the conference without challenging its inaccuracy. This is the first occasion when the maternal grandmother's minimisation of her daughter's responsibility (if not denied it altogether should have been challenged. Instead, we noted a prevalence of self-reported detail in the documentation without any professional critique and challenge. So for example mother was claiming to have matured since the death of her first child so that the same situation would not happen again and this was taken at face value. What it actually meant was not unpacked, nor was there any plan to test her claim. In place of constructive challenge and pro-active planning, instead we see the start of a pattern of the family setting the agenda of professional meetings and subsequent intervention.	**Aspects of the role (of the Chair).** The Conf. Minutes note: "The Chair suggested that conference members had read the account in the social worker's report of the events leading to the first child's death in April 2005, and that *it was not necessary to discuss the detail at this conference*" (emphasis added). Thus she shut down the very first opportunity that the multi-agency group had to ensure they were all clear about relevance of the past to the present, effectively censoring the remit of thinking. Input from staff suggested that in this and other ways the Chair set the tone of the meeting as sympathetic and supportive toward mother, rather than focusing on identifying and addressing risks she might pose to the child. None of the staff challenged this. It was the PSO's first ever CP Conference so she did not know how usual or advisable this was. **Organisational culture of multi-agency child protection** • All aspects of this system are designed to address the immediate risk of harm to a new born, and are not designed to think about and plan for future risks that may emerge at a later stage of a child's life – as were relevant in this case. • The culture of working openly with families, seems inadvertently to have made it difficult to disagree with family members. The need to be non-judgemental seems to have become mistakenly conflated with the need to make professional judgements.

For example, the notion that the father was a problem rather than a support was first introduced here by the mother. Her self-reporting of this issue is presented as if it was fact as opposed to something to be checked. We wonder why no link was made to mother's previous experience of DV at this stage, as it was known. In the context of the above, the focus of the meeting and associated plan became more about supporting and reassuring the mother , especially because of the child's father's purported affect on her as well as his potential risk to the child. Conversely, the nature and timing of potential risks she might pose went unidentified or thought through. Input from the feedback meeting and conversations suggested that if mother had not raised the issue of the father and his purported potential for domestic violence, the conference decision would probably have been not to make the child subject to a CP Plan. Overall, by avoiding raking up the unfortunate event of the past seems to have had the effect of leading professionals to avoid dealing with the very issues they should have been there to address in the first place. The fact that the first child wasn't known to social care before death, seems wrongly to have reinforced the idea that mother was a benign influence and that there was no need to go over the past in order to ensure this child's present and future safety and wellbeing.	• This would no doubt have been exacerbated given the sensitivity of the topic - a mother's culpability in the death of her own child. Research shows the difficulty of identifying parental practice as neglectful when there is no intent or malice involved– as has been the situation in the case of the death of the first child. • The fact that the first death had happened three years ago also made it easier to put it from mind. **Aspects of the family (maternal grandmother)** She was described as being a very strong force. **Aspects of the family (Mother).** She was compliant and cooperative, had experienced genuine trauma and loss at the death of her first child, and had recently been low and on antidepressants, linked to anxiety that something could happen to her new baby as it had done her first.

Key Practice Episode 3

Description of episode and its significance **Core Assessment, including parenting assessment on mother and risk assessment on father** The CP Plan tasked the SW with completing a Core Assessment with mother which 'specifically addresses her parenting capacity in light of the historical concerns' and to include the father. It also tasked the Family Support Worker to undertake a 6 week Parenting Assessment with her. These assessments are significant because, away from the influence of the IRO/Chair, they presented an opportunity to critically review the way that the case had been framed. The assessments also played a critical role in the subsequent decision to remove the Plan.	
Judgement of practice	**Identification of contributory factors & related questions**
The opportunity to achieve more clarity about the exact nature of risks to the new child in light of the mother's history was not used in the Core Assessment. Instead we see a repeat of the framing of the case as had developed through the pre-birth assessment and pre-birth CP Conference which highlighted: • protective factors, including supportive wider family, including father and parental grandmother	**Organisational culture (CYPD)** • All aspects of this system are designed to address the immediate risk of harm to a new born, and are not designed to think about and plan for future risks that may emerge at a later stage of a child's life – as were relevant in this case. • The categorisation of mother's conviction as

- the lack of concern about her care of her first child prior to the death,
- mother's cautiousness about his safety and well being in light of the death of her first child
- mother's assertions that she has matured a lot since the first death and would never make the same mistakes again

However, a strong onus is put on the referral to Family Support Services "for a full parenting assessment to be carried out due to events in April 2005". The purpose of this is described as "to ensure that the child will be safe in the care of his mother". This parenting assessment conducted by the family support worker manifest very good practice. The worker described it as 'almost writing itself' it ran like clockwork'. If you wanted a text book client, the mother was it". Yet two problematic issues are identified. Firstly, it seems problematic to commission such a critical aspect of the assessment process to family support workers (who are not qualified as social workers)?

Secondly, what the Family Support service was commissioned to do was not what was required. They were commissioned to do a standard parenting assessment that focused on the core tasks of providing basic care, rather than a bespoke assessment that focused on this particular mother's particular parenting issues. i.e. they were standard parenting assessments and so look at standard indicators as opposed to identifying and exploring the specific, particular risks that contributed to the death of the first child and linked conviction. This was not a typical long-term neglect case but it was treated as if it was, hence the use of standard forms and classifications that focus on cleanliness etc. While all evidence suggests that she had been positively looking forward to having the second baby and intent on providing good care for him, her prior history should have drawn professional's attention to the question of how well mother could put her baby first on occasions when she really didn't feel like it - balancing the demands of motherhood and her desire for a social life and whether she could continue to put her child's needs before her own as the child grew older? Where issues pertinent to the death of the first child were talked about with the mother, it seems like they were restricted to the question of who would she leave the new child with (the red herring mentioned below).

The risk assessment carried out by the social worker was triggered by mother's assertion of father controlling temperament and potential for domestic violence. Problematically, it seems to have relied primarily on self-reporting on the part of the father himself: "father advises that ...". The view of the Community Service Officer who had worked with him was also sought. However, given that her role was entirely focused on supervision of his unpaid work, and involved no offence related or personal work

'neglect' seems to have inadvertently lead professionals to think in terms of chronic neglect and its usual indicators e.g. children being clean, fed, stimulated, clean home conditions and distracting them from thinking about the potential risks of incidents of neglect, of the kind for which she had been convicted.

Agency management (CYPD interface between Family Support and Social Work) Input from CYPD strategic managers suggest that the initial idea was that family support workers would do the parenting assessment in conjunction with more qualified social worker, the reality is that it is they who do the assessment – i.e. the systems is set up currently in such a way that leaves the less qualified people doing the most crucial bits of work.

Supervision It is still not clear whether there was any active supervision within social care for the social worker during this period. The Senior Practitioner from the Assessment team described herself as giving advice to the SW who took over the case in the absence of that SW's manager. This removed the possibility of a fresh pair of eyes to challenge the framing of the case.

Agency management & tools. Do assessment processes and procedures in CYPD keep 'risk assessments' separate and additional to Core Assessments? Research suggests that the common assessment framework that focuses on need has made it more difficult for workers to focus simultaneously on risk and to keep risk integral to all assessments. Where is the encouragement and support for thinking critically about the information that has been gathered, for putting the analysis into assessment?

Organisational culture of multi-agency child protection Is a Core Assessment a joint, multi-agency responsibility in practice? Who's responsible for thinking in a Core Group? If this is informally delegated to the social worker, what does working together actually mean in practice?

there is the possibility that the relevance of her input for DV issues was overestimated. The review team also query how helpful it is to have such a 'risk assessment' separated out from the Core Assessment.	

Key Practice Episode 4

Description of episode and its significance **Mother's moving out of her grandparents to her own accommodation end January 2009.** On a statutory visit mother told the SW that she had seen and accepted a property and was hoping to collect the key that very day. The SW advised her that this needed to be agreed by Core Group members. SW spoke to Probation Service Officer and Health Visitor and called mother back to say no-one had objected. This is a significant episode because it was a key part of the CP Plan that she should remain there "until the Core Group feel it is satisfactory to move on".	
Judgement of practice	**Identification of contributory factors & related questions**
Good practice on the part of the social worker in ringing the other Core Group members to ascertain their views. Yet this episode can also be seen as an example of mother forcing the Core Group's hand. She hadn't actually ask permission but informed after she had already got everything arranged. This was not challenged by the SW or other core group members. A positive, optimistic view is expressed by all staff but there didn't seem to be any in-depth exploration or testing of her ability or support needs in managing on her own in her own tenancy. Looking at her history as available in the probation files would have revealed that in fact while she had had her own tenancies in the past, the patterns seemed to be that if anything rocked the boat, she either returned home to her grandparents or found other sources of support which were often inappropriate e.g. such as the family at whose house her first child died; or the father of her first child.	**Organisational culture of multi-agency child protection (not challenging families))** • The culture of working openly with families, seems inadvertently to have made it difficult to disagree with family members. The need to be non-judgemental seems to have become mistakenly conflated with the need to make professional judgements. • This would no doubt have been exacerbated given the sensitivity of the topic - a mother's culpability in the death of her own child. Research shows the difficulty of identifying parental practice as neglectful when there is no intent or malice involved– as has been the situation in the case of the death of the first child. **Aspects of multi-agency (Core Group dynamics)**

Key Practice Episode 5

Description of episode and its significance
KPE: March review meeting & decision CP Plan no longer required. This was the first review meeting since the initial pre-birth CP Conference. The Health Visitor and Probation Service Officer provided reports but did not attend in person. SW and Family Support Worker attended, as well as mother and Great Aunt. The recommendations including statutory SW visits, Core Group meetings and completion of assessments were all confirmed to have been fulfilled. The update of the situation highlighted no concerns from SW, Family Support Worker, HV or Probation worker. This meeting was significant because it served to reinforce the view that had been established at the pre-birth conference i.e. mother had matured, was compliant, and all the indicators they were looking at in terms of the child were positive. The opportunity this review meeting held for critical review and re-assessment of the framing of the case was missed.

Judgement of practice	**Identification of contributory factors & related questions**
Given that mother was categorised as posing a risk to children in light of her previous conviction, the conference decision to deregister the child after such a short time is surprising (3 months since the child's birth). The rationale for this decision is clear in the SW's report – "*Initial concerns were around the child's care as at the time of the first child's death she was left in the care of a 12 year old. There has been no evidence that this would be the case with the new child and mother has advised that she has matured since the sad loss of her first child and would never put the second child in the same position"* It seems to the review team that the issue of the decision to leave the first child with a 12 year old was something of a red herring as the child had survived this decision and died later while in the mother's care. There were other significant errors of judgement on the part of the mother before, during and after the decision to leave the child with the 12 year old including her decision to stay with these friends the whole w/end given the child had been unwell for two weeks and there was no where suitable for her to sleep. We also question why differences in the age of the second child at the time of review, relative to the age of the first child at time of death were not taken into consideration. To assume that her behaviour when the child was 3 months old would stay the same as he got older seems problematic given that it was at 7 months old that her first child died. This suggests that assessment was being seen as a one-off event and not an on-going process. Additionally, it was approaching the anniversary of the first child's death which makes the timing of this decision to 'de-register' seem questionable. It doesn't seem like there was there any exploration with the family or professionals of the potential impact of this on the mother and her ability to care	**Role of the Chair**. It was the same IRO who chaired the pre-birth CP Conference. It is not surprising therefore that there doesn't seem to have been any challenge by the Chair to the proposal to deregister or the premise it was based on. This raises questions about the extent to which it is the Chair's role to provide a "fresh pair of eyes" and critical review of the Core Group input and analysis. **Organisational culture of multi-agency child protection** • All aspects of this system are designed to address the immediate risk of harm to a new born, and are not designed to think about and plan for future risks that may emerge at a later stage of a child's life – as were relevant in this case. • Without any immediate risks, the Core Group seemed to lose any focus or purpose. It was very focused on the here and now without any analytic process of what that meant for the future. It was very led by the issues the family brought to the table, rather than having any clear plan about what they and the family were meant to be working on and whether any progress was being made. • This raises questions about whether a culture developed whereby CP Plans are considered something to be got rid of rather than a useful tool to support professional practice? • It is not unusual for CP Plans to be insufficiently specific about the nature of the problems, the outcomes desired or what difference it is hoped the interventions will make **Supervision** Input from conversations suggests that across health visiting and probation, managers rely on staff to bring cases where they have 'concerns' to their attention. This leaves staff to police their own biases which research demonstrates is impossible. It is still not clear whether there was any active supervision within social care for the social worker

for the child. We also question whether sufficient thought was given to what would happen when family support was withdrawn? There does not seem to have been any explore and/or testing of the extent to which her doing well as a parent was dependent on this input? Visits with the Probation Service Officer which had been a staple in mother's life for the past three years had come to an end as the Order had expired. Family Support too was withdrawn once the 6 week assessment period was completed. The Review Decision and Recommendations include that 'CYPD Support to be in place if needed, for a further 3-6 months' but it is not at all clear what such support would entail, who would provide it, for what purposes or how it would be evaluated that it was no longer needed.	during this period. This raises the question about what 'supervision' means in different agencies and where, if anywhere, critical review/reflection is expected to take place. This aspect of supervision would explicitly focus on challenging the assumptions and biases of the staff member in contrast to having a performance or management focus – as was necessary in this case.

Key Practice Episode 6

Description of episode and its significance **CIN Plan April 17th** This CIN Plan was drawn up after the decision at the March review meeting that a CP plan was no longer required, following allegations via the paternal grandmother of mother tricking a 16 year old friend into looking after the child while mother herself went back home with friends to get drunk after a funeral as well as other examples of drinking and not being attendant to the child's needs. It is significant because it was the first time that concerns similar to those that had led to the conviction for neglect in relation to the death of the first child had arisen.	
Judgement of practice	**Identification of contributory factors & related questions**
Good practice is evident in the SW's responding to and investigating the paternal grandmother's allegations, despite the lack of a CP Plan that might have made the case look lower priority. However, the plan itself entails only 'monitoring' on the part of the social worker with fortnightly visits of mother's meeting all of the child's basic care needs, and by the HV "as necessary" of his development. It is therefore unclear what exactly it was meant to achieve or by what means. It might have been more appropriate instead to call a new CP Conference at this point and formulate a new, more targeted CP Plan to address the particular issues raised.	**Organisational culture of multi-agency child protection.** • The CP Review had not been specific about the kind of 'support' that should be initiated. • At this stage there was effectively no Core Group beyond the HV to work with the SW in thinking about the case, or whose services she could draw on in the plan. She was feeling very isolated. • If there are only two professionals in a core group, this lessens the formality of it and it becomes easy to lose clarify of task/focus.

Key Practice Episode 7

Description of episode and its significance **HV referring to Sure Start for family support** At this point the Health Visitor also referred mother to Sure Start Children's Centre, who in June informed the Health Visitor that they were in the process of allocating a family support worker for mother. Yet after the SW's unannounced visit raised concerns about mother's drinking and care of the child, the planned joint visit was put on hold until the outcome was clear. This episode is significant because this was a key opportunity for some direct services to become engaged with mother.	
Judgement of practice	**Identification of contributory factors & related questions**
The HV was positively pro-active about linking the family into universal services, in the face of the withdrawal of CYPD, family support and probation input. Good practice – beyond silo, task focused. However, it was unnecessary to put the joint visit with the Sure Start Family Support worker on hold until the outcome of the SW's increased concern following the unannounced visit was clear. This is a common misunderstanding nationally about the interface between universal and specialist services.	**Aspects of multi-agency working.** Feedback from the follow-on meeting was of a widespread lack of clarity about what Sure Start does: where are they? What do they do? How do you access their services?

Key Practice Episode 8

Description of episode and its significance **KPE: July re-registration and CP Plan** This meeting was significant because it was the culmination of a good response to an escalating situation and created the opportunity for a clear formulation of the nature of the concerns, what to work on and how, as well as how to measure progress.	
Judgement of practice	**Identification of contributory factors & related questions**
Much good practice is notable in the lead up to this CP Conference. Quick and appropriate action was taken by the social worker in response to the recognition of similar patterns of behaviour and concern that had emerged in relation to the death of the first child, when that child was about the same age – mother drinking, unsuitable people around, concerns about arrangements for the care of the child. This included gaining legal advice through a 'legal gatekeeping' meeting and arrangement of the CP Conference. For the first time, the similarity of issues and concerns to those related to the death of the first child are explicitly identified. At the legal gate keeping meeting, it was decided that accommodation would not be offered under	**Agency culture (courts).** CYPD did not feel that the threshold had been met for an EPO. Does this reflect a bias toward tangible present evidence on the part of the courts? How do they respond to a case that argues the comparability of current and previous behaviour, drawing heavily on history? **Organisational culture of multi-agency child protection (not challenging families))** • The culture of working openly with families, seems inadvertently to have made it difficult to disagree with family members. The need to be non-judgemental seems to have become mistakenly conflated with the need to make professional judgements.

Section 20 so that the child would be looked after until the assessments were completed. The notes explain that this would be the ideal situation yet adding 'it would ease our anxieties but many not be an appropriate course of action'. Input from the feedback meetings clarified that it was not felt that 'because it was thought that the mother would not agree. The review team wonder whether, given the history, an emergency protection order might have been presented. At this CP Conference, as at the initial pre-birth one, the maternal grandmother explicitly claimed that her daughter had been wrongly convicted because the child had died of natural causes. Similarly too, there is not evidence that this was challenged. New information was made available here about the extent of maternal grandmother's substitute parenting (saying she took care of him every afternoon, as well as Friday nights and sometimes Saturdays). She also explained that they had not been available for the past two weeks because they had been preparing to move house. The review team wonder whether this might explain the rise in referrals over this time. However, the connection does not seem to have been made in the meeting, nor its implications in terms of the recommendations for the Plan. It is unclear what the CP Plan was designed to achieve? The focus seems to have been on monitoring the mother and preparing for the father's court hearing, neither of which are specifically designed to change the mother's patterns of behaviour or test that change. This is reflected in the make up of the core group members the social worker, health visitor and family support worker supervising father's contact sessions.	**Organisational culture of multi-agency child protection** • Has it become the norm that CP Conference are more task focused about the decision that the child requires or does not require a plan, than about information sharing, discussion and interpretation of that information and its implications in terms of the content of the Plan? • Is a Core Assessment a joint, multi-agency responsibility in practice? Who's responsible for thinking in a Core Group? If this is informally delegated to the social worker, what does working together actually mean in practice? • It seems usual for CP Plans not to be sufficiently specific about the purpose of all the actions, in order that it can be evaluated as to whether they are making any positive difference. **Supervision** – Input from the conversations suggests that the SW did not get support with thinking through what the implications for action/intervention of her changing view of the case. Instead, at this point too the relevance of the past for the present still went unexplored. Comments such as "compared to a lot of families we deal with this was by no means the worst" suggest that the crucial detail that in this case a previous child had died were still being ignored.

4. Identification of underlying patterns of systemic influence on practice and linked recommendations

A key feature of the systems model is the endeavour to make the particular case being reviewed act as 'a window on the system'. This involves moving from the analysis of intricate details of the case (via the 'key practice episodes' and their contributory factors), to a 'deeper' level of analysis. This deeper level is about what we can learn from this particular case that is relevant to professional practice more broadly. In terms of service improvement we are not really interested in issues that are unique to particular cases. Instead, we want to identify *patterns* in the ways that workers interact with and are influenced by different aspects of single and multi-agency systems. While these influences on practice may manifest slightly differently in different cases, the underlying issues are the same. So we call these 'underlying patterns of systemic factors'.

The systems model that SCIE has developed includes 6 broad categories of these underlying issues:

- patterns of human reasoning
- patterns of family- professional interaction
- patterns of human-tool interaction
- patterns of communication and collaboration in response to incidents and crises
- patterns of communication and collaboration in assessment and longer term work
- patterns of human-management system operation

Each pattern features on interactions between people and aspects of the system, including other people. They may have many different subcategories and these will be developed and expanded as more case reviews using this model are developed. There is, of course, overlap between categories. Importantly, not all categories can be covered so selection is necessary.

Patterns of human judgement and reasoning

As stated in SCIE Report 19:

> A fundamental premise that shapes the whole-systems approach to understanding the role of the human operator in error causation is that studies need to be based on a realistic idea of human capacity. Work on human cognitive factors aims to inform our understanding of what standards are likely to be achieved. Designing a safe system means taking into account people's psychological limitations and requires understanding and recognition of the main human errors of reasoning, and building in strategies for detecting and correcting them (Fish, et al. 2008: 66).

'Garden path' errors

With hindsight, this case features a central bafflement. Key professionals seemed to manage to 'forget' that the mother concerned was a Risk to Children – in the old terminology, she had been a schedule one offender; her first child had died of natural causes aged seven months, and she had been found guilty of neglect in relation to that death and sentenced to a three year community order. Of course they did not really forget,

but this history was somehow not deemed significant in how they responded to the family and the approach taken to working with the mother during the pregnancy and early life of her second child (until the 'unannounced' visit turning point). With hindsight this is baffling. Her second child also died of natural causes at exactly the same age to the first, and against a background of a similar pattern of concerning parental behaviour. Knowing the outcome, a whole sequence of judgements and decisions seem bizarre and unjustified, not least the decision to remove the Child Protection Plan after just three months. It is easier to comprehend, however, once we see what information the workers were using and what they were overlooking. Moreover, research into common errors of human reasoning offers an explanation of how such a biased basis for judgments come about: the "garden path" syndrome.

Garden path errors are a subset of a broader weakness that has been identified in human cognition:

> One of the most persistent and important errors in cognition is people's slowness in revising their view of a situation or problem. Once they have formed a view of what is going on, there is a surprising ability to fail to notice or to dismiss evidence that challenges that picture (Kahneman et al., 1982). Becoming fixated on one assessment despite an emerging picture that conflicts with it becomes a significant source of cognitive error.
>
> *Garden path* problems are 'a specific class of problems where revision is inherently difficult since early cues strongly suggest [plausible but] incorrect answers, and later, usually weaker cues suggest answers that are correct' Woods and Hollnagel, 2006, p.75). Besides being influenced by the relative strength of cues, the worker is also hampered by the fact that data tends to arrive incrementally, not in a single, eye-catching batch. 'The vulnerability lies not in the initial assessment, but in whether or not the revision process breaks down and practitioners become stuck in one mindset or even become fixated on an erroneous assessment, thus missing, discounting or re-interpreting discrepant evidence' (Woods and Hollnagel, 2006: 75) (Munro 2008: 53).

In this case, early cues suggested a doting new mother, highly anxious that her second child might die like her first. This led to the tendency to treat the death of the first child as an unfortunate accident and a minimisation of the significance of the role the mother played in the death of her first child, in terms of risk factors for her second.

One key way in which garden path errors are picked up is when new evidence seriously challenges the judgment – this happened for the social worker following her 'unannounced' visit and she registered that the core group may have got the case all wrong. Otherwise, research has shown that it is exceptionally difficult for us to police our own biases of this kind. Resistance to revising our judgements and plans is our more usual human inclination. Briefing 3 of the Centre for Excellence and Outcomes in Children and Young People's Services or C4EO's Safeguarding series focuses on this issue: "The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information?" http://www.c4eo.org.uk/themes/safeguarding/files/safeguarding_briefing_3.pdf (Burton 2009). It provides a useful summary of research evidence on the topic.

Recommendation 1. CYPD have arranged a series of events to share with staff the contents of C4EO Safeguarding Briefing No3, on the oversight and review of cases in light of changing information. The LSCB should consider running equivalent workshops on the

topic for multi-agency groups of staff. One-off training is limited in its effectiveness so these workshops would need to be tied in with the other developments recommended in the communication and collaboration section below around improving the quality of thinking.

Recommendation 2. Staff have fed back from this pilot that having the concepts of 'garden path error' and 'red herring' has proved useful, supporting them to think more critically about their cases and judgments: "*Though these terms may be clichés in life, when applied to the safeguarding task, they take on an important and useful relevance*". Some have given examples of how it has changed their practice in relation to other cases. The LSCB should consider commissioning or requesting the commissioning of a brief publication that would capture common errors of human reasoning.

The C4EO briefing summarises the two main strategies for responding to changing circumstances or evidence:

1) professionals playing their own devil's advocate and
2) bringing a fresh pair of eyes to consider the case

These relate to multi-agency and supervision practices respectively, neither of which were successful in this case. They are explored further below in patterns of human-management system operation and patterns of communication and collaboration.

Patterns of human-management system operation

The role of supervision in critically reviewing mindsets

Being closely involved with a family can make it difficult to stand back and critically review the information available, testing current interpretations and considering alternative explanations or implications of what is going on. Consequently, a key mechanism for disrupting a fixed mind set about a case is the introduction of a fresh pair of eyes. In social work literature, the importance of the critical review aspect of supervision is a constant theme. However, our review has shown that, across agencies, supervision was not successful in fulfilling this function in relation to this particular case. Moreover, discussion with the case group has highlighted that detailed supervision, across social care, health visiting and probation, is restricted to cases that staff themselves are concerned about - exception reporting. Cases that workers are wrongly unconcerned about – such as the one reviewed - will therefore never be picked up and reviewed with a fresh pair of eyes. Moreover, we were told that supervisors rarely, if ever, read the files of cases that they discuss in supervision but rely instead on verbal reports from the workers. This reduces significantly the opportunity to spot inconsistencies in available evidence or assumptions that have not yet been adequately tested, potential biases or misjudgements. This was as true in health visiting where, for example, the managerial aspects have been split from the reflective aspects by having a clinical supervisor as well as a line manager. This particular case therefore gives a concrete example of the causal implications of not prioritising and resourcing the critical review aspects of supervision, including for cases that are <u>not</u> judged as high risk. The inevitable errors in human reasoning may be overlooked and opportunities to challenge situations that may have drifted may be lost.

The C4EO briefing indicates that such a loss of the analytic and reflective aspect of supervision is widespread and has led to proposals of other potential forums and

mechanisms for avoiding complacency and shaking up professional's thinking. Discussions with the case group too revealed a total lack of hope that a critical review element could be incorporated into supervision, given the current performance management focus: "it would be pie in the sky to wish for it". Staff instead stressed the need to develop and support their own capacity for critical thinking through Core Groups, including through the role of the Chair – as discussed in the section on multi-agency patterns.

Recommendation 3. All agencies should review the cost-benefits of providing a critical review of workers thinking about cases through the supervisor's role and/or other means. If the result is that it is not considered value for money then a clear organisational statement is needed to that effect, which is owned at a strategic level. Health visiting, probation and CYPD should identify current requirements on supervisors that are intended to ensure effective oversight and review of workers' thinking about specific cases, and assess whether they are effective and why - for e.g. the requirement to 'dip sample' cases – and amend their quality assurance strategies as necessary.

Patterns of communication and collaboration in assessment and longer term work

The capacity for 'thinking' of multi-agency groups (CP Conferences & Review groups, Core Groups and Team Around the Child TACs groups)

Of the various safety mechanisms that exist in children's services to try and minimise the impact of our cognitive frailties as human beings, many are integral to our processes for working together across agencies. Some, like Child Protection Conferences with their Independent Chairs, and Core Group meetings are intended to facilitate the incorporation of all relevant information and enable the discussion, debate and review of judgements and decisions. Others, like Child Protection Plans, are tools designed to encourage professionals to formulate and clarify the nature of the problems, the rationale behind plans to address them, to check on progress made and reassess the accuracy and adequacy of the plan accordingly.

In reviewing this particular case we have learnt that there were various challenges to the effective working of CP Conferences, CP Plans and Core groups. Some of these include:

- being clear about the reason and function of a Conference and subsequent Core Groups,
- keeping hold of the original reasons for involvement and avoiding becoming reactive only to presenting problems which may turn out to be red herrings
- ensuring Plans are sufficiently clear about the nature of the problems and explicit about the purpose of all actions, in order that the effectiveness and change can be evaluated at review meetings to see if they are making any difference
- challenging erroneous views of family members
- dealing with conflicting views between professionals, particularly when family members are present at meetings
- making time for 'thinking' (analysis)
- testing claims of parents about progress/change rather than relying only on self reporting

Discussions between the review team and case group suggest that beyond this particular case, weaknesses in the effective working of CP Conferences, CP Plans and Core groups could be minimised by developing multi-agency core groups' capacity for thinking.

This suggestion tallies with current arguments about safeguarding practice generally and social work in particular which hold that in service delivery and development attention needs to be focused on the 'intellectual skills' required to advance professional thinking about cases. See for example the British Journal of Social Work's Special issue on "Risk and Social Work: critical perspectives" http://bjsw.oxfordjournals.org/content/40/4.toc Volume 40 Issue 4 June 2010. It is argued that too much focus has been placed in recent times on organisational structures, written protocols and procedures and that instead what is needed now is to invest in this area of skill development as well as quality supervision to sustain it. Macdonald and Macdonald argue that:

> to make good judgments, social workers need certain intellectual skills, namely
> (i) an ability critically to appraise evidence – both research evidence and evidence in relation to individual children and their families;
> (ii) an ability to formulate hypotheses about children's circumstances in ways that enable receptivity to new evidence (particularly contrary evidence),
> (iii) an ability to set clear goals and indicators of change; and
> (iv) a knowledge of what interventions are most likely to impact positively on identified problems.
> ... Such skills do not guarantee "getting it right", but they improve the likelihood of getting it right, and – more importantly perhaps – the likelihood of realising if an error has been made or something is not working as intended (Macdonald and Macdonald 2010: 1184).

If safeguarding is indeed everyone's business, these should be required skills of workers from across all agencies not just social workers.

We focus here on the crucial role of the Chair in multi-agency meetings. In subsequent sections, we deal with the way in which these skills could be promoted through designing risk and challenge into processes and documentation (see human-tool interaction section), and through increasing workers' knowledge about types of relationships between professionals and families.

Recommendation 4. LSCB members should consider how the necessary intellectual skills can best be developed, supported and rewarded in the multi-agency workforce involved in safeguarding children.

The skills required to chair multi-agency meetings (CP Conferences & Reviews, Core Groups and Team Around the Child meetings)

The review of this particular case highlighted the powerful role of the Independent Chair in setting the tone and remit of the CP Plan and Core Group thinking, in an unhelpful way. This reminds us of the critical role of the Chair in multi-agency meetings and the particular skills that are required if the role is to be played successfully so as to facilitate effective work with families. These include;

- ensuring the participation of all members
- asking the right questions
- articulating risks and concerns
- actively encouraging the constant testing and revision of hypotheses and judgments

- critiquing mindsets, judgements and assumptions; going beyond story telling to probe, challenge and check the evidence, recognising cycles and trigger points, playing devil's advocate
- saying the unsayable; articulating and supporting the discussion of sensitive issues
- dealing with conflicting perspectives
- challenging inaccuracies, including on the part of family members
- ensuring plans are clearly formulated so that they can be evaluated
- ensuring the selection of interventions is appropriate and are clearly defined.

The relevance of these roles and associated skills are not restricted to Child Protection Conferences or Review meetings of CP Plans. The case group drew our attention to difficulties inherent in current chairing arrangements of Core Groups too. There was a strong feeling that the usual process of the social worker attempting to a) contribute, b) chair and c) note take is unrealistic and makes it particularly difficult to ensure independent challenge. The new role of Practice Managers in CYPD will soon assume that chairing role so it becomes important to ensure that they are appropriately skilled. Review team discussions also highlighted the relevance of these issues to the newly formed Team Around the Child meetings, which will in principle be Chaired by any professional.

Recommendation 5. The LSCB should draw up a plan to commission training for chairing of multi-agency meetings. This would cover Independent Reviewing Officers of CP Conferences and Reviews, as well as those likely to chair Core Groups and TAC meetings. It will require investigating what available models of Chairing exist and whether they are adequate or whether a bespoke programme would need to be developed. The Board should consider how to make this more than simply block training; how could this approach to quality chairing be promoted and rewarded, for example, as an accredited scheme, with on-going workshops and/or forums for chairs?

Timing of the first Core Group meeting and construction of the CP Plan

The standard procedure is that you have a Case Conference, which makes recommendations. The Core Group then meet to turn those recommendations into a CP Plan. This should happen within 10 days. Feedback from the case group suggests that this process is not conducive to good multi-agency working because:

a) There is often a problem with the minutes being delayed so you can end up having the first Core Group without notes or recommendations of the Conference.
b) There is also the problem that it is often impossible to reconvene all the relevant professionals within that 10 day window, and if they don't turn up to the first Core Group meeting, you tend to have lost them forever.

There was support for the idea of doing away with the gap and instead having some extra time at the end of the Conference for the Core Group to put the Plan together, rather than having to reconvene.

Recommendation 6: LSCB members should investigate whether other areas/LSCBs have tried to address the problem of the timing of the first Core Group meeting and development of the CP Plan, following a conference, and whether and why those efforts have been effective.

Knowledge of what interventions are most likely to impact positively on identified problems

We saw in this case that, as is common in many areas of the country, the tendency to assume that universal support services (here Sure Start) should be put on hold while a child protection investigation is conducted. So we discussed with the case group whether Sure Start Children's Centres are sufficiently integrated into multi-agency safeguarding work, what hinders and what would help. The result was a stark lack of clarity about what Sure Start does: where are they? What do they do? How do you access their services? There was a strong indication of a dramatic split experienced by staff between Sure Start and other agencies. Sure Start Children's Centres were commonly perceived as having become exclusive – for middleclass families, leaving others feeling excluded. The view was that even if Sure Start are working closely with families, they do not see it as a need or part of their role to take part in Core Groups. Beyond Sure Start, we also saw in this case, a lack of consideration of the use of agencies that provide direct interventions/services to families, suggesting a potential lack of knowledge of what is potentially available, let alone knowledge about any associated evidence for effectiveness.

Recommendation 7: LSCB members consider how best to make sure staff know about available services, including family support, Sure Start Centres and associated pathways e.g:

- convening a workshop led by Sure Start and FIPS, to which all other agencies send representatives
- creating an interactive high level map available through the Council website, such as is being developed for Drug and Alcohol teams.
- encouraging the newly formed District Boards to convene workshops to bring staff from different services together
- create a 1 page summary of available services that differentiates between, for example, different types of programmes linked to their evidence base of effectiveness (for whom, in what circumstances etc.)

Patterns of professional-family interactions

As stated in SCIE's *At a glance* No1:

> Professionals interact with families; they form relationships to gain information and to help the family change. These relationships can influence professionals' thinking, for good or ill. A poor relationship, for example, may lead to a worker missing key information, or compassion for a mother may distract a social worker from the misery being experienced by her child (Fish and Munro 2009: 3).

As a result, patterns of family–professional interaction need to be seen as patterns of systemic factors.

Maintaining respectful uncertainty in the context of neglect and in the face of parental trauma and loss

In the course of putting the story of this case together, the review team were struck from quite early on by the way that the mother was often represented as a victim. This surprised us given that she had received a neglect charge and sentence in relation to the death of her first child. Staff often spoke though of the 'unfortunate' death and of the 'tragic' occurrence, as if it had been an unavoidable accident so best kicked into the long grass and forgotten. This understanding was reinforced through discussions at the first follow-on

meeting which clarified that the agenda for the initial Child Protection Plan, set at the pre-birth Child Protection Conference, was quite unbalanced. It was more about putting the mother's mind at rest and supporting her, than on monitoring or managing risks to the child in light of the history, including testing the extent to which change/progress had occurred.

Again, this is not an issue unique to this particular case, or to the individuals involved in it. Maintaining what Lord Laming termed 'respectful uncertainty' toward parents, and other significant adults, is a difficulty inherent in safeguarding work. It is a common finding in cases of physical and emotional neglect, that the workers tend to feel compassion for the abuser and that this affected their willingness to describe their actions as abusive (Stevenson 1998). This is particularly so if there was no intention to cause harm on the part of the parent. The tendency is to fashion them as victims. What this case alerts us to is the particular difficulties involved when the issue of neglect is compounded by the death of the child concerned. The trauma and loss of this experience for the mother, in this case, seemed to shore up the view of her as a victim when she became pregnant again and disinclined professionals from articulating and addressing the reason for their involvement. This was exacerbated by the time that had passed since the first death. Had she become pregnant 6 months after the death of her first child and conviction for neglect, as opposed to three years later they would probably not have been so likely to 'forget' her implication in the initial death.

We noted in the tables of key practice episodes that in the culture of working openly with families, the need to be non-judgemental seems to have become mistakenly conflated with the need to make professional judgements. The review team has noted the current prevalence of staff feeling uncomfortable even to use the term 'concern' in relation to families. This change in cultural context can only exacerbate what is already a difficult task.

Recommendation 8. The LSCB members should consider how best to refresh staff knowledge, across agencies, about common, problematic patterns of professional-family interaction - see SCIE Report 19, Section 4.2.5, Page 63 - and open up discussion about professional responsibilities to identify and talk about risks and concerns.

Patterns of human-tool operation

Designing risk & challenge into documentation and processes

Input from discussions suggests, as is common in other areas, that staff do not feel that the Framework for the Assessment of Need and accompanying documentation for assessments, sufficiently encourages them to think about and document 'risk'. Case group members suggested that it would be useful to find some way that both 'risk' and challenge could be built into the agendas and forms of CP Conferences and Core Group and Review meetings. They suggested check lists or prompts about what it is essential to be clear about e.g. Why are we all here? Spell out the risks? Have they changed? What is the evidence for that? What does that evidence actually look like? What is the balance of factors?

Recommendation: LSCB members should consider ways in which 'risk' and challenge can be designed into the CP Conference, CP Plan and Core Group meeting processes through the accompanying documentation (agendas and forms). These might include

questions as prompts to spell out what professionals need to be clear about and how specific they need to be.

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