Ten pitfalls and how to avoid them

What research tells us

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NSPCC

Cruelty to children must stop. FULL STOP.

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Acknowledgements

Setting the scene

This booklet aims to provide practitioners with a concise and accessible summary of research relevant to the initial stages of assessment in children's services. It has been written primarily for local authority practitioners undertaking statutory initial assessments and making Section 47 (Part V, S47 of the Children Act 1989 [Protection of Children]) enquiries, but the material has far broader relevance.

Given the range of practitioners involved in making early assessments of children's needs under the Common Assessment Framework (CAF), this booklet will appeal to professionals in health, welfare, education and criminal justice services. For all practitioners tasked to make robust, evidence-based judgements in child welfare that pay due regard to needs and risks, *Ten pitfalls and how to avoid them* offers invaluable advice.

It revises and updates the work of Hedy Cleaver, Corinne Wattam, Pat Cawson and Rosemary Gordon. This team of authors produced the original version of *Ten pitfalls and how to avoid them* as part of *Assessing Risk in Child Protection*, an NSPCC Policy Practice Research Series report published in 1998. Since the publication of the original booklet, there have been significant changes to processes of referral and response in local authority children's services that have necessitated this revision.

The original booklet pre-dated the introduction of the *Framework for the Assessment of Children in Need and their Families* (Department of Health [DH]*, 2000). It drew heavily on research published in 1995 by the Department of Health that highlighted problems with the child protection orientation of much social work with children and families. The child protection "net" was perceived to be catching too many families, who were then subject to intrusive and inappropriate intervention, with local authorities providing little by way of effective family support.

This updated booklet is now written in a very different context, where substantial steps have been taken to enact a family support ethos. However, problems of effective filtering and assessment at the "front door" remain. Deciding what level of support/safeguarding response is required remains a vexing problem in child welfare, and decisions are often taken in challenging circumstances and with limited information.

Working under the *Framework for the Assessment of Children in Need and their Families*, practitioners who now offer a first response in local authority children's services are required in the first instance to deal with all referrals of children through initial assessment procedures. Only when it is suspected that a child is suffering, or likely to suffer, significant harm are enquiries made under Section 47 (Department of Health [DH], 2000). However, processes brought forth under the framework, while reducing the tendency for precipitous over-intervention, have not addressed the core problem of how to filter initial contacts and referrals effectively.

Family life is dynamic and changing; during the course of initial decisions, new information may come to light requiring practitioners to reassign cases. It is critical that practitioners are aware of this possibility and are prepared to change courses of action. Problems of differentiation are compounded by the sheer volume of referrals that arrive at the front door of the local authority. Initial assessment teams have always operated on the basis of filtering out far more work than they take in, but decisions to signpost families to other services must be grounded on a robust assessment of the case (Wattam, 1997; Platt, 2006; Sheppard, 2009; Broadhurst et al, 2009).

More recently, new measures have been introduced to attempt to reduce demand at the front door, while shoring up safety and efficiency. These new measures are the Common Assessment Framework (CAF) and the Integrated Children's System (ICS). There is currently insufficient evidence to definitively conclude that the CAF has either reduced the volume of referrals to local authorities or has provided key agencies with a more effective referral tool (Peckover et al, 2008; Pithouse and Broadhurst, 2009; Gilligan and Manby, 2007).

The ICS is by far the most ambitious attempt to micro-manage and standardise social work practices (Wastell et al, 2010). However, evidence suggests that practices may be more prone to error under this apparatus. The increased recording requirements introduced with the ICS, together with templates and timescales that can be ill-suited to the task, can provide latent conditions for error by encouraging premature categorisations and precipitous case closures (Broadhurst et al, 2009).

So what then the solution? *Ten pitfalls and how to avoid them* is part of a literature that offers an alternative. Notwithstanding the utility of minimal procedures, here we concur with the architects of this original booklet, who underscored the importance of critical thinking and reflexive awareness of "error traps" in day-to-day practice. Attempts to minimise error through standardisation and micro-management cannot substitute for informed professional judgement (Munro, 2005b; 2008).

As one of the original team of authors presciently observed: "…'significant harm' cannot be decided otherwise than on a case-by-case basis" (Wattam, 1997). Further to concurring with Wattam, we also argue that practitioners are generally adept at identifying risks and do so on a daily basis.

Nevertheless, practitioners should strive for optimum decision making, being aware of the individual causes of human error. Child welfare practitioners are not alone in making errors of judgement and information processing. Cognitive psychologists, primarily studying doctors' decision processes, have identified common deficits in human information processing (Wolf et al, 1985; Kahneman et al, 1982; Dowie and Elstein, 1988).

Moreover, alongside these individual tendencies we must also attend to those created by the system; so-called "systemic" errors, such as the organisational climate, resource constraints, or the design and limitations of the tools at practitioners' disposal (Glisson and Hemmelgarn, 1998; Munro, 2005a; Bostock et al, 2005; Fish et al, 2008; Fish, 2009; Broadhurst et al, 2009). It is in this spirit that we offer the revised version of *Ten pitfalls and how to avoid them*.

Risk must be managed on each and every occasion through careful consideration of both case-specific and research evidence. This revised booklet offers practitioners an accessible guide to research evidence to support the second half of this equation. Research-informed practice provides a useful counter balance to intuitive or gut reasoning. The guidance will be very useful for newly qualified practitioners, but will also serve as an aide-mémoire for the more experienced.

The revised version of *Working Together to Safeguard Children: A guide to inter-agency working* (Department for Children, Schools and Families [DCSF], 2010) requires that initial assessment is undertaken by qualified and experienced social work practitioners. This is an important step forward in improving quality; however, even the most qualified practitioners will benefit from a reflexive awareness of both individual and systemic error traps.

Writing in the context of very significant socio-technical changes in children's services, this revised version offers an updated bibliography of key material to inform practice. The modernisation agenda has significantly reconfigured the "front door" and this has given rise to a new set of literature that demonstrates a far greater awareness of the systemic or organisational context in which human errors occur.

Presentation of the research is necessarily selective and follows an up-to-date review of the literature by the new team of authors. Comprising a team of academics, research analysts, and expert practitioners and managers, the team is well placed to offer a consensus-based summary of the most relevant material. Following the format devised by the original author team, key research messages are summarised for each pitfall, followed by a list of critical questions for the reader.

The questions that we include in this revised booklet are designed to prompt critical thinking about current systems and practices. However, a number of our questions reflect those asked by the original author team, indicating the continued persistence of certain error traps despite very significant policy and legislative changes.

Children living at home: the initial assessment process

Ten pitfalls and how to avoid them

What research tells us

1. An initial hypothesis is formulated on the basis of incomplete information, and is assessed and accepted too quickly. Practitioners become committed to this hypothesis and do not seek out information that may disconfirm or refute it.

2. Information taken at the first enquiry is not adequately recorded, facts are not checked and there is a failure to feedback the outcome to the referrer.

3. Attention is focused on the most visible or pressing problems; case history and less "obvious" details are insufficiently explored.

4. Insufficient weight is given to information from family, friends and neighbours.

5. Insufficient attention is paid to what children say, how they look and how they behave.

6. There is insufficient full engagement with parents (mothers/fathers/other family carers) to assess risk.

7. Initial decisions that are overly focused on age categories of children can result in older children being left in situations of unacceptable risk.

8. There is insufficient support/supervision to enable practitioners to work effectively with service users who are uncooperative, ambivalent, confrontational, avoidant or aggressive.

9. Throughout the initial assessment process, professionals do not clearly check that others have understood their communication. There is an assumption that information shared is information understood.

10. Case responsibility is diluted in the context of multi-agency working, impacting both on referrals and response. The local authority may inappropriately signpost families to other agencies, with no follow up.

Pitfall 1

An initial hypothesis is formulated on the basis of incomplete information, and is assessed and accepted too quickly. Practitioners become committed to this hypothesis and do not seek out information that may disconfirm or refute it.

Processes of initial assessment are subject to tight timescales. Within 24 hours, an initial decision must be made about what action will be taken in response to contacts and referrals. Within 10 days, an initial assessment must be complete (Department for Children, Schools and Families [DCSF], 2010).

While swift intervention is important where problems of need or harm are reported, it is equally important to avoid hasty judgements that can "stick" with respect to future decisions and actions. A substantial body of research evidence has clearly identified the tendency for "early evidence bias" in human decision making – that is, a first summing up of a situation strongly influences the analysis of subsequent or new information (Munro, 1999; Gambrill, 2005; Burton, 2009). Given the need to record judgements at an early point, there is a very real danger that practitioners who are not mindful of this potential bias in human reasoning will simply search for evidence that confirms a first hypothesis.

Professionals must keep their judgements under critical review (Munro, 2008; Fish et al, 2008) and be able to acknowledge where initial decisions are mistaken. The tragic case of Victoria Climbié is a clear example of the potentially disastrous impact of early "mislabelling". Wrongly categorised as a "child in need", subsequent information concerning Victoria was considered in this light and, consequently, agencies failed to take protective action (Laming, 2003).

The cases that are most likely to catch the attention of the frontline practitioner are those that present the clearest evidence of harm. Research on biases in human reasoning finds that recall is stronger for very vivid or emotive material, such as visible injuries to children (Dowie and Elstein, 1988). Clearly, it is important to give priority to serious injuries; however, the practitioner must remain sensitive to less obvious signs and symptoms of harm to children and young people (Rose and Barnes, 2008; Daniel et al, 2009; Brandon et al, 2009).

The problem of early decisions that "stick" is rather compounded by current arrangements for initial assessment. Tight timescales can necessitate the making of judgements on the basis of incomplete information and provide practitioners with little space for reflecting on, or probing uncertainty.

In particular, research suggests that hard-pressed initial assessment teams may be rather too quick to filter out referrals, such as those requiring no further action or signposting to other agencies. This is particularly so where referral information does not readily indicate significant harm to a child (Broadhurst et al, 2009).

In such cases, there is often limited scope for follow-up and, as a number of serious case reviews have clearly illustrated, hasty categorisations can be very consequential regarding harm to children (see London Borough of Redbridge Local Safeguarding Children Board, 2008). Harm to children, not readily manifest when presented alongside requests for housing assistance, etc, is easily missed where assessment is essentially rushed and incomplete (Brandon et al, 2008). A review of serious cases of child abuse by Dale et al (2002) found that premature categorisation and misdiagnosis significantly contributed to failures on the part of agencies.

It is important that practitioners record their uncertainties and are open to both confirming and disconfirming information (White, 2009). Indeed, it is essential that they learn to practise the art of playing devil's advocate to their own formulations and indeed those of their colleagues. Initial assessment must be supported through avenues for case discussion that provide appropriate challenge and probe the evidence upon which judgements are made.

Frameworks that stimulate critical thinking, such as that proposed by Benbenishty et al (2003), are of particular value in facilitating the type of reflexive thinking that enables robust analysis of case evidence. Regular use of such frameworks in supervision will likely foster the kind of critical reflection that will improve practitioners' analytic skills.

Questions for practitioners:

Am I remaining curious and inquisitive about what I am seeing and assessing?

Am I open to new information?

How confident am I that I have sufficient information upon which to base my judgements?

Do I need to add a "health warning" about the strength of evidence contained in this assessment and the implications for decision making?

Would I be prepared to change my mind about this case?

What aspects of supervision are getting prioritised at the moment? Is sufficient time being allowed for critical reflection and evaluation of my judgements and decision making?

Questions for managers:

When was the last time I initiated the critical review of how a case was being understood, as opposed to responding only to cases that practitioners bring to me in supervision?

Am I confident that I promote a culture of openness and exchange in relation to practitioners' anxieties and uncertainties?

Am I able to prioritise the needs of children over and above performance targets where necessary?

What are the unintended incentives of the systems and culture within my team?

Do the subheadings, boxes and instructions in the assessment forms used encourage practitioners to record unease and gaps in understanding, or do they inadvertently encourage only factual statements and assertions?

To what extent does a shared culture exist in which it is acceptable and even desirable for professionals to query each other's assessments?

Do I enable practitioners to think through what they find and whether it makes sense?

Pitfall 2

Information taken at the first enquiry is not adequately recorded, facts are not checked and there is a failure to feedback the outcome to the referrer.

Despite successive reconfigurations of first point of contact, it is clear that errors continue to plague initial interactions between referrer and recipient. The centralisation of first contacts through permutations of customer care/call centres may, in fact, have exacerbated this problem (Broadhurst et al, 2009). Research suggests that the more layers or intermediaries that comprise the referral and receiving system, the more likely are errors of communication and/or information loss (Fish et al, 2008).

As information passes from one part of the system to the next, it is frequently translated into another format, such as spoken voice into written word (Reder and Duncan, 2003; White, 2009). Where information exchange is not face-to-face (ie takes place via fax, telephone, email or post), vital non-verbal and visual cues that are critical in facilitating mutual understanding are missing (Laming, 2003).

In addition, information received in this way provides little opportunity for the immediate checking of mutual understanding between referrer and receiver. It is vital that practitioners are mindful of possible weaknesses within referral systems, and that they work to counter such limitations and persist in feeding back problems they encounter to their managers (Bostock et al, 2005).

The analysis of mistakes made in the tragic case of Victoria Climbié highlighted key weakness in the way in which referrals were taken by social services (Laming, 2003). Although there is only a limited evidence base concerning effective referral management, Reder and Duncan's (2003) analysis of communication in child protection networks offers a number of practical recommendations. When receiving a telephone contact or referral, it is important that at first enquiry, those receiving referrals make sure that they and the referrer have correctly understood each other.

In addition, the referrer's information should be probed to distinguish between observations and opinions, and these should be recorded accordingly. Where verbal information is unclear, further detail should be requested. Before ending a telephone conversation with a referrer, practitioners should ensure that they read back their notes to the referrer to check for mutual understanding and accuracy, that action points are agreed and that an avenue for feeding back to the referrer is ascertained (see Reder and Duncan, 2003, for a fuller discussion).

Organisational pressures can impact significantly on effective first response, particularly where referral rates are very high (Bostock et al, 2005). Where workload pressures or other priorities make the satisfactory completion of this task difficult, these should be fed back to managers. In anticipation of information being passed on to the next point in the system, it is critical that those taking the initial contact or referral diligently attend to the legibility and accuracy of their recording. Where issues are uncertain, this should be highlighted, indicating the need for further exploration by those tasked with the initial assessment (Bostock et al, 2005; Fish, 2009).

Where information is received in written form, the same principles apply, although there is arguably an even greater imperative to avoid working with incomplete information. Where mistakes are made in the electronic recording of information, practitioners must always remedy such errors, even where difficulties of requesting such changes can act as a disincentive (Broadhurst et al, 2009). Any difficulties or disincentives should be fed back to managers and IT departments. Analysis of serious case reviews clearly suggests that outcomes must be fed back to referrers, and in cases of no further action, universal services need to be notified so that they can remain vigilant to further concerns (Brandon et al, 2008).

The above points apply regardless of whether the referrer is a professional, child or parent. In all cases, it is advisable that the receiving agency always aims to achieve optimum understanding of the case at this first point, so as to minimise problems of misdiagnosis that can then be hugely consequential (Laming, 2003; Bostock et al, 2005; Brandon et al, 2008).

Agencies should be cognisant of the latent conditions for error that call centres create and be prepared to monitor and review whether the trade-off is justifiable in terms of errors made against costs saved (Fish, 2009; Broadhurst et al, 2009). First points of contact should be staffed by practitioners with appropriate local and child welfare/protection knowledge, qualifications and experience (Department for Children, Schools and Families [DCSF], 2010).

Where face-to-face contact demands particular expertise, such as interpreters, this should be provided. Practitioners are advised to be mindful of the social context of their work – the impact of self, having a "bad day", practitioner relationships and so forth (Cooper et al, 2003; Reder and Duncan, 2004; Brandon et al, 2008).

Miscommunication can occur where agencies use specialist/technical language. It is important that opportunities are available for agencies to develop shared understanding (Moran et al, 2007) and for case-holding social work practitioners to engage in ongoing education/training so that they are able to expand post-qualifying requisite specialist knowledge.

Questions for practitioners:

Did you play back your recording of the referral to the referrer and check for accuracy, as well as agreeing actions and method for feedback?

Did you actively question the referrer to ensure you got as much information as possible and fleshed out anything that was unclear or incomplete?

Have you checked that you have extracted the most important details from all of the details provided?

If you did not check your notes against information from the referrer at the point of referral, what steps have you taken to do this subsequently?

Questions for managers:

Is the "front-door" organised to ensure optimum conditions for the receiving and recording of information? Consider location of the fax machine, space to "hear" calls and/or opportunities for face-to-face communication.

Have I ensured the quality and effectiveness of business support?

Have I spent time with the referral team recently, used the systems I expect my staff to use and watched them using them?

Am I confident in the skill and expertise of practitioners handling initial contacts/referrals?

Do I know the error rate and is it one I can defend? Have I stimulated discussion about how errors might be meaningfully and constructively monitored within the team?

Have I considered rotating staff taking referrals to prevent unhelpful habitual practices bedding-in and to prevent boredom?

Pitfall 3

Attention is focused on the most visible or pressing problems; case history and less "obvious" details are insufficiently explored.

Research suggests that assessment can be rather too focused on the content of the referral – the immediate issue – while failing to consider a case history. Incidents need to be considered in context; concerns need to be connected in order to build up a fuller picture of a child's life (Munro, 1999; Hollows, 2003). It is absolutely vital that a careful sifting of case history be integral to assessment and that time must be made available for this essential analysis. The problems of making decisions on the basis of incomplete information are well documented (DePanfilis and Girvin, 2005).

Case chronologies or cumulative summary sheets, accessible at the front of electronic files, will greatly aid case analysis, and will encourage practitioners to contextualise presenting issues in a broader child and family history. Best use of, or adaptation of, IT systems to support optimum decision making should be a priority within agencies (Ayre, 1998; Wastell et al, 2010). Relaxation of Integrated Children's System (ICS) compliance requirements enables local authorities to review their assessment forms. This ensures that practitioners spend sufficient time on gathering and analysing information, rather than excessive inputting to electronic fields that may be unhelpful (Peckover et al, 2008).

Effective communication requires an openness to detail, a willingness to engage with referrers and an avoidance of hasty categorisation. The facts are rarely out there simply to be passed on; rather, a case formulation emerges through discussion and interaction. It is critical that highly skilled professionals who adopt the mindset of the curious social researcher deal with cases at an early point (White, 2009). Both inappropriate gate-keeping and unhelpful or overly prescriptive recording formats will serve to block curiosity and openness to the detail of incoming information.

Questions for practitioners:

What is the most striking feature of this situation and if it were removed, would there still be concerns?

Have I considered the presenting issue in context?

Have I carefully examined a case history or have I been tempted to ignore it?

Questions for managers:

Is the development of the electronic recording system practitioner led?

Within the case work of my team, are we good at pulling out and recording significant life incidents in the families we work with? Does this inform and refresh the analysis of the family functioning?

Do I encourage the production and use of cumulative case summaries?

Do I feed back/input to those in charge of IT developments, regarding best organisation of electronic case files?

Am I an expert user of our social care IT systems? How can I improve my knowledge?

Does my department provide sufficient training and guidance to underpin the electronic recording system?

Pitfall 4

Insufficient weight is given to information from family, friends and neighbours.

There can be a tendency to prioritise contacts and referrals from professionals, lending insufficient weight to information from family, friends and neighbours in the early stage of both referral and assessment. Research has identified that busy initial assessment teams can treat information from family, friends and neighbours as "malicious" (Broadhurst et al, 2009; Buckley, 1999), particularly where a motive for the contact/referral, such as an ongoing feud, is evident (Wattam, 1992).

However, as a number of serious case reviews have highlighted, and indeed the case of Victoria Climbié exemplified, observations and information from family, friends and neighbours may provide vital insights into the workings of families (Laming, 2003). Evidence suggests that even when a referral is maliciously motivated, it may still carry substance.

In addition, family members may make tentative referrals or report minor issues, when actually, more serious issues are occurring (Cicchinelli, 1991). It is important that equal weight is given to contacts and referrals from family, friends and neighbours, and that anonymous calls are taken seriously. They may provide vital information and should be followed up.

In cases of problematic family dynamics, or where parents are fighting over care of a child (residence, contact disputes, etc), practitioners must avoid the temptation to see information in light of such disputes (Wattam, 1992; Buckley, 1999). It is important to keep an open and enquiring mind.

Questions for practitioners:

Would I react differently if these reports had come from a different source?

How can I check whether or not they have substance?

Even if they are not accurate, could they be a sign that the family are in need of some help or support?

Questions for managers:

Am I confident that practitioners are treating referrals from diverse sources with equal priority?

Does my own behaviour in the prioritisation of referrals encourage particular biases?

Does my team provide a systematic response to anonymous referrers who may not be available for call back, such as fast tracking to a duty social worker?

Pitfall 5

Insufficient attention is paid to what children say, how they look and how they behave.

Despite very significant emphasis on "seeing the child" in initial assessment, a volume of serious case reviews and public inquiries have clearly evidenced practitioner failings in this respect (Ayre, 1998; Rose and Barnes, 2008; Brandon et al, 2008; Brandon et al, 2009).

In 1998, Ayre noted a lack of child observational data in practitioners' records and reports – a finding that has been reiterated in more recent work (Rose and Barnes, 2008). Aldgate et al (2006) noted how, for a number of reasons, children can be difficult to see, while recent research has shown that practitioners tend to see children in relation to their attachments and development, rather than attending to them as individuals (Thomas, 2010). This can cause practitioners to miss vital clues about wellbeing and safety, particularly in borderline cases.

Practitioners may lack communication skills or may feel awkward in asking to see children alone. However, it is imperative when making initial assessments that practitioners take time to see, speak to and observe children (Glaser, 2009). In order that they can be appropriately supported, staff need to be encouraged to inform their managers if they find themselves in situations where they do not feel confident in seeing and speaking to children.

As in the case of baby Peter Connelly, a small percentage of parents who severely and/or frequently abuse their children adopt a range of often plausible strategies to prevent the practitioner from seeing the child (Haringey Local Safeguarding Children Board, 2009; Munro, 2005b; Ferguson, 2009). Parents may take steps to conceal injuries. Practitioners must, therefore, be vigilant to this possibility and ensure that they recognise parental resistance to seeing the child. Practitioners should return to the family home, or seek permission to see a child in another venue, such as the child's school. Where parents obstruct access, practitioners may need to make use of the provisions within the Children Act 1989, such as the Child Assessment Order, or police powers. Where staff feel that competing organisational priorities prevent them seeing children, they should alert their managers.

Moreover, seeing the child in the early stages of work must equate to more than just "ticking a box" and should constitute a detailed qualitative observation (Aldgate et al, 2006). Hart and Powell (2006) stated that a case file should give "a real sense of the day-to-day experiences" of the child. The practitioner should be able to picture what life is like for particular children in their families.

The importance of seeing children physically moving, eg crawling or walking, has been recently discussed by Ferguson (2009), drawing attention to failings in the cases of Jasmine Beckford and repeated in the case of baby Peter Connelly.

Certain groups of children are particularly vulnerable; notably babies and young children, who are not able to speak out or seek help, children with physical or learning disabilities, and deaf children. These children are especially at risk when they are unable to communicate easily what is happening to them (or steps are not taken to facilitate communication) and are dependent on others for intimate care. When making an assessment of the needs of disabled children, including children who are deaf, it is critical that practitioners seek ways of communicating effectively with children and seek information from all possible sources.

Other relevant practitioners, including specialist teachers of disabled children, can be particularly well placed to offer information about a child's wellbeing or any deterioration in mood and behaviour (Morris, 2003). When families of a disabled child request help from services, studies suggest that practitioners can readily respond to the request for help, accepting the parent/carer's description of the presenting problem. Notwithstanding the importance of meeting parents/carers' support needs, assessment should be holistic – to include sensitive analysis of risk factors – and should elicit views of the disabled child (Morris, 2003; Ofsted, 2009). Practitioners should seek specialist expertise where, for example, they lack knowledge of deaf culture and the necessary communication skills needed (Young et al, 2008).

As a serious case review in Birmingham (Barnett, 2006) indicated, there are also problems of seeing older children. The phenomenon of agency neglect of adolescents is now well documented (Hicks and Stein, 2010), with the needs of young people aged 11–17 easily overlooked by services. This is evidenced by the relatively lower number of older children subject to child protection plans. Yet very recent research has found that young people who have experienced troubled childhoods can experience an escalation of difficulties in adolescence due to increased propensity for risk-taking/acting out behaviour at this age (Rees et al, 2010).

At initial assessment, it is important that relevant expert assessment is sought where appropriate and any uneasiness about a child's health, injury or other aspect of presentation is sensitively but appropriately probed. Specialist input at an early stage can make a significant contribution to the quality of the assessment and linked plan of intervention. It is also critical to ensure effective assessment of children where there are issues of language or assisted communication, drawing on appropriate expertise.

If staff experience that they are impeded from accessing expert assessments because funding is generally only available at the point of court proceedings, they must flag this problem with their managers. If, instead, staff simply stop requesting them, the danger is that the degree of unmet need remains hidden from senior management and not, therefore, addressed (Fish et al, 2008).

Questions for practitioners:

Have I been given appropriate access to all the children in the family?

If parents are cooperative, what type of cooperation was it? Was it, for example, ambivalent/hostile/confrontational?

What is the child's account of his/her situation and needs?

Have I taken full account of the child's additional communication needs; for example, in the case of children who are deaf or disabled? Have I sought appropriate specialist expertise to facilitate communication?

If the child uses a language other than English, or a method of alternative non-verbal communication, have I made every effort to enlist help in understanding him/her?

Did the interview with the child appear coached? What is the evidence to support or refute the child/young person's account?

If I have not been able to see a child, is there a very good reason, and have I made arrangements to see him/her as soon as possible?

How should I follow up any uneasiness about the child(ren)'s health or wellbeing?

What do I know about this child? Do I know what they enjoy, like, dislike etc?

How is the child moving, eg when crawling or walking?

Have I consulted other relevant/specialist practitioners who have contact with the child, to draw on his/her observations of any significant changes in the child's wellbeing or behaviour?

Would I draw this conclusion or make this decision if the child were not disabled?

Would I have taken any further protective action if this were not disabled?

Questions for managers:

Can I get a sense from practitioners' verbal accounts and documents of how this child is living?

Am I sure that the social worker has actioned appropriate expert assessment – particularly in the case of children who are disabled or deaf?

Am I encouraging staff to improve their skills and confidence in seeing and speaking to children and young people with different needs and abilities?

Am I making sure that there are clear organisational messages about the priority of seeing and speaking to children and young people?

Have I asked staff if the balancing of competing demands and priorities currently feels manageable or whether they trade-off seeing and speaking to children in order to meet other priorities?

Does my department provide sufficient focus on observations and interaction with the child within the electronic record of the case?

Pitfall 6

There is insufficient full engagement with parents (mothers/fathers/ other family carers) to assess risk.

Engaging effectively with parents to assess risk can be particularly challenging. Nevertheless, it is a critical part of the work of ensuring the safety and wellbeing of children. Parents can often feel very upset and intimidated when their children become subject to referral to the local authority, particularly where they are unaware of, or not in agreement with, the referral (Farmer and Owen, 1995; Thoburn, 2009; Broadhurst and Holt, 2009).

Parents will bring past experiences of social work intervention to current encounters. However, the way parents respond to concerns or allegations should not be taken as an indication of how they respond to their children. In order to cope, parents may use a number of strategies, including blocking communication, pleading ignorance or trivialising the significance of an action (Brandon et al, 2008).

It is important to take into account the diversity of family life and households, and to ensure appropriate assessment of other family carers, partners and friends. Too often, assessment is overly focused on mothers, leaving fathers and other members of households out of analysis (Featherstone et al, 2007; Haringey Local Safeguarding Children Board, 2009). Of equal importance is gaining as full a picture of household composition as possible, particularly in relation to any adults in the household whose history suggests a risk to children. This includes a propensity to violence or sexual abuse.

Effective home visiting is critical to initial assessment. Performing the home visit requires that the social worker adopt the perspective of qualitative researcher, paying attention to the detail of family/household dynamics, being sure to observe children in the presence of their parents and other adults in the household, as well as on their own (Ferguson, 2009; Fauth et al, 2010). Practitioners should not assume that parents who appear guilty or evasive are guilty of harm to or neglect of children; parents may have reasons for avoiding scrutiny by the authorities that are not related to the care of their child (Hart and Powell, 2006).

Equally, however, it is important to avoid being persuaded by parents who appear particularly willing or cooperative. Public Inquiry reports into child deaths or injuries show that parents who appeared cooperative sometimes did so as part of a strategy to deceive and disarm social workers (Brandon et al, 2008).

The recent case of baby Peter Connelly indicates the lengths to which parents will go to cover up maltreatment (Haringey Local Safeguarding Children Board, 2009). Practitioners must seek clear evidence to support their assessment of parenting capacity/potential for maltreatment.

Budd (2005) advises practitioners to be clear about what is being assessed at initial assessment in relation to parenting capacity. Social workers should have the opportunity to interact with parents and observe their interactions with children (Quinton, 2004). Systemic barriers to this interaction should be raised with senior managers. Direct observation of the parent-child relationship must be a part of assessment, rather than simply parents accounts of their capacity to parent (Fauth et al, 2010).

It is important to interrogate how feelings and relationships with parents influence assessment and decisions (Broadhurst et al, 2010; Ferguson, 2009). Reder and Duncan (2003) discussed the way that relationships between practitioners and families could become increasingly subjective as practitioners were drawn into a variety of dynamics. They argued that practitioners should be mindful of any alliances into which they were drawn or into any over-identification with particular family members.

Equally, Ayre (1998) identified problems when professionals become simply acclimatised to poor parenting. In this context, a change of practitioner or a second opinion (to include those of other relevant professionals) is important. It is also important to be mindful of overly optimistic assumptions about family members, but equally to avoid overly precipitous intervention.

Open and honest communication with parents in initial assessment provides a good starting point for further partnership work (Bell, 1999; Quinton, 2004; Broadhurst and Holt, 2009). Research suggests that more effective work with parents is achieved when practitioners are honest with parents but equally convey an understanding of the emotional impact of their enquiries (Dale et al, 2002; Peckover, 2003; Cooper et al, 2003; Budd, 2005; Fauth et al, 2010).

Co-working with non-statutory agencies that have achieved engagement with "hard to reach" families may facilitate cooperation (Morris et al, 2008). Where professional engagement appears to fail, this can often centre on parents feeling that they have been given inadequate or inconsistent information, with little opportunity for independent advocacy. In such circumstances, parents can feel powerless and experience the child protection system as arbitrary and opaque (Dale et al, 2005).

Research has shown that the gender of parents can lead practitioners to make assumptions about culpability (Scourfield, 2003; Featherstone, 2006). The case of baby Peter Connelly, for example, illustrates how uncomfortable and unfamiliar we are culturally with the idea that mothers may be perpetrators of or accomplices to systematic physical abuse (Haringey Local Safeguarding Children

Board, 2009). Stevenson (2007), meanwhile, noted that practitioners could feel compassion for the abuser, to the detriment of being able to more clearly describe their actions as abusive.

In addition to the much documented dangers of cultural relativism (Beal et al, 1985), particular issues can also arise when working across cultural differences (Fontes, 2005; Chand and Thoburn, 2005). When families react in ways that seem inappropriate to the social worker, this may be because of an experience of racism or because of their expectations of professionals, given their own life experiences. Consultation with a specialist can help to set unfamiliar behaviours in their context (Chand and Thoburn, 2005).

Questions for practitioners:

Do I have the confidence to challenge parents appropriately, and be honest and open about my concerns while acknowledging strengths?

What is my relationship with the parent(s) and how does this influence my assessment?

Have I spoken with, and listened properly to, those who know the parents better than I do?

Am I open to being deceived (seduced/intimidated/threatened)?

Have I unpicked and understood the difference between perceived and actual risk? If not, how can I get support with this case?

Do I know who lives in/frequents this house and have I assessed their relationship to the child/potential risk?

Have I taken steps to get to know other significant adults/absent parents who have a bearing on the child's life?

Questions for managers:

Is time available for effective interaction with parents?

Do I encourage practitioners to engage with parents in order to promote effective practice?

Do I check out practitioners' feelings and perceptions of parents in supervision?

Are members of my team doing unannounced visits as a regular part of practice?

Is it safe for practitioners to acknowledge their inability to challenge parents?

Do I probe practitioners about household composition and encourage practitioners to think broadly about a child's network?

Pitfall 7

Initial decisions that are overly focused on age categories of children can result in older children being left in situations of unacceptable risk.

There is a tendency within children's services to consider risk in relation to age categories – younger children are seen as more vulnerable and thus are prioritised. Notwithstanding the vulnerability of infants and young children, practitioners need to be aware of this bias and be mindful that older children are not necessarily resilient to risks.

Evidence from analyses of serious case reviews has drawn attention to serious harm experienced by older children, as well as a heightened risk of suicide. For example, Brandon et al (2008) found a significant percentage of serious case reviews centred on young people aged over 15 years. Research has also documented substantial incidence of neglect among the adolescent population, associated with a range of negative outcomes (Stein et al, 2009).

Recent research suggests that agencies do not always respond appropriately to neglect in adolescents (Hicks and Stein, 2010). Older children are less likely to become the subject of child protection plans, although neglect issues may be very significant (Rees et al, 2010). Young people who are "hard to help" are particularly vulnerable, as services can be inappropriately scaled down in the face of a resistant young person (Brandon et al, 2008; Barnett, 2006). Where there is a long history of involvement with services, agencies can become desensitised and can inappropriately withdraw help.

Older children presenting to agencies can be experienced as more demanding than younger children, wanting clear assurances of confidentiality and control over the help-seeking process (Stanley, 2007; Barnett, 2006). Research stresses the importance of sensitive initial engagement with young people that raises awareness about the range of available services. This approach offers the young person some choice and control over help-seeking options. Where risks are identified, a consistent response through an allocated practitioner, proactive in seeking out contact with the young person, is important (Chamberlain and Smith, 2003; Thoburn, 2009).

Models of assertive help/outreach are not easily offered by the local authority at initial assessment. However, the local authority may be able to ensure at an early point that the young person is referred to specialist community-based adolescent services (Biehal, 2005). This requires more than simply signposting on the part of the local authority; rather, the local authority should facilitate engagement and follow up the process of case transfer.

At an early point, it is critical to pick up the clear signs of a young person's heightened vulnerability. This vulnerability can include, for example: self harm; a history of going missing/or currently a "runaway"; poor social networks; unaccompanied asylum seekers; long history of social services involvement (Brandon et al, 2008; Barnardo's, 2009). These indicators are also associated with increased vulnerability to commercial sexual exploitation (Barnardo's, 2009). Any transition of cases from children to adult services should be proactively managed (Stein et al, 2009).

Research has highlighted the need for age-specific approaches to child maltreatment, and the importance of acknowledging the different maltreatment experiences and needs of young people (Butler and Williamson, 1994). Recent work by Hicks and Stein (2010) has drawn attention to the importance of agencies working closely to achieve agreed understandings and referral processes regarding adolescent neglect.

Questions for practitioners:

Have I made a robust assessment of the support that this young person has in his/her formal/ informal networks?

Am I overly optimistic about this young person's resilience to presenting risks?

Would I treat this young person differently if he/she were a much younger child, and is that appropriate?

Have I probed this young person's history/presentation regarding risk factors, including going missing, self-harm, suicidal ideation and signs of child sexual exploitation?

Questions for managers:

Do I have clear criteria to identify and assess adolescent neglect?

Are local agencies working together effectively to detect adolescent neglect?

Am I using the child's age as an ad hoc rationing criterion?

How confident am I that the signposting of adolescents to other services is effective?

What gaps exist in services for neglected adolescents and how might these be addressed?

Are the services to prevent children becoming looked after sufficiently targeted at young people? Are staff required to keep teenagers out of the looked after system at all cost?

Pitfall 8

There is insufficient support/supervision to enable practitioners to work effectively with service users who are uncooperative, ambivalent, confrontational, avoidant or aggressive.

Practitioners' fear of violent men remains an important theme in many inquiry reports/serious case reviews (Brandon et al, 2008; 2009). When a child's father or carer is known to be hostile or has a record of violence, professionals can often be intimidated into not pursuing enquiries (Humphreys, 1999).

Stanley and Goddard (2002) found that feelings comparable to helplessness were a daily feature of many child protection practitioners' lives, and that children were consequently being left in dangerous situations. It is important that fathers/male carers are engaged in initial assessments wherever possible, and that social workers intervene effectively in the context of domestic and family violence (Orme et al, 2000).

Research has found that professionals can be reluctant to admit their fears to colleagues and managers, and to ask for appropriate help. This reluctance can greatly hinder effective safeguarding work (Humphreys, 1999). Systems that support safe working practices and encourage open and honest sharing of fears need to be in place and followed (Littlechild, 2002; 2003). Effective co-working with families with known histories of hostility and/or violence to practitioners is vital. The support of the police should be drawn on where there is doubt.

Lord Laming (2009) reiterated the long-accepted position that high-quality supervision is critical to good practice. Supervision is the primary mechanism for ensuring effective oversight and review of practice, and should provide a forum for practitioners to share anxieties about cases (Gibbs, 2001; Littlechild, 2002).

There has been a tendency for supervision to be overly focused on agencies' performance/audit demands. Recent debates stress the importance of reclaiming quality clinical supervision to ensure effective case work.

Questions for practitioners:

Before you visit a household, think through your safety plan; ensure someone in your team knows where, when and why you are visiting, and when to raise the alert if you are not back.

Do I feel safe approaching this household?

Do I feel safe inside this household?

If not, why not? Exactly what in the family's behaviour and in my response made me feel unsafe?

How do the children and young people in this household appear to cope with hostility/aggression?

Am I able to voice my concerns and ask for support, both from colleagues and my manager?

How do I operate when I feel challenged or threatened? What is my coping strategy? How does this affect the families I work with? Am I aggressive, collusive, accommodating, hyperalert? Do I filter out or minimise negative information?

If I, or another professional, should go back to the household to ensure the child(ren)'s safety, what support should I ask for?

Does my manager know I am afraid and anxious?

Risk checklist:

- Why am I undertaking this visit at the end of the day when it is dark and everyone else has gone home? (Risky visits should be undertaken in daylight whenever possible)

- Should this visit be made jointly with a colleague, other professional (eg health visitor or police) or manager?

- Is my car likely to be targeted or followed? If yes, it may be better to go by taxi and have that taxi wait outside the house will I complete the visit.

- Do I have a mobile phone with me or some other means of summoning help (eg a personal alarm)?

- Could this particular visit be arranged at a neutral venue? How might I then organise to see the family at home under safer conditions?

- Are my colleagues/line managers aware of where I am going and when I should be back? Do they know I may be particularly vulnerable/at risk during this visit?

- Are there clear procedures for what should be done if a professional does not return or report back within the agreed time from a home visit?

- Does my manager know my mobile phone number and network, my car registration number, and my home address and phone number?

- Do my family members know how to contact someone from work if I do not come home when expected?

- Have I taken basic precautions, such as being ex-directory at home and having my name removed from the public section of the electoral register?

- Have I accessed personal safety training?

- Is it possible for me to continue to work effectively with this family?

Questions for managers:

Do I have in place and strongly support a safe practitioner policy?

How easy is it for practitioners to tell me that they are afraid or what they are beginning to be afraid of?

How alert am I to social workers avoiding direct contact with families?

Can I identify potential dangers for my staff and respond accordingly with their safety in mind?

Am I creating a supportive team environment where staff can depend on supportive colleagues?

Am I sensitive to practitioners' emotional responses and do I respond accordingly? Can I recognise when staff are under pressure and am I able to respond to this positively?

Do we have sufficiently healthy working relationships with the police and other relevant professionals to help in cases where there is deemed to be a significant risk to practitioners?

Pitfall 9

Throughout the initial assessment process, professionals do not clearly check that others have understood their communication. There is an assumption that information shared is information understood.

Problems of information sharing and effective communication are cited again and again in public inquiry reports (Rose and Barnes, 2008; Brandon et al, 2008). These problems can simply be about very practical issues, such as delays in sharing information, lost messages, addresses or names that are incorrectly recorded (Laming, 2003).

With the advent of Every Child Matters, a series of measures have been introduced to improve information sharing. Notably, the Common Assessment Framework (CAF), designed to bring key agencies together at an early point to assess need, and the Integrated Children's System (ICS), designed to enhance recording and workflow within the local authority.

However, there is more to information sharing than simply format and procedure. Professional communication is essentially interpretive, the quality of which lies in professional skill and willingness to move beyond "habitualised and stereotyped phrases with little diagnostic meaning" (White et al, 2008).

It is important not to conflate information sharing with communication. Communication is the process by which information is transferred from one person to another and is understood by both parties (Reder and Duncan, 2003; Bostock et al, 2005). As Reder and Duncan (2003) note, each party attributes meaning to shared information, and thus a whole set of other issues are implicated in the process that are not just to do with practical or technical concerns.

The quality of relationships will greatly impact communication; mandated networks of exchange rely on more than procedure. In Brandon et al's (1999) reanalysis of Part 8 case reviews (now termed "serious case reviews") in Wales, they concluded that communication failures could originate from a lack of respect or mistrust of other professionals' perspectives. As Reder and Duncan (2003) stressed, improvements in interpersonal processes as well as practical measures are needed to improve communication. Organisations will fail if they do not pay attention to the psychological and interactional dimensions of communication.

The recipient's immediate context has a critical impact on effective communication. Understaffed teams, located in offices that are not conducive to optimum working, will impact negatively on communication. Notwithstanding resource constraints, agencies must provide staff with optimal practical and emotional working conditions if effective communication is to be achieved.

It is important that inadequate knowledge about rules of confidentiality and data protection do not hinder information sharing. Sinclair and Bullock (2002) conducted a reanalysis of Part 8 case reviews and found that insufficient understanding regarding issues of consent, confidentiality and referral was an impediment to effective practice.

Questions for practitioners:

Am I open to being deceived?

Am I open to and curious about information?

Do I understand rules of information sharing and protocols?

Do I ever use sentences like "well I've told X" to alleviate my own anxiety about a case?

Do I own professional responsibility for my role, or am I over-dependant on my manager?

How can I ensure that information I have passed on has been understood?

Questions for managers:

Is the office environment conducive to accurate and effective communication?

Do I model good practice in communication, eg demonstrating methods for checking understanding?

Are there adequate opportunities for staff from different agencies/professionals to get together and are these opportunities explicitly aimed at improving relationships?

Are efficient business support processes effectively supporting communication systems in the office?

Have I made clear what my expectations of good communication are?

Pitfall 10

Case responsibility is diluted in the context of multi-agency working, impacting both on referrals and response. The local authority may inappropriately signpost families to other agencies, with no follow up.

Problems of ineffective multi-agency working have featured consistently in public inquiries and serious case reviews (Brandon et al, 2009; Thoburn, 2009). The Children Act 2004 (HM Government, 2004) provides the legislative mandate for effective multi-agency work to safeguard children. However, evidence suggests that there is a continued problem within adult services of under-reporting concerns about children. This may, in part, be due to the failure to connect or consider the impact of adult problems like mental health or substance misuse on children (Gilbert et al, 2008; Brandon et al, 2008; Cleaver et al, 2008; Stanley et al, 2009).

Brandon et al (2008) found that a very significant percentage of children who were the subject of a serious case review were not open cases to social services. This suggests that universal services need to be more vigilant to risks. Stanley et al (2009) suggested that adult services should adopt a more holistic understanding of risks (eg should understand that problems of domestic violence, substance misuse and child maltreatment may co-exist) in order to increase their awareness of risks to children.

Local authority practitioners should ensure that referral processes do not unnecessarily "stall" referrals from partner agencies, which will discourage timely engagement with families. An example of this would be requesting the completion of a common assessment framework (CAF) when the case might be better dealt with under Section 47. Specialist and differing thresholds among diverse practitioner groups have also been identified as impacting negatively on effective referral processes (Barbour et al, 2002). Ensuring that the "front-door" provides partner agencies with the opportunity for the informal discussion of concerns may go some way to improving this issue.

Equally, there is evidence that partner agencies "talk up" referrals when they do not feel confident in dealing with lower-level concerns, or are reluctant to take on the role of lead professional (Pithouse and Broadhurst, 2009). Local developmental work is needed to maximise the benefits of multi-agency working and to examine barriers to effective referral (Moran et al, 2007; Tompsett et al, 2009).

Anning et al (2006) stressed the importance of clarifying core roles and responsibilities to promote mutual respect and understanding.

There is clear evidence that the quality of local partner relationships is key to effective joint working, and that structures and systems alone are unlikely to make a significant difference (Glisson, 2007; Ward et al, 2004; Audit Commission, 2008). We know from patient safety literature that an established team may be more likely to be effective and safe (McKee et al, 2010) than one assembled ad hoc, for example "around the child".

Multi-agency working is promoted as the way of ensuring that vulnerable children do not slip through the net of preventative services. However, responsibility can become diluted in professional networks, particularly where roles are unclear. Research in the US has found that increased inter-agency collaboration can reduce the individual sense of responsibility for the case (Bickman et al, 1997; 1999; Glisson and Hemmelgarn, 1998).

During initial assessment it is critical that, where there are a number of agencies involved with a child, each agency clearly understands their role and level of involvement. Failure to achieve this understanding is implicated in many child abuse deaths (Brandon et al, 2008). Where complex cases involve several professions and two or more agencies, effective work can be undermined by the misunderstanding of respective responsibilities (Moran et al, 2007). Practitioners must be clear about who is responsible for what in the common, initial and core assessment processes.

Questions for practitioners:

Am I routinely writing to agencies to keep them informed at key points in a case, eg on completion of assessment, case closure or case transfer?

Am I open to discussion with partner agencies regarding concerns to children?

Am I clear and have I clarified respective roles and responsibilities with partner agencies?

Do I know colleagues working in partner agencies locally and do I understand how they work?

Questions for managers:

Do referral processes provide opportunities for informal discussion with partner agencies?

In the overseeing of cases, am I clear about the roles and extent of involvement of other agencies?

How well do I know how key players (eg paediatricians) in other agencies work?

Am I feeding back to agencies at management levels when they are operating inappropriately?

Are there local agreements on the effective challenge to inappropriate referrals, while maintaining positive and effective working relationships with other agencies?

Does my department use data to analyse professional referrals in order to learn more about volume and quality, and to target where support to other agencies may be needed to bring about improvements?

How effective is child protection training and have we developed mutually respectful relationships open to challenge and discussion?

Are opportunities for joint training across agencies evaluated in terms of their impact on local referral and intervention practices?

Are staff encouraged to shadow professionals in other agencies to understand their roles and challenge barriers? Are these arrangements reciprocated?

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