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Social Worker Experience of Fatal Child Abuse - An Interpretative Phenomenological Analysis

A Doctoral Project Report submitted in partial fulfilment of the requirements of Sheffield Hallam University for the degree of Professional Doctorate.

Lee W Pollard
April 2014

ABSTRACT

This research project is an interpretative phenomenological analysis (IPA) of the lived experiences of four social work practitioners who have been directly involved in cases of fatal child abuse. Through the use of semi-structured interviews, detailed narrative and hermeneutic analysis, the research examines how the tragedies impacted upon the workers in both personal and professional capacities and locates those experiences within the relevant organisational context. Within the research, the workers recount their experiences relating to such issues as the support and supervision they received following the children's deaths, their experiences of the review process and the short and longer term impact of the deaths upon their social work practice and their personal relationships.

Analysis of the workers' accounts reveals that all were significantly affected in different ways by the tragedies; however their emotional and support needs were largely ignored by the organisations in which they practiced. Although there are some examples of good practice, it is apparent that on a number of occasions the needs of the organisation were prioritised above the individual needs of the participants.

The study reveals that following the children's deaths, the support and supervision the social workers received was often inappropriate and inconsistent and the serious case reviews that were undertaken further contributed to the isolation and blame already being experienced by the workers involved.

The theoretical analysis within the study relates the workers experiences to Doka's (2002) typology of disenfranchised grief, Nagel's (1979) concept of "moral luck" and also Hawkins and Shohet's (1989) model of effective supervision. The study introduces a new concept developed by the author. Termed the "personification of systemic failure", this concept highlights how such factors as media responses, organisational culture, working practices and the serious case review system, combine to provide a means by which systemic failures are minimised and ignored in

favour of attributing blame to the actions or inaction of individual social work practitioners.

The penultimate section of the study contains a detailed discussion of the research findings and also makes a number of recommendations for future research and practice initiatives in the area of fatal child abuse. The paper is concluded by a personal, reflective account of the "research journey" undertaken by the author during the study.

ACKNOWLEDGMENTS AND THANKS

Without the openness, commitment, honesty and passion of the four brave individuals who shared their experiences, this study would never have happened. Each and every one of you is a credit to our beloved and much maligned profession.

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This research project is dedicated to the memories of "Kieran", "Sarah", "Rebecca" and "Sam", Joan and Arthur Gaunt, my beautiful Grandparents and to Keith Horsfield. Though I never got to say this Keith, I would be proud to call you my Dad. I wish that just one more time, even if it was only for one minute, I could see you all again. I miss you so very, very much.

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"You could not be the same person...to experience working in an environment where you have had a link with a family that has tragically, horrifically lost a child, and to carry on doing what we do. It's not a job is it? You cannot call social work a job. You don't log on and off. Yes, it has changed me; I think yourself as a person and your own relationships as well changes. Strangely enough I'm not in one (laughs) I now have my own barriers up around things, so it does change you as a person, but how could it not change you? If it didn't change you then it would be worrying really. You do think about it, it does come back to you. It is something that will never go away. I think about how people can seem quite nice, quiet, approachable and friendly but you cannot define someone that could kill a child. You cannot say that's somebody who could kill a child or my assessment of you is that I think you could do that. If people knew why they did it they wouldn't do it. I didn't think anybody intentionally sets out to kill a child, but maybe they do. I hope they don't otherwise I would lose faith. It is something that will never go away, that's for sure...It might be beneficial to draw out all the issues for that particular case and resolve some practice or communication issues and maybe we do stop them but we will never know will we? We will never ever know. We may stop them all of the time, daily in this country but how would you ever know? How do you measure that? No one really cares about the ones we stop do they?"

Donna, Social Worker, Interview Transcript, April 2013

1. INTRODUCTION AND RATIONALE

1.1 Personal Involvement

My interest in researching the lived experience of social work practitioners involved in cases of fatal child abuse began in 2006, shortly after I had completed the Advanced Course in the Management of Unexpected Childhood Deaths at The University of Warwick. I was required to attend the course in my role as the Development Officer for Barnsley Safeguarding Children Board (BSCB) and had been given the co-responsibility for developing the Child Death Review Team and the Child Death Overview Panel within the authority. Child Death Review Teams were already firmly established in the United States, parts of Australia and Canada (Durfee, et al, 1992) and "have brought together interested and experienced professionals with a primary mission to prevent child death or injury" (Reder, 2004, p.110).

Chapter 7 of the revised Working Together to Safeguard Children guidance (DoH, 2006) stated that from 2008 all Local Safeguarding Children Board (LSCBs), in England and Wales would be required to maintain a rapid response process whereby "a group of key professionals would come together for the purpose of enquiring into and evaluating each unexpected death of a child" (DoH, 2006, 7.1) and also a Child Death Overview Panel (CDOP) responsible for collating and analysing information relating to the deaths of all children and young people, up to the age of 18, in their area. The broad aims of the child death review process were: i) identify whether any of the deaths gave rise to the need for a Serious Case Review (SCR), ii) identify any matters of concern affecting the safety and welfare of children throughout the

authority, iii) review the appropriateness of professional responses to, and involvement with the child before and at the time of death and iv) to determine whether or not the death was deemed preventable (DoH, 2006, 7.25).

My attendance on the Advanced Course in the Management of Unexpected Childhood Deaths required me to familiarise myself with the processes involved in reviewing child deaths and to prepare a report for submission to the BSCB. During the course, a range of professionals including coroners, paediatricians, paediatric registrars and perinatal pathologists gave detailed insights into their roles and responsibilities in relation to child deaths. After participating in the workshops I reflected upon how "clinical" and emotionally detached the medical practitioners appeared, and how their analysis of events contrasted sharply with the often emotive and deeply moving insights given by "non-medical" personnel or parents who had experienced the loss of a child.

During my own career as a children and families social worker and principal child protection training officer I had experienced only peripheral involvement in cases of fatal child abuse. As a social worker I had been exposed to the high levels of stress and anxiety associated with managing a child protection caseload, yet (thankfully) despite a few "near misses" my experience in this area was limited to the reading of a number of Serious Case Reviews and their recommendations and background reading relating to the child death review process. The course provided me with my first "human" perspectives. The realisation that within every tragedy, alongside the formal, legal and procedural processes, there existed a plethora of human actions and interactions, each impacting upon those involved in different ways and at differing

levels and that from a professional perspective, each account was potentially shaped by the role requirements and expectations of each particular occupation.

Relating these incidents to my own profession, I began to reflect upon how the experience of being involved in a child death may impact upon social work practitioners. My reflection took the form of comparing how, in both personal and professional contexts, the role of "medical" practitioners, nurses, paramedics, paediatricians etc., appeared to contrast sharply with the role of children and families social workers. Whilst not in any way seeking to minimise the potential trauma associated with the death of a child, it is fair to surmise that serious injury and death, however tragic, are an expected and unfortunately regular occurrence within an accident and emergency department or special care neonatal unit. Even within some areas of social work practice, for example a palliative care or children's disability setting, the death of a client is an unwelcome, yet not unexpected occurrence. However, within statutory children and families social work departments such events represent the extreme "sharp end" and thankfully rare aspects of professional practice, and the sudden, unexpected and often violent nature of the child's death potentially culminates in increased feeling of stress and trauma for social work practitioners.

In relation to roles and responsibilities, social workers alongside other professionals, have a legal mandate in relation to family support and child protection; as a result they are required to remain "child focussed", to uphold the legal principal of "paramountcy" by placing the child's safety, wishes and feelings at the very centre of the decision making process. Although such roles and responsibilities are not

exclusive to social workers, such requirements place the social worker in a pivotal position. As a result, they are often charged with the responsibility for co-ordinating multi-agency meetings or support networks, working in partnership with the child and his or her parents and ultimately working in a proactive, preventative capacity to negate or minimise harm to the child or young person. Social workers are central to the protective process. It is possible that for the social worker involved, the death of a child represents not only feelings of failure at a professional level but also at a deeply personal level. Potentially, the nature of the feelings experienced by those who are deemed as having failed to protect a child are significantly different to the feelings of paediatricians or nurses who attempt to treat the consequences of those failures.

1.2 Social Work in Context

The rise of new forms of "managerialism" within social work practice, described by Adams, et al (2009, p.52) as where "corporate planning processes have been transplanted from the private sector into human services" and where "effective practice is often conceptualised organisationally as meeting the demands of funding bodies where financial accountability and certainty evolve as key driving principles" has been identified by some commentators (Preston-Shoot (1996) Parsloe (1996), Ferguson (2008) as being responsible for the reduction in "human" aspects of social work in favour of a bureaucratic, mechanistic, adherence to practice guidance. Such a situation is described by Preston-Shoot (1996) as where "social workers have been drawn into routines rather than professional servicing; into implementing agency procedures, such as case management, contracting and purchasing, and budgeting, rather than engaging and investing emotionally in and being with clients". Although,

it is difficult to argue that the rise of managerialism has not had a significant affect upon social work practice, the extent of its impact must be considered. Thompson (2009) stresses that despite the perceived rise of managerialism, the core principles and human focus of social work have not been completely abandoned and that despite an increased emphasis upon the bureaucratic elements of practice, "good" practice although potentially more difficult, can still be achieved. Thompson's views are supported by Lishman (2009, p.44) who emphasises that "even in the current managerial and "what works" context of social work and social care it is difficult to imagine how, for example the transition from a family (however problematic) or foster care (however problematic) to residential care for a child or adolescent, can be sensitively and successfully achieved if the social workers and social care workers involved do not use empathy".

Despite the perceived increased bureaucratization of social work practices, there still exists a professional requirement to transcend the mechanistic adherence to guidance and procedures and to emotionally invest in an empathetic understanding of the human condition. The DfES guidance, *Common Core of Skills and Knowledge* (DfES, 2005) identifies the importance of building relationships and adopting an empathic understanding of children and young people's situations as a key skill within social work practice. It is difficult to imagine a practice scenario within social work that does not require at least some degree of emotional investment on behalf of the social work practitioner; this is potentially significantly increased within the often frightening and unpredictable domains of child protection. Despite the advancement of managerialism, social work at its core remains a very human and emotionally demanding profession.

1.3 Empathic Understanding, Relationships and Social Work Practice

In terms of the relationships between social worker and service users, social workers are actively encouraged to adopt an empathetic understanding of each client's situation, and to foster an appropriate professional relationship as a means of amongst other things "engaging in collaborative problems solving and achieving shared positive outcomes" (Lisham,2009, p.75). In addition, studies have shown that clients value "social workers who are honest, who are warm and friendly" (de Boer, 2007, p.32). Potentially, social workers may work with a child and their family for a number of weeks, months and even years. Despite a general shift away from long term "casework" within social work and a move towards referral and assessment, for children in need or specialist area teams, it is still possible that social workers may be involved with a child from birth, during its early formative years or may be involved with a number of siblings within a particular family. They may have worked in an intimate one to one capacity, during therapy, counselling or transporting the child to school or contact visits. They may have been present during key life events such as birthday parties. It is possible that these attempts at emotionally "knowing" and empathising results in a much closer attachment to the child than that experienced by other professionals. It is possible therefore, to suggest that following the death of a child, the sense of loss experienced by the social worker who has maintained ongoing involvement in the child's life may differ significantly to that of a paramedic or paediatrician whose interactions with the child, due to their own role requirements, may be severely limited. This view is support by the findings of Gustavsson and MacEachron (2002, p.907) who describe how: "The nature of the relationship between the worker and the child plays a role in how the worker will respond to the death of the child. While child deaths are a source of sadness, some children may

have made a stronger attachment to the worker than did other children. This is especially likely if the child has viewed the worker with affection and as a safe and nurturing object. When there is a strong relationship, the worker can find the death of a child especially painful".

1.4 Media Perspectives

It is difficult to reflect upon the experiences of social workers involved in cases of fatal child abuse without making some reference to the role of the media. A study of newspaper reporting of social services undertaken by Franklin (2000) revealed that media stories relating to "child abuse" are afforded priority within newspaper coverage, accounting for 46 % of all reports. The survey of nine national newspapers revealed the only one adopted a positive position in its overall coverage of social work and social services. The most common descriptions of social workers were "negative", "incompetent", "negligent", "failed" and "abusing trust".

In relation to fatal child abuse, the disproportionate amount of criticism levelled at social work practitioners in the media was recognized within the studies of Reder and Duncan (1995, p.1) who describe how "No one can hear about the death of a child and not be moved. When that child dies as a result of abuse, we inevitably feel a mixture of horror, anger, pity and sadness. If the child was already known to professional workers whose task it was to protect him or her, the question is inevitably asked: "Shouldn't they have prevented it?" It is only a small step to identify with the helpless child and focus all our rage on the professionals, even blaming them for the child's death. Indeed newspaper editors capitalise on this process through provocative and accusing headlines".

There is little doubt that such media portrayals of the shortcomings of individuals (usually social workers) involved in child abuse tragedies have shaped the public image of social workers and social work practice. In addition however, it is also possible that "official" publications such as SCRs and public inquiries have also contributed to the prevailing aura of negativity; as Davies (2012, p.121) argues "The legacy of decades of inquiries into serious injury and death of children at the hands of their carers, despite the interventions of social workers, means that public perceptions of the entire social work profession are often defined by highly publicized failings".

Such situations have led to some senior social work academics, particularly Professor Roy Jones, to question the overall efficacy of the existing child death review process and indeed formulate the view that rather than facilitating learning and understanding, they compound the negativity towards social workers and social work practice. "I cannot imagine what new general learning will come from more and more serious case reviews. Instead they have become a tool for apportioning and allocating accountability...they feed the blame culture. They are also costly and a major distraction from focusing on current practice as resources and management attention are heavily deployed" (Jones, 2013). It is a fair assumption that for social work practitioners, the already distressing experience of being involved in the unexpected death of a child is potentially exacerbated by the public exposition of their personal and professional "failings". The child's death becomes both a deeply personal yet very public tragedy.

1.5 The Doctorate in Professional Studies.

My initial reflections had enabled me to contrast how different professions may be affected by the death of a child; however it was not until my enrollment on the Doctorate in Professional Studies course at Sheffield Hallam University that I began to seriously explore the possibility of undertaking a research project on the subject. The modular focus of the doctoral program required the undertaking of a literature review around an area of interest; this would enable the critical assessment of the literature and an assessment of the viability of the subject as an area for a doctoral dissertation.

My initial literature search into the topic of "social worker involvement in fatal child abuse" revealed only a very limited amount of studies, a situation acknowledged by Gustavsson and MacEachron (2002, p904) who emphasize that "death from the perspective of the child welfare worker has received scant attention in the professional literature". Despite the endeavors of King (2003) and Horwath (1995), there appeared to be a general consensus among authors who had studied the subject, that the "human" perspectives relating to fatal child abuse had been significantly absent from social work literature and in some cases, inquiries relating to child abuse had in addition inadvertently reinforced the feelings of guilt and inadequacy already experienced by the social workers involved. As Ferguson (2005, p.781) reports " in recent years, attention to the psychological and emotional aspects of doing child protection has been largely ignored in the literature and squeezed out of the understandings of welfare practice. For three decades now, the deaths of children in child protection cases have hung like a dark shadow over the professions who work with child abuse, and especially social work. The dominant response to this has been

a rational-bureaucratic one of developing the law, procedures and performance management". Ferguson's views are also reflected by Peter Reder who emphasizes how not only do "inquiries and reviews follow a pattern of targeting recommendations a bureaucratic level" (Reder, 2004, p.4) but additionally, "since the outcome is known to have been so undesirable, those practitioners who were most directly involved are presumed to have made errors. The mindset underlying the inquiry/review is that they delivered a below standard of service and may have been incompetent. Second, it is presumed that the only way to identify errors and incompetence and learn lessons is for their work to be scrutinized by someone who is more knowledgeable, more senior and more independent. Thirdly, necessary changes can only come about by imposition from above, since those low in the hierarchy are the ones who made errors and are believed to be the least capable of identifying them. A fourth presumption is that those low in the hierarchy have the least motivation to learn and to take responsibility for the improvements" (Reder, 2004, p.103).

Lawson et al (1995) highlight how in focusing upon the bureaucratic processes involved in protecting children, child abuse inquiries not only fail to recognize the emotional and psychological contexts of child protection practice, but inadvertently reinforce the false premise that adherence to policies and procedures will largely remove the risks and uncertainties involved. "Inquiry reports have consistently recommended that procedures be tightened, that professionals receive more training and, that there should be more working together, particularly in terms of communication and information exchange. There is an unwritten, naïve assumption that if only the right procedures were put in place, then children would not die at the hands of their carers. In fact, however, professionals will never be able to remove all

the risks" (Lawson, 1995, p.342). Such revelations highlight the possibility that however insightful or methodically thorough studies into fatal child abuse may be or how many changes to policies and procedures are recommended and implemented by highly skilled and motivated practitioners, completely removing the risk within child protection practice is impossible or at best, extremely unlikely. It is surely a lamentable inevitability that despite the best efforts of everyone involved, some children will die as a result of the actions or inactions of their parents and carers. It is within this context that research initiatives and practice developments must be situated. Although contributing to a total end to all forms of child abuse is clearly a noble endeavour a reduction in its incidence and severity is surely the most realistic and achievable goal.

Following the initial literature search, and in light of its findings, I developed the opinion that a research project that explored the lived, "human" experience of social worker involvement in fatal child abuse could provide valuable insights into the subject area and potentially make an important and original contribution to several areas of social work practice. The lack of research relating to the topic is such that the undertaking of the research opens the possibility to generate new areas of knowledge and understanding. My aim throughout the research is to step outside of the procedurally driven review process, typified by procedural recommendations and demands for systemic change, and look inwards at the lifeworld of those involved. My aim is not to embark upon a research journey, equipped with testable hypothesis and the imposition of pre-existing theoretical assumptions but to "give voice" and reveal the "humanity" of those individuals directly involved in the death of a child.

As far as possible, this research seeks to facilitate the telling of each participant's own story and to capture the perceptions, reactions and emotions within each account.

1.6 Why IPA?

A phenomenological research paradigm and in particular Interpretative Phenomenological Analysis (IPA) has been chosen as it represents an "interpretive, qualitative form of research that seeks to study phenomena that are perceived or experienced. Offering a means by which to identify the essences of the experience" (Gelling, 2012, p.13). A particularly relevant feature of phenomenological research methods is the commitment "to take the researcher into the unknown about a particular life event such that the knowledge gained adds significantly to the body of knowledge about the phenomenon and will open new avenues of research to help humans gain a better understanding of themselves and their relationship to the world" (Turner, 2009).

Prior to selecting IPA as a research methodology I critically evaluated a number of research paradigms and assessed their suitability for possible use in the project. Within the broad umbrella of qualitative research there exists a multitude of different approaches to collecting and analysing data. By drawing upon the research knowledge and experience of my tutors and supervisors and through personal investigation, I narrowed the choice to three possible options: thematic analysis, grounded theory and IPA. Although there are many clear areas of ideological and methodological convergence between each approach, there are also a number of crucial differences. These areas will now be examined and the overall efficacy of each approach and the rationale behind the selection of IPA as a research paradigm will be discussed in detail.

Despite the recognition that ultimately "thematic analysis is a poorly demarcated and rarely acknowledged, yet widely used analytic method" (Braun and Clarke, 2006, p.77) there are many consistencies within thematic approaches to qualitative research. Using structured and semi-structured transcribed interviews as primary sources of data, thematic analysis is described as "a method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail" (Boyatzis, 1998).

My initial reservations regarding the use of thematic analysis per se primarily centred upon two interconnected issues. First of all, it is difficult to identify and isolate the philosophical underpinnings of thematic analysis as a research method. In contrast, IPA offers an established (albeit not uncontested) approach to research which rests upon solid ontological and epistemological foundations. IPA and in particular its phenomenological foundations, provides a paradigm within which the origins and nature of lived experience are located. This enables the researcher to contextualise the research and firmly ground its findings within a clear schema. The recognition that "reality" emerges through the interpretative interaction between individuals and their environment, provides a starting point from which to begin to seek out and analyse the *essence* of and divergences within those experiences. IPA provides a clear, systematic, though not overly prescriptive methodology by which to access and subsequently analyse such experiences.

IPA's requirement to identify the superordinate and master themes that emerge from the analysis of the research data, clearly contain elements of thematic analysis. But where thematic analysis stops, IPA effectively begins. IPA represents an attempt to

step beyond the headlines and bring to light the very nature, context and significance of each identified experience. It transcends the acknowledgement of frequency, moves beyond the mere identification of commonalities and immerses the researcher (and hopefully the reader) in a quest for deeper understanding.

Grounded theory is a set of inductive and iterative techniques designed to identify categories and concepts within text that are then linked into formal theoretical models (Glaser & Strauss 1967). Charmaz (2006, p2) also describes grounded theory as a set of methods that "consist of systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories 'grounded' in the data themselves". As with thematic analysis, there are similarities between grounded theory and IPA; for example both require there to be no pre-stated hypothesis or *a priori* assumptions in relation to the selected area of analysis. However, there are also crucial differences between IPA and grounded theory. The first difference I identified greatly affects the nature and focus of this study. According to Glaser and Strauss (1967) the central aim of grounded theory is the generation of theory. One must initially question the amount of epistemologically sound theories that are likely to be generated from such a small scale study? Although, such an approach would not be totally out of the question, the theories that could possibly emerge from four semi-structured interviews may be seriously limited in terms of both their generalisation and transferability. Any claims made by IPA towards the establishment of theory or wide scale generalizability must therefore be clearly qualified.

A central concern was also the possibility that the quest for generalisation and theory in relation to all of the participants would ignore or at the very least moderate the

identification of the differences, subtleties and nuances within each individual's experience. For IPA the identification of difference may be as compelling and informative as the recognition of the commonalities of experience. As the analysis of the data was undertaken, this issue became particularly relevant, as the experiences of Donna contrasted significantly with those of her fellow interviewees, yet within such difference there emerged a plethora of information that may have otherwise been overlooked. As my interest in the subject area began with the recognition of the existence of inherently different experiences and interpretations for individuals experiencing the same or similar events, it would ultimately seem foolish to then seek out only what is common within each of those experiences.

My final reason for choosing IPA over grounded theory centres upon the issue of interpretation. IPA accepts that the analysis of the data is potentially not the *only* possible analysis. Although theories are clearly utilised in order to aid the theoretical understanding of the given phenomena, it is accepted that other theories may serve equally as well in the quest for understanding. Where grounded theory may present the emergent theories as its conclusion, IPA may present its analysis as one of many things. At its core it must provide a detailed insight into the lived experience of those involved. It stands as a research study in its own right; however, it may also serve as a catalyst for a wider study, and it is open to revision, further analysis and critique. In keeping with the phenomenological doctrine that events and experiences are essentially interpretative in nature, the overall approach therefore becomes one of "here is my research make of it what you will", and in essence "it is what it is".

1.7 Interpretative Phenomenological Analysis: A Critical Evaluation.

Although the origins of IPA can be traced back to Husserl (1985) it represents a comparatively new methodological approach to conducting qualitative research. Emerging in the mid 1990's, and owing much to the endeavours of the psychologist Jonathan A Smith (2009) IPA has a strong research tradition within health psychology but has since been applied to research projects within the disciplines of nursing, education and social psychology. IPA is clearly suited to the investigation of the lived experiences of social workers involved in cases of fatal child abuse as it is primarily "concerned with the detailed examination of human lived experience. And it aims to conduct the examination in a way which as far as possible enables the experience to be expressed in its own terms, rather than according to pre-defined categories or systems" (Smith, 2009, p.32). IPA concurs with Heideggerian perspectives in acknowledging that phenomenological inquiry is from the outset an interpretative endeavour, it aims to step beyond the mere presentation of a detailed narrative of events and requires the researcher to provide interpretation and insight. "IPA also pursues an idiographic commitment, situating participants in their own particular contexts, exploring their personal perspectives, and starting a detailed examination of each case before moving to more general claims" (Smith, 2009, p.32).

During the early planning stages of my research, I had discussed the possibility with my research supervisors that due to several factors, for example, the highly sensitive nature of my chosen subject area or agency concerns about "bad press", the recruitment of a large number of research participants may be difficult. IPA's methodological approach strives for depth and detail within a research project, placing these factors firmly above the search for breadth and quantity. "This is

because the primary concern of IPA is with a detailed account of individual experience. The issue is quality not quantity, and given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus upon a small number of cases" (Smith, 2009, p.51). A critical evaluation of the use of IPA in health psychology undertaken by Brocki and Weardon (2006) revealed that the number of interviews used in IPA based studies ranged from one to thirty. In addition, Collins and Nicholson (2002) and Smith (2004) in Brocki and Weardon (2006) emphasise that "as an idiographic method, small sample size are the norm in IPA as the analysis of large data sets may result in the loss of potentially subtle inflections and meaning and a consensus towards the use of smaller sample sizes seems to be emerging". Smith (1999, p.413) stresses that ultimately IPA research should be "judged first and foremost on how illuminating it is of the particular cases studied and that the micro-level theorising should be richly informative of those particular individuals and may well be fairly modest in its claims to generalisation".

As has been previously mentioned, my early investigations had revealed only a relatively small amount of literature on the subject of social worker involvement in fatal child abuse. This revelation was for me initially concerning as I originally believed that the lack of a bedrock of theoretical knowledge or previous research could potentially hinder my research project. However, since IPA research studies are not theory driven or based upon the rejection or confirmation of pre-defined hypotheses "literature reviews can be quite short and may be more evaluative than most. Your aim, as usual, is to introduce readers to the field but you will also need to inform them about some of the strengths and weaknesses within the key contributions

to that field and to offer an argument which shows why your study can make a useful contribution" (Smith, 2009, p.43).

As with many research paradigms, IPA and other phenomenological based approaches have not escaped critique. IPA in particular has been criticised due to its use of small samples sizes and the predominantly idiographic nature of its studies. As Malin (1992) argues "generalisations are largely not feasible and idiographic studies are potentially "subjective", "intuitive" and "impressionistic". Paley's (2005) critique of phenomenological research entitled "Phenomenology as Rhetoric", highlights a number of its perceived shortcomings, in particular the apparent willingness of researchers to move uncritically from "essence-as-uniqueness to essence-as-what-is-common" based upon only a very limited or in some cases single sample size. Paley's view is that "the effect of aggregating a number of accounts is merely to collate unsubstantiated narrative gratuitously, and offer as "findings" something that is nothing more than an anthology of folk psychology and folk sociology" (Paley, 2005, p.108). Both critics, Malin in particular, adopt a somewhat naïve interpretation of the aims of IPA; its central aims have never been to make large scale generalisations or to formulate "objective" descriptions and analysis of the experiences of the individuals or groups involved, quite the opposite in fact! A key aim is for an acknowledgement of the limitations of each study and a recognition of the reflexivity of the researcher involved. The outcome is "theoretical transferability rather than empirical generalizability" (Smith, 2009). Though Paley is correct in challenging *some* of the claims made by *some* phenomenological studies, he is surely wrong to dismiss all phenomenological studies outright? Poor quality research can by found within any research paradigm. It is one thing to critique "bad" research,

however it does not immediately follow that the entire philosophical and methodological basis upon which is founded must also be discredited.

Although the phenomenological approach I have chosen potentially reduces the ability to make sweeping recommendations or broad policy changes based upon the research findings, it is feasible that in addition to providing a detailed insight into a previously neglected area of social work practice, aspects of the research may be used as the catalyst for future research projects, policies and service provision in relation to safeguarding procedures and the child death review process. This study emerges at a time when research informed, evidence based practice resides at the forefront of effective social work provision. It is defined as the "conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare of individuals, groups and communities" (Macdonald and Sheldon, 1998, p.1) and the undertaking of social work practice "that is informed by research evidence indicating the most effective form of intervention to be used in specific circumstances" (Adams, et al, 2009, p.144). Although it must be acknowledged that some of the central tenets and the blind adherence to all things evidence based, have been afforded a certain amount of criticism (Webb, 2001) it is evident that a number of evidence based interventions have been pivotal in facilitating the development and refinement of several key areas of social work practice.

Despite its origins being firmly rooted in psychology, IPA's attempts to provide detailed insights into the lifeworld of the research participants closely reflect many social work skills and values: potentially it is a very empowering form of research, giving participants "a voice" and locating the interviewees as "experts" in relation to

their own experiences, interpretation and understanding of life events. IPA's method allows participants to state their own understanding of their experiences and describe the underlying reasons and context of their actions. As in social work practice, the researcher aims to ascertain information regarding a specific theme or incident but attempts to do this without imposing their own personally developed hypothesis or undeclared values upon events. The researcher initially acts as a "guide" or "facilitator", enabling disclosure but does not seek the imposition of strict methodological or theoretical structures upon proceedings. Following the undertaking of the interview, the researcher then utilises their own skills and theoretical knowledge to gain or develop understanding of the person and their experience. As in practice, the researcher is able to draw upon theories and research evidence to aid analysis and inform judgements before critically reflecting upon their own experience. IPA also gives a "voice" to many individuals or groups who otherwise may be silenced or marginalised within society: Robson (2002), Touroni and Coyle (2002) and Flowers and Duncan (2000). It is a central aim of the research to provide a voice to practitioners whose disclosures may otherwise remain unheard but may be crucial in developing social work practice in relation to safeguarding and protecting children.

1.8 Research Aims and Objectives

It is envisaged that the practice focus of my research will render it particularly relevant and beneficial to both researchers and social work practitioners. The potential also exists to transfer some of the learning to other caring professions. In addition to informing the evidence base of social work practice, the undertaking of the research coincides with emerging calls for a refocusing of the social work profession, in particular child protection services. The Munro Review of Child Protection, an independent review of child protection in England, commissioned in 2010, recognises the need to "create a balance between, essential rules, principles and professional expertise" and emphasises that "helping children is a human process. When the bureaucratic aspects of the work become too dominant, the heart of the work is lost" (Munro, 2011, p.13). The report broadly recommends that social work realigns its professional focus, away from a procedurally driven system in favour of more client centred approaches and a transition within social work is required from "compliance to a learning culture" (Munro, 2011, p.8). It is possible that the "human" focus of the research into the experiences of social workers involved in fatal child abuse will in some way contribute to this endeavour. In light of such findings the overall aims and objectives of the research are:

- To enhance the understanding of how involvement in cases of fatal child abuse may impact upon social work practitioners both personally and professionally
- To locate the experience of social workers involved in cases of fatal child abuse within its organisational context in order to identify and inform potential areas of practice development

- To contribute to further research and development initiatives relating to cases of fatal child abuse and the child death review process.

Perhaps the central benefit of the research is its potential impact upon the children themselves. It is possible that social workers whose practice emanates from a secure knowledge base, who are safe in the knowledge that they operate within a working environment that is cognizant of and consistently responsive to the emotional demands of their profession, are better equipped to provide a more effective service for the children in their care. Although, this research project focuses upon events and responses relating to the death of a child, it is undertaken with the ultimate aim of enhancing the services designed to protect children and reduce child deaths.

2. FATAL CHILD ABUSE AN OVERVIEW

The following section provides a detailed overview of the subject of fatal child abuse. Drawing from current research, the overall aim is to locate the study within its wider social and organisational context by highlighting such factors as the incidence of fatal child abuse and the ages, gender and ethnicity of the children involved. The section begins by providing a definition of what constitutes an "unexpected" child death. The most prevalent causes of death and the likely relationship between the child and the perpetrator are also disclosed. As the study directly relates to the deaths of children who were "known" to social services information is also provided in regard to this area.

Ever since the death of Dennis O'Neil in 1945, public inquiries have provided a number of detailed insights into the circumstances surrounding the deaths of children and young people. In addition, Serious Case Reviews, their predecessors Part 8 Reviews, and to a lesser extent Individual Management Reviews, have for a number of years, contributed to the understanding and identification of the prevalence of cases of fatal child abuse. Although public inquiries and reviews have provided a rich source of data for researchers and practitioners alike, their findings were often criticized for being among other things, locality specific, expensive and of varying quality, (Reder et al., 2004).

Despite the undertaking of a number of meta-analyses of public inquiries, SCRs and Part 8 Reviews (Reder et al, 1993, 1999, James, 1994, Falkov, 1996, Corby, 1998) in the UK "there is no one data source which captures all violent and maltreatment-related deaths" (NSPCC, 2011). However, the inception of Child Death Review

Teams and Child Death Overview Panels in April 2008 has ensured that a nationwide and regimented approach to data gathering and analysis of child deaths has been developed. Although it must be acknowledged that "there are slight discrepancies in data on child deaths from violence or abuse, particularly in relation to infants and adolescents" (NSPCC, 2010) it is primarily upon such findings and subsequent meta-analysis of those findings undertaken by different agencies and individuals that the following section is based. Although an IPA based study does not necessarily require the production of large amounts of quantitative data, it is envisaged that providing an overview of some of the available data will define some of the key terms used within this research and in addition, establish a clear context for the study as a whole.

Since April 2008, LSCBs have had a legal responsibility to provide an overview of the deaths of all children up to 18 years of age, excluding stillborn and planned terminations carried out within the law, within their authority, to enable, among other things, consistency within the data gathering process. Working Together to Safeguard Children (HMSO, 2010) provides clear and concise definitions of child fatalities by separating them into "preventable" deaths and "unexpected" child deaths. Preventable deaths are defined as "those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths" (HMSO, 2010, 7.23) and unexpected child deaths are defined as "as the death of an infant or child (less than 18 years old) which:

"Was not anticipated as a significant possibility for example 24 hours before the death; or

Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death." (HMSO, 2010 7.21)

It is the second definition that is most relevant to this research project and although not all unexpected child deaths can be attributed to abuse and neglect, it is this definition that will be used as when referring to "cases of fatal child abuse" within this research project.

2.1 INCIDENCE

Insight into the prevalence of child deaths can be found in an analysis of SCRs carried out by the NSPCC in 2010 (NSPCC 2010). The analysis of 579 reviews undertaken by local authorities between 2005 and 2010 revealed that: the total number of violent and maltreatment-related deaths of children (0-17 years) is estimated at around 74 (0.67 per 100,000 children aged 0-17) per year, approximately 50-55 directly caused by violence, abuse or neglect, and a further 20-25 in which maltreatment contributed but was not the primary cause of death. A further study undertaken by Brandon et al (2011) indicated slightly higher incidence of fatal child abuse than the study undertaken by the NSPCC, concluding that "drawing on the SCR notifications from the single year 1 April 2009 to 31 March 2010 and comparator data from other sources, we estimate that the total number of violent and maltreatment-related deaths of children (0-17 years) in England is around 85 (0.77 per 100,000 children aged 0-17) per year. Of these, around 50-55 are directly caused by violence, abuse or neglect, and there are a further 30-35 in which maltreatment was considered a contributory factor, though not the primary cause of death

2.2 AGE OF CHILDREN

Rates for SCRs were highest in infancy (6.02 per 100,000 infants), dropping in the pre-school, school-age years, and rising slightly in late adolescence. Between 2005 and 2010 there were an average of 69 SCRs per year relating to child fatalities where abuse or neglect were known or suspected to be a factor. 44% of these related to infants (NSPCC, 2010). A later study also undertaken on behalf of the NSPCC in 2011, (Bunting, 2011) focused primarily upon maltreatment related deaths in children under one year of age. This study indicated that:

"Child death review statistics highlight that 1% of deaths in the 0-27 day age group were assessed as preventable and 8% potentially preventable; this rose to 2% for preventable deaths and 22% for potentially preventable deaths for the 28-364 days age group."

2.3 GENDER OF THE CHILDREN

Of the 114 serious case reviews for which data were available on age and gender, 61 (54%) related to males and 44 (39%) to babies aged under 1 year (Figure 2.1, Table 2.1). Of the 73 fatal cases 52% were male and 42% aged less than 1 year (Brandon, 2011).

2.4 CAUSE OF DEATH

Findings show that physical assault, in particular non-accidental head injury, is the most common cause of maltreatment related death and serious injury involving infants (Bunting, 2011).

2.5 PERPETRATORS

Killings of children by a natural parent are committed in roughly equal proportions by mothers (47%) and fathers (53%), but where the child is killed by someone other than a [birth] parent, males strongly predominate. The proportion of child homicides in which the perpetrator is a parent is exceptionally high among infants. For example between 1995 and 1999 in England and Wales, 80% of homicide victims under one year old were killed by a parent (Brookman, 2003, p.16).

2.6 ETHNICITY

There are no published statistics specifically relating to the ethnicity of children who have died as a result of abuse or neglect. However, some insight is provided into this area by DoH statistics published in March 2013. Although these figure relate to "modifiable deaths", defined as "cases where there are factors which may have contributed to the death, for example suicides, death by fire or burns or drowning. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths" (DoH, 2013). The majority of SCRs conducted were for white children (61%). A similar proportion of deaths across white, black/black British and other ethnic group children were identified as having modifiable factors (21% of deaths where the child was white, 20% where the child was black/black British and 21% where the child was of other ethnic group). When the child was identified as having an "unknown" ethnicity the proportion of deaths which were identified as having modifiable factors was significantly lower (12%). The proportion of deaths of Asian children where modifiable factors were identified was also significantly lower (15%). Children of mixed ethnicity were more likely to have modifiable factors in their death (28%)

(DoH, 2013). Although studies have revealed little significant variation in the ethnicity of children whose deaths were deemed to be a result of modifiable factors, a study undertaken in 2011 emphasised that "there is a tendency for children of black/black British ethnicity to be over-represented in serious case reviews, as they are in the population of looked after children" (Brandon, 2013, p.33).

2.7 INCIDENCE OF FAMILIES KNOW TO CHILDREN'S SOCIAL CARE.

Brandon's analysis of Serious Case Reviews undertaken between 2009 and 2011 indicates that 58 of the 138 children involved in the reviews were known to children's social care services at the time of their death or serious injury and in addition 32 children had previously been known to children's social care prior to their death or serious injury. Although, 29 of the children subjected to SCR had had no previous involvement with children's social care, the figures still represent a significant number of children who died or were seriously injured while maintaining "open case" status. In relation to my own study these figures reveal that in the short period between 2009 and 2011 there were potentially 58 social work practitioners who experienced the death or serious injury of a child on their case load. It is possible that such figures are somewhat of an underrepresentation of the actual number of social workers involved in case of fatal child abuse as it is possible that some of the cases were not subjected to SCR. In addition there are also potentially a significant number of social work practitioners who were also directly involved in these cases either in a co-working or managerial capacity.

2.8 THE CHILD DEATH REVIEW PROCESS

All of the cases that are referred to in the study were subjected to either the Serious Case Review or Individual Management Review. Since their inception, SCRs have developed into the primary means by which information into cases of fatal child abuse is obtained. In total "in the year 1 April 2010 to 31 March 2011, Child Death Overview Panels (CDOP) in England reviewed 4,061 deaths of children aged 0-17 years; 2,423 (60%) of those related to children who died before 1 April 2010 and 1,638 (40%) between 1 April 2010 and 31 March 2011. Since the child death overview processes started in 2008 there has been a steady increase in the annual number of child death reviews which are completed by CDOPs. An estimated 71% of all child deaths between 1 April 2008 and 31 March 2011 have been reviewed" (Sidebotham et al, 2011, p.8).

The purpose of a SCR is laid down in Working Together 2010, Chapter 8 and is stated as needing to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Improve intra and inter-agency working;
- Better safeguard and promote the welfare of children.

Whilst the criteria for convening a SCR are stated as:

A LSCB should always undertake a serious case review when a child dies (including death by suicide), and abuse or neglect is known or suspected to be a factor in the child's death. This is irrespective of whether Children's Social Care is or has been involved with the child or family. This should include a child who has been killed by a parent, carer or close family relative:

- with a mental illness
- known to misuse substances, or
- perpetrate domestic abuse (DoH, 2012, 13.1)

In some of the cases an Individual Management Reviews were undertaken in order to provide insight and to analyse each or a particular agencies involved with the children and the families of the children who died. Whilst the purpose of SCRs and IMRs is clearly stated, it becomes apparent within the study that a number of issues arise for those involved. Such issues centre upon the format and type of the "learning" that is obtained from the reviews and also the impact that participating in them may have for each of the workers. These aspects of the review process will be discussed in detail in the data analysis and theoretical discussion of this study.

3. THE LITERATURE SEARCH AND REVIEW PROCESS

3.1 Search Strategy

According RMIT (2005) the general purpose of a literature review is to:

- establish a theoretical framework for your topic / subject area
- define key terms, definitions and terminology
- identify studies, models, case studies etc. supporting your topic
- define / establish your area of study, i.e. your research topic

In addition the three key points of a literature review:

- Tell me what the research says (theory).
- Tell me how the research was carried out (methodology).
- Tell me what is missing, i.e. the gap that your research intends to fill.

Moustakas (1999, p.111) emphasises that the central task of literature review within a phenomenological research project, is to allow the researcher to "assess the prior relevant studies; distinguish their designs, methodologies and findings from the investigator's own study and indicate what new knowledge he or she is seeking and expects to obtain". An additional aim of this section is to critically examine the literature relating to the wider social, policy and practice context surrounding the subject of fatal child abuse. The rationale for undertaking such an approach centres upon the belief that social work practice does not operate in isolation from a number of additional factors, and that individual actions cannot be clinically detached from the, micro, meso and macro societal contexts within which they take place.

The process of searching for the relevant literature initially involved the use of the Sheffield Hallam University Library Gateway "LitSearch" function. The initial

search involved identifying relevant databases from which to begin the search. The primary search criteria used in order to identify the most suitable databases were those relating to "health and social care" and the designated sub-category was "social work". The search revealed a total of thirteen relevant databases.

Once the databases were identified, the LitSearch facility then allowed each database to be searched by entering a single word or a selection of key words. The system is based upon Boolean logic and allows for the combining of words into interconnected search statements, for example "child*" AND "fatal" AND "Social Work*". The application of an asterisk to a "root" word or words, for example "Social Work*", would also reveal sources that contained the terms "Social Work", "Social Worker" and "Social Working".

For the purpose of the review the keywords initially entered were:

- child* abus*
- infan* abus*
- child abuse"
- death
- dying
- died
- fatal*
- mortalit*
- "serious case review*"
- "part eight review*"
- "social work*"

- "child welfare work*"
- experience?
- stress
- trauma
- protection

According to Randolph (2009, p.7) the purpose of applying inclusion and exclusion criteria to a literature search is to determine "which articles will be included in the review and which articles will be excluded. The particular criteria are influenced by the review's focus, goals, and coverage". Due to the nature of the study, I wished to review both qualitative and quantitative data around the subject of fatal child abuse. I also aimed to provide a historical context to some of the issues involved, particularly in relation to such areas as media responses to child deaths and the development of support and supervision systems for social workers. My previous work and study in relation to the subject of social workers and fatal child abuse had enabled me to develop the opinion that there existed only a limited amount of research and publications in this area; I was concerned that too specific criteria may decrease the chances of obtaining all of the relevant articles.

It was subsequently my aim to keep the focus of the literature search deliberately broad and I applied only limited amounts of inclusion and exclusion criteria to my search. As a result, no exclusions were placed on factors such as date, type of research, of geographic area. All available types of literature were also included in the search. These ranged from peer reviewed journals, for example Child Abuse Review,

through to the "grey" literature of Community Care Online which provided first-hand accounts of practice related issues by social work practitioners. When searching for literature relating to the SCR process or the relevant legal/procedural framework, only English and Welsh included.

From the thirteen databases that were searched only seven revealed relevant articles:

Fig 1. Database Search Results

DATABASE	**ARTICLES**
SCOPUS	16
Social Care Online	8
Community Care Inform	8
Social Care Abstracts	2
ASSIA	1
PsychInfo	1
Social Care Abstracts	1

Evans (2002) and Montori *et al* (2004) identify the possible shortcomings of an overreliance on electronic database searches as a means of providing a comprehensive review of the literature. In order to compensate for this discrepancy the process of "snowball sampling" as advocated by Greenhalgh and Peacock (2005), in which "the sampling strategy develops according to the requirements of the study and is responsive to the literature already obtained" was employed (Aveyard, 2008, p.68-69). Snowball sampling ensured that such items as reference lists, bibliographies

and the additional works of key authors, which are not produced via electronic database searches were also evaluated.

In order to ensure that any identified research was thoroughly and effectively assessed the critical appraisal tools for evaluating research, developed by the Critical Appraisal Skills Programme (CASP, 2006) were used. These tools were specifically developed to aid health and social care researchers and provide a structured but not overly prescriptive template by which to gauge the efficacy of social care research.
In relation to non-research based articles, contributions were assessed within the broad criteria suggested by Hek *et al* (2000) which advocate an evaluation of such factors as whether articles are peer reviewed, well written and published within "quality" journals. Though such categories are clearly open to interpretation and do not totally guarantee either quality or validity, they offer an attempt at a structured critique of the articles in question.

The review begins by examining and evaluating the literature relating to the media portrayal and social perceptions of cases of fatal child abuse. It will highlight how, and in what ways, such cases and the reporting of such cases, have been instrumental in shaping predominantly negative societal perceptions of social workers and social work practice. In addition, the review will examine how some researchers believe that non-accidental deaths of children have become the primary drivers for drastic and seemingly disproportionate changes to child care law and policy.

The focus of the review will then be narrowed in order to critically explore the literature directly relating to social workers experience of fatal child abuse. The

section will address some of more the "emotional" and "personal" insights that have been provided by research into the subject. The review will progress by highlighting any potential gaps and contradictions within the existing literature and provide a critical assessment of the current "state of play" regarding research into social workers experience of fatal child abuse. In conclusion, the review will serve as a catalyst for an informed justification for the subsequent research study, emphasising any potential areas of "new" knowledge generation and learning that the study may provide.

3.2 Child Deaths and the Media

The death of a child through non-accidental injury or neglect often attracts a significant amount of both public and professional attention, as Keys (2009, p.297) illustrates "child abuse tragedies provoke concern within all sectors of society, stimulating reflection and action by governments, organisations and individuals responsible for providing care to children and families". In addition, Davies and Mouzos' (2007) study reveals that "the murder of a child attracts more public outrage and media attention than perhaps any other crime". Unfortunately, the research reveals that the history of media attention towards child abuse tragedies has resulted in a predominantly negative portrayal of individual social workers and social work practice in general.

As early as the denunciation of the social work practice of Diana Lees in the case of Maria Colwell (Corby, 1993) through to the more recent tragedies involving Victoria Climbie and Peter Connelly, there has been a continual media vilification of social work practice, resulting in what Goddard and Liddell (1995, p.357) describe as "child

abuse and child abuse issues being largely examined through the lens of moral panic". Wilby's (2008) study examining the media portrayal of social work reveals the extent to which some media publications will seek to highlight both individual social worker and agency failings:

> "Following the death of Peter Connelly in 2008, "Blood on their Hands" was The Sun's headline, extending the blame to Haringey Council. The culpability of the council and its social workers seemed all the greater because Victoria Climbie was murdered eight years ago in the same borough. "How many more children have to die?" demanded the Daily Express. The Sun took no prisoners. It insisted the social workers responsible ("this disgusting lot") should be sacked, prosecuted for negligence and barred from working with children again" (Wilby, 2008).

Such media reports have extended to publicly naming the individual practitioners involved; the names of Lisa Arthurworrey, Gillie Christou, Naria Ward and Sharon Shoesmith are now synonymous with poor practice and symbolise the human faces of both individual and systemic failures. The manifestation of such perceptions, according to Keys (2009, p.298) results in a situation where "child protection is a phenomenon that seems to be characterised within the public domain by failure rather than success; rarely do we hear in the media, for example, of reports of good practice resulting in children being kept safe". It is an uncomfortable inevitability that despite the best efforts of all those involved, some children will die as a result of the

unpredictable, harmful actions or inactions of their parents and carers. Ultimately, no amount of evidence based practice and sound professional judgements will guarantee the protection of every child in every family. Such a situation is a challenging and unpalatable acknowledgement even for the most liberally minded journalist or well informed member of the public. This dichotomy between public expectation and the realities of social work practice is acknowledged by Munro (1996, p.806) who argues that "both the general public and social workers need a clear understanding of the distinction between avoidable and unavoidable errors". Although a noble intention, it is difficult to assess whether there is actually a public thirst for understanding and informed insight and whether this ultimately outweighs a wider desire for blame, retribution and all things sensational.

3.3 Child Deaths and the Social Worker

While public enquiries and Serious Case Reviews represent the "professional" scrutiny into practitioner conduct and procedural adherence, they must do so within the abovementioned media context. Such a situation has lead Kearney (2013, p.51) to assert that "anxiety about the possibility of non-accidental child deaths have been a major influence on child care policy and practice in the UK and elsewhere". Although, according to Ayre (2001, p.889) some parts of the media have contributed to "creating a more protective environment for our children" it is within the caveat of predominantly negative media coverage that has seen the creation of a:

> "unholy trinity of media pillorying, detailed post mortem recommendations about the operation of the system on the heels of inquiries and the increasing prescription of practice, resulting in social

workers and other child welfare professionals becoming focussed on the need to avoid a non-accidental death that is the classic instance of a low probability/high consequence risk that leads to risk-averse cultures and practices in all walks of life".

Although many of the studies that have been described make a valuable contribution to our understanding of the wider societal perceptions and media portrayal of cases of fatal child abuse, it is the voices of the social workers themselves; those potentially affected most by such perceptions that is surprisingly absent. If we are to accept the premise that social workers operate in the full knowledge of the risks associated with front line child protection practice and the possible negative media speculation and repercussions that may result as a consequence of their own real or perceived failures, it is surely worth exploring if and in what ways their experience of events and their subsequent actions were affected by such perceptions. To investigate how it feels to be the practitioner whose professional practice and integrity are scrutinised at a time of extreme personal distress, or to examine how the individual perceptions of being the publicly named person whose actions or inactions contributed to the fatality, is to attempt to reveal and provide detailed insights into the minutiae of social work practice. To investigate the first hand experiences of those directly involved is to extend and develop the previous studies and in doing so apply a more "human" perspective to events.

It is difficult to imagine a more tragic event than the death of a child. Even when the death is "expected", for example as a result of long term illness, it is not purely the loss of the child themselves but the loss of the son, daughter, brother, sister, footballer

and dancer to be that we may mourn. It is the irretrievable loss of promise, it is the end of potential, it is the establishment of an "empty historical track" Klass (1988, p.13). The impact of such loss upon parents and carers has been particularly well evidenced by Archer, et al (1999). However, such studies concentrate predominately upon the loss of a child through natural causes.

A systematic approach to searching for the literature directly relating to social worker experience of fatal child abuse (see chapter three) reveals surprisingly little research and in particular, very little British research, has been conducted in this area. Some of the earliest insights into the subject are provided by Olive Stevenson, whose 1979 reflections on her involvement in child abuse inquiries, among them the Maria Colwell inquiry, acknowledges that "the launching of an inquiry is like casting a huge stone in a pond. The ripples spread outward often involving many who do not expect it and more important, in ways they did not anticipate. The emotional cost is very, very high and can only be justified if the inquiries appear to play a constructive part in protecting the lives of other children" (Stevenson, 1979, p.3).

It is perhaps the meta-analysis of 35 English and Welsh, child abuse enquiry reports undertaken by Reder et al (1993) that begins to show the impact of cases of fatal child abuse upon social work practitioners. Known as the "Beyond Blame" project, the research is "an attempt to get beyond the blaming stance often adopted when children known to statutory agencies die at the hands of their caretakers" (Reder *et al*, 1993, p.1). Although focussing predominantly upon the analysis of the systems operating within child protection tragedies, Reder's study begins with the recognition that "not only does the death of a child horrify us but front line professionals, especially social

workers, have become extremely sensitive to the critical and often mindless rage that is heaped upon them at the news that a another child known to statutory services has died (*ibid*)".

3.4 Stress, Trauma and Support

Unfortunately, several studies relating to social work stress, trauma and its consequences fail to discuss the subject of fatal child abuse in their analyses. Nelson and Merighi's North American, qualitative research study undertaken in 2003 examines the subject of emotional dissonance amongst medical social work practitioners. The researchers list such things as end of life concerns, family discord, lack of community resources and institutional pressures as contributing to "intensely emotional situations" in medical social work practice (Nelson and Merighi 2003, p.64). No mention is made of the sudden and possibly violent death of a child as contributing to the stress experienced by such practitioners; however, one would assume that it would rank above the stated "discharge planning" as a stress inducing event!

Mark Horwitz's 1998 article examining social work trauma, highlights how "trauma effects can develop when a social worker is confronted with an event or series of events that cannot be readily managed either emotionally or practically and in which there is an element of danger" (Horwitz, 1998, p.365). The unexpected death of a child would clearly fall within this categorization. However, before examining the impact of child deaths upon social work practitioners, Horowitz highlights four different types of "direct trauma" consisting of the threat of assault and vandalism, organisational demands and blame from public sources. The assertion must be

maintained that it is clearly possible that social work practitioners who are directly involved in case of fatal child abuse may experience a combination of all of these sources of direct trauma. Only when referring to "Indirect" sources of trauma does Horowitz begin to explore the potential impact of child deaths upon social work practitioners, emphasising the heightened sense of trauma experienced by social workers who identified with the deceased child. Horwitz's assertion that psychological trauma theory offers the most suitable solution to the alleviation of such trauma must be challenged. Whilst we may accept that, "psychological trauma theory supports the notion that no healing can take place until the person is safe from future harm" (Horwitz, 1993, p.369), it is surely rendered impractical to the social workers who wish to continue in practice following the death of a child? However tragic such events may be, there can be no guarantees that they will not happen again to the same worker.

Regehr and Chau's (2002) study begins to provide some insight into the personal impact of child deaths upon social work practitioners. The study primarily examines the impact of inquiries into the deaths of children in care upon child welfare workers. Although based in Canada, the study refers to how "in recent years public inquiries into the murders of children have served to dramatically shift child welfare services throughout North America and Britain" (Regehr, et al, 2002, p.885). An important feature of Regehr and Chau's study is its acknowledgement of the sweeping impact of child deaths and of how the predominantly negative repercussions associated with the tragedies, permeate at individual, agency and community levels, ultimately influencing and increasing negative media perceptions and exacerbating the policing functions of child welfare practice. Building upon the work of Hill (1990) the study

emphasises how "anecdotal literature on child protection workers suggests that death inquiries have a devastating impact on morale. Staff become depressed and anxious, work becomes defensive and routinized, resignations are common and recruitment of new staff is difficult" (ibid, p.888). Importantly, the study acknowledges that despite having a significant and predominantly negative impact upon several aspects of social work practice and social work practitioners, "no studies have focused on the impact of child death reviews on child welfare workers" (ibid, p.888). This study is one of the very few research projects relating to this subject of fatal child abuse that presents verbatim, first-hand accounts of social workers' experience. Although mainly focussed upon the Inquiry process this study presents several telling insights into stress and emotional discomfort experienced by the workers involved.

Despite the recognition of the lack of research relating to social worker experience of fatal child abuse there a several researchers have provide telling insights into the subject. Gustavsson and MacEacheron's, (2002) study begins to examine how the sudden, unexpected death of a child may be more difficult for the worker involved due to such factors as the traumatic nature of the death and the fact that the worker may have no time in which to prepare for the loss. Although referring to the suicide of children known to social services, this North American study reveals how existing feelings of guilt and sadness experienced by the social worker may be further compounded by the reactions and responses of significant others. Not only is the worker involved confronted by his or her own emotional responses to the incident but also a situation where "professional judgement is questioned as workers wonder how they missed the warning signs. Co-workers or other case principals such as attorneys and judges may wonder why the worker did not foresee the possibility of suicide.

They may communicate their questions and imply assignment of blame to the worker who is already dealing with sadness and guilt" (Gustavsson and MacEachron, 2002, p.908). Crucially, the paper acknowledges the complexities involved in the resolution of such feelings, emphasising the importance of the personal attributes of the social worker involved and the interrelationship between the individual and his or her external working environment.

Jan Horwath (1996) and Sue King (2003) both writing in the peer reviewed journal Child Abuse Review, have published separate research papers which develop some of the issues raised. Jan Howarth's paper, by the author's own admission, is aimed at eliciting comments from other authors and researchers, and acknowledges the need for further, more extensive research into the subject. Entitled "The Impact of Fatal Child Abuse Cases on Staff: Lessons for Trainers and Managers" (Horwath, 1995) Jan Horwath conducted an unspecified number of face-to-face interviews with frontline practitioners who had direct experience of being involved in cases of fatal child abuse. The interviews reveal how the impact of the fatalities permeates negatively throughout the social work team involved and affects not only social work practitioners but support workers and other allied professions. Horwath's often graphic first hand accounts reveal how one typist described her experience " I kept thinking if I'd paid attention to what I was typing I might have noticed something which could have saved the child" (Horwath, 1995, p. 351) and how a social worker recounted "I had to live with this for two years. It was only after the criminal proceedings were over and the inquiry report completely exonerated me that I felt I could look people in the eye. This all happened years ago, but I still question my ability if placed in a high risk situation" (Horwath, 1995, p. 351). The study reveals

how most of the people interviewed possessed no knowledge, or received preparation, relating to the then Part 8 reviews that were undertaken, despite workers identifying fatal child abuse as their "worst case scenario".

A pivotal section of the paper recounts how supervisory responses, such as offers of therapy, counselling or time off as sick leave, were perceived as inappropriate and effectively only served to reinforce the worker's feelings of inadequacy. Frustration was documented when no debriefing was offered to workers following the fatalities, despite support being available for other agencies following tragedies such as the Hillsborough incident and the Warrington Bombings. This depiction is supported by Schulman (1993) whose research revealed that "social services and health systems are often least effective at dealing with traumas in a manner that protects staff from their impact. In fact, because of the stress on the larger system, intervention by administration often adds to the problem rather than helps staff cope with it". Horwath identifies several key lessons to be learnt from her research. These focus on the perceived need for appropriate team support and debriefing, possibly from an external source, and the provision of specialised training in the subject area.

3.5 The Child Protection System

Published shortly after the inquiry into the death of Victoria Climbie in 2003, Sue King's report "Managing the Aftermath of Serious Case Reviews" (King, 2003) builds upon the earlier study of Horwath. King describes the Serious Case Review system as "daunting and draining processes (where) learning focuses very much on policies, procedures and practice" and that in order to learn from them effectively "attention must be paid to the emotional needs of staff and to the recovery of the

interagency relationships, which have frequently been affected following a serious incident" (King, 2003, p. 261). Emphasising the need for targeted training following child abuse fatalities, the paper also acknowledges that each agency and its managers need to "recognise the likely range of reactions of staff to a serious incident involving a child" as this is clearly "important in developing effective strategies to support staff at different stages of the process, which culminate in managing the aftermath of serious case reviews (King, 2003, p. 264). The Munro review of Child protection (Munro, 2011) describes the child protection systems in England as being shaped by four key driving forces.

- The importance of the safety and welfare of children and young people and the understandable strong reaction when a child is killed or seriously harmed;
- A commonly held belief that the complexity and associated uncertainty of child protection work can be eradicated;
- A readiness, in high profile public inquiries into the death of a child, to focus on professional error without looking deeply enough into its causes;
- The undue importance given to performance indicators and targets which provide only part of the picture of practice, and which have skewed attention to process over the quality and effectiveness of help given.

Each of the four drivers lends weight to the view that current child protection system is overwhelmingly process and target driven while at the same placing unrealistic and narrow expectations upon social work practice. The report's views are echoed by further studies, for example a mixed method survey undertaken by the union UNISON in 2009 conducted in response to changes recommended to children's

safeguarding systems following the death Victoria Climbie in 2003. The study paints a worrying picture of modern day social work practice. The conclusions of the annonymised, online and postal survey of 369 union members who worked directly in children's social work, are described by the report's authors as revealing "a ticking time bomb in child protection". In relation to supervisory practices, necessary for a supportive working environment, the survey revealed that "a fifth of the respondents feel that social workers access to adequate supervision had improved since 2003 and around half think the situation has not changed. However 28% report that there is now less access to supervision" (UNISON, 2009, p.5). Such a situation is even more worrying when placed within the context of "half the respondents believed that social work services are now worse resourced since 2003" and "nearly three-quarters of all respondents report that average caseloads for social workers working with children and families have increased since 2003" (UNISON, 2009, pp. 3-4). Although published in "Community Care", a non-peer reviewed magazine for social care professionals, a 2009 survey echoed the findings of the UNISON survey. In all of the 422 social care professionals surveyed 28% said they received no supervision at all and 31% said the supervision they received was not adequate for their caseload (Community Care, 2009, p.46). No details are provided of the methodology employed by the Community Care researcher however.

Overall, the literature review reveals a general acceptance amongst researchers that there is a lack of research relating to the experiences of social workers involved in cases of fatal child abuse. In addition, surveys of social work practitioners indicate that the current overall working environment is far from ideal and falls short of the

nurturing, supportive workplaces which are conducive to fostering and developing safe and effective working practices.

Although several studies have concentrated upon specific areas of practice, for example, supervision or the inquiry process, as far as can be discerned there are no studies that examine such experiences, first hand and in their entirety. Many of the studies cited provide telling insights into the subject yet overall the voices of the practitioners involved are notably silent. It is envisaged that empowering social work practitioners to provide their own accounts, free from the fear of retribution by their employers and the external judgements of Serious Case Reviews will illuminate and inform many previously unexplored areas of social work practice.

4. RESEARCH ETHICS

This section provides details of how the ethical issues that arose prior to taking the study were addressed in line with Sheffield Hallam Research Ethics Committee requirements.

Prior to undertaking the research project and in line with University policy, a full research proposal outlining the research aims, objectives, methodology and ethical considerations was submitted to the Sheffield Hallam Research Ethics Committee (REC). Such a process is designed to ensure that when working with research volunteers "their interests are put first at all times and that researchers do everything possible to fully inform people who have consented to take part. Care is always taken to provide confidentiality and anonymity" in addition "The Research Ethics Policy is also concerned with the quality of the research process. Maintaining the highest standards of integrity, impartiality and respect for data is essential" (Hallam, 2013). The research proposal received approval from the REF in September 2011.

There are six key principles of ethical research that the Economic and Social research Council (ESRC, 2010) expects to be addressed when undertaking a research project involving research participants. Each of these principles was addressed throughout the research process:

1. ***Research should be designed, reviewed and undertaken to ensure integrity, quality and transparency.***

In addition to gaining ethical approval from the Sheffield Hallam Research Ethics Committee, all participating local authorities were offered the opportunity to subject the research proposal to their own ethics committees prior to any research

commencing. The Professional Doctorate programme, in order to ensure and evaluate the integrity and quality of its research projects, also requires the regular presentation and peer review of research activity to both fellow students and course tutors. Throughout the supervisory process all aspects of Principle 1 were addressed and regular contact was possible between the researcher, research supervisors and a member of the Sheffield Hallam Ethics Committee.

2. ***Research staff and participants must normally be informed fully about the purpose, methods and intended possible uses of the research, what their participation in the research entails and what risks, if any, are involved.***

Prior to contacting any potential research participants individually, all participating LSCBs representatives were contacted either by e-mail or telephone directly by the researcher in order to gain their approval for the research to be conducted within their local authority. Each representative was provided with a detailed written overview of the research aims and objectives, an explanation of the methodological process involved and a participant information sheet (See appendix one.). These documents contained my own personal contact details and the offer for any potential participants to contact me directly should they require any further information or issues clarifying. This approach was taken in order to avoid any harm or distress that may be caused by receiving a blanket e-mail concerning a potentially upsetting subject. Representatives were then asked to identify any potential participants within their area who may fit the recruitment criteria and distribute the information to them.

Any potential applicants responding to the request for volunteers were offered the opportunity to discuss any aspect of the research they were unsure about. During the discussion all respondents were verbally informed of what would be required from

each interviewee should they consent to taking part in the research. At this stage it was made clear that:

- Participation in the research would be entirely voluntary.
- Participants would be provided with a detailed written overview of the aims and objectives of the research and the research design.
- Participants would be fully informed of the purposes of the research, including the fact that elements of the research, as well as being conducted as part of the Professional Doctorate programme, would also be submitted for consideration for publication and conference presentations. At this stage it was also clarified that the annonymised direct quotes from participants may also be used.
- The overview would include details of the data collection process, the rights of participants to withdraw and the potential risks and benefits of being involved in the research.
- Participants would be informed of the approximate duration of the interviews and location of each interview will be agreed between the participant and researcher.

The same process was conducted for participants who responded to requests for research volunteers via social work internet forums. To request volunteers I posted the message:

Dear Colleagues, I am a Senior Lecturer in Social Work at Sheffield Hallam University undertaking a doctoral research project examining the lived experience of social practitioners who have been directly involved in cases of

fatal child abuse. I am seeking social workers who fit these criteria to take part in a semi-structured interview lasting no longer than one hour. Your identity and geographic area will remain anonymous and the interview would be at a date, time and venue of your choosing. For further information please contact: l.pollard@shu.ac.uk

3. The confidentiality of information supplied by research participants and the anonymity of respondents must be respected.

All participants were assured that their own anonymity and that of their colleagues or service users would be guaranteed by the use of pseudonyms throughout the "writing up" process. Each of the participants was provided with an alias as were the children referred to in the study. Any references to the local authorities or geographic area involved were removed during transcription. All recorded interviews were held on a password protected computer and deleted following transcription.

4. Research participants must take part voluntarily, free from any coercion.

All participants were asked to sign a consent form (see appendix two) indicating that they had:

- Read and understood the information sheet for the study.
- Had the opportunity to consider the information , ask questions and have had these answered satisfactorily
- Acknowledged that their participation is voluntary and that they were free to withdraw without the need to give a reason, up to the point of data analysis beginning

- Had been informed that the interview would be recorded and that they fully consent for the recording to be made
- Understand that the information will be treated as confidential and will be annonymised
- Agree to the use of annonymised direct quotes from the interview in publications and presentations arising from this study
- Agree to take part in this study

Participants were not offered any financial incentives or re-imbursement for taking part in the study. Respondents and potential volunteers who voiced any doubts or concerns relating to their participation in the research were encouraged not to participate.

5. Harm to research participants and researchers must be avoided in all instances.

All participants were informed of their right to terminate the interview at any time or take any number of "time outs" should they become anxious or distressed in anyway. Should any participants request any addition support post interview, they were encouraged to contact the researcher in person. It was agreed that the researcher would provide information, if needed, relating to external sources of support from professional bodies, for example The British Association of Social Workers. In relation to the possibility of distress or harm to the researcher, it was agreed that if needed they would access support from research supervisors or SHU staff/student welfare services

6. The independence of research must be clear, and any conflicts of interest or partiality must be explicit.

All participants were fully informed of the purpose of the research and the status and prior experiences of the researcher.

5. METHODOLOGY

This section details the methodology used during the research project. It begins by providing a critical overview of the selected research paradigm and explains the data collection, interview structure and recruitment processes that were employed.

The debate between opposing ontological and epistemological traditions have provided a fertile source of debate for researchers, social theorists and philosophers alike and have had a directly impact upon research and research methodology. As Crotty (2009, p.9) emphasises, our choice of epistemological perspective "implies a profound difference in how we do our research and how we present our research outcomes". Such emphasis is further developed by Marshall and Rossman (2006) whose concept of "epistemological integrity" examines the interconnectedness of "the nature of the research, overall strategy, research questions, design and methods". This approach advocates that the researcher reflects upon the "values and ideals, principles and rules by which the phenomena under investigation can be known" (King, 2010, p.8). Prior to undertaking the research, I had envisaged that due to the nature of the phenomena I aimed to study, my research paradigm would be predominantly qualitative and interpretative in nature and employ a research methodology that would bring me as close to the lived experiences of interviewees as possible.

Marshall (1999, p.2) emphasises that;

> "Qualitative researchers are intrigued with the complexity of social interactions as expressed in daily life and with the

> meanings the participants themselves attribute to those interactions. This interest takes qualitative researchers into the natural settings rather than laboratories and fosters pragmatism in using multiple methods for exploring the topic of interest. Thus, qualitative research is pragmatic, interpretive and grounded in the lived experiences of people".

Marshall's summary of the essential features of qualitative research encapsulates many of the aspects of lived experience I aim to study within my research project. My selection of IPA as a research methodology originated while undertaking the "Research Methodologies" module on the Professional Doctorate programme. During the module I was required to present my research ideas to fellow students who provided peer feedback and critically evaluated the overall efficacy of my proposal. It was during the workshop that a colleague suggested that a phenomenological methodological approach to undertaking my research and in particular the use of interpretive phenomenological analysis (IPA) as an overall research design would, in her opinion, be very effective. In light of the comments, I researched the suggested approach further, reading extensively around the broader philosophical underpinnings of phenomenology and the methodological approaches associated with IPA. I developed the opinion that for a number of reasons, such an approach would ideally suit my research area. My reasons for adopting such an approach will now be discussed in detail.

5.1 PHENOMENOLOGICAL RESEARCH

Despite Spielberg's assertion regarding the difficulties of "stating point blank what phenomenology is" (Spiegelberg, 1984, p.1) there is a general acceptance that phenomenological research methods are situated in the philosophical traditions of Brentano, Husserl, Merleau-Ponty and Martin Heidegger. Although, as will be discussed later, there are some clear differences of opinion between each tradition, it is apparent that phenomenology in its broadest sense shuns traditional empirical/positivist doctrine and attempts to return to "the things themselves" (Husserl, 1970, p.252). The ontological starting point for the investigation of such "things" begins with the acceptance that "it is not actually possible – even if it might be desirable – to remove ourselves, our thoughts and our meaning systems from the world" (Larkin, 2006, p.106) and ultimately "it is impossible to ignore the subjectivizing influences of language, culture, ideology, expectations or assumptions" and therefore "the individual (is) a part of reality, rather than an ego dualistically separated from the world" (Rennie, 1999, p.6). "The entity is an entity "in itself" and independent of any apprehension of it; yet, the being of the entity is found in encounter and can be explained, made understandable, only from the phenomenal exhibition and interpretation of the structure of the encounter" (Heidegger, 1985, p.217). Thus, phenomenological research "involves a return to experience in order to obtain comprehensive descriptions that provide the basis for a reflective structural analysis that portrays the essence of the experience" (Van Kaam, 1966, p.295). Subsequently the role of the researcher is to determine "the underlying structures of an experience by interpreting the originally given descriptions of the situation in which the experience occurs" (Moustakas, 1994, p.13).

IPA's commitment to the exploration of depth, detail and personal experience, enable the provision of insight into the subject area that would potentially remain hidden if nomothetic approaches were used. However, focussing upon "the particular" may be viewed as significantly decreasing the applicability of the research to a wider social context and ultimately relegate the status of the research to that of catalyst, the spark that leads to the undertaking of "proper" research, complete with testable hypothesis and epistemologically valid revelations. Though the role of catalyst would not be entirely disastrous, it does call into question the overall efficacy of such approaches. To counter such arguments, it should be acknowledged that the lack of generalizability of IPA based research is offset by its ability to provide a deeper insight into the lives of the individuals than many other approaches. Smith (1999) emphasises, that in relation to IPA, "such research should be judged first and foremost on how illuminating it is of the particular cases studied and that the "micro" level theorising should be richly informative of those particular individuals and may be fairly modest in its claims at generalisation".

It is Warnock's 1987 revelation, emphasised by (Smith, 2004, p.41) that "delving deeper into the particular also takes us closer to the universal" that offers a plausible justification for idiographic based approaches such as IPA. Warnock and Smith emphasise that, by undertaking such studies, it is possible to reveal how "at the deepest level we share a great deal with a person whose personal circumstances in many ways seem entirely separate and different from our own" and that such insights "bring us closer to significant aspects of a shared humanity"

Given, among other things, the sensitive nature of exploring the lived experiences of social workers involved in cases of fatal child abuse, it would be naive to assume that my research could be based upon a large sample size. IPA's focus upon the quality and depth of analysis rather than the quest for large numbers is appealing at practical and epistemologically justifiable levels. The nature of the study defines the necessity for purposeful sampling (social workers who have been directly involved in case of fatal child abuse) A sample size of 4 interviewees will be suffice to identify the "similarities and difference between participants but not be (so) many that the researcher is in danger of being overwhelmed by the amount of data generated" (Lyons, 2007, p.40) and in addition "to find levels of analysis which enable patterns to emerge across case studies while still recognising the particularities of the individuals lives from which those patterns emerge" (Smith, 1999, p.413).

5.2 PHENOMENOLOGICAL EPOCHE, REFLEXIVITY AND BRACKETING

This section outlines the process involved in undertaking the required "shift" away from a natural attitude towards the research data in favour of adopting a phenomenological orientation towards viewing and analysing the lived experiences of those involved. Central to this process is the issue of "bracketing" which is also explained in detail.

In order to access and analyse the lived experiences of the individuals involved, Husserl advocated a shift away from our "natural attitude", a phenomenological reduction or *epoche' :*

> "in which we become onlookers. We contemplate the involvement we had with the world and with the things in it, and we contemplate the world in its human involvement. We are simply no longer participants in the world; we contemplate what it is to be a participant and its manifestations. But the intentionalities that we contemplate – the convictions, doubts, suspicions, certainties and perceptions that we examine and describe – are still our intentions. We have not lost them; we only contemplate them. They remain exactly where they are with the same correlations between intentions and objects still in force. In a very curious way, we suspend them all just as they are, we "freeze" them in place" (Sokolowski, 2008, p.48).

In order to compensate for the pre-imposition of their own views upon proceedings by the researcher during phenomenological research, IPA draws upon Husserlian phenomenological traditions which identify the need to "bracket" our pre-conceptions or foreknowledge, in order for the "true" form of the phenomena to be disclosed. This phenomenological reduction requires " a suspension of judgement as to the existence or nonexistence of the content of an experience...an attempt to place the common sense and scientific foreknowledge about a phenomenon within parentheses in order to arrive at an unprejudiced description of the essence of the phenomena" (Kvale, 2009, p.27).

IPA firmly locates the individual's perceptions of events and lived experiences as central to the research process but also emphasises the status of the researcher in

facilitating and analysing the nature of the lived experience. In acknowledging the potential difficulties associated with the suspension or "bracketing" of the researcher's own beliefs and assumptions, IPA advocates an active realignment of the researcher's attention. By temporarily holding foreknowledge in abeyance the researcher undertakes a conscious shift in focus, away from "the self" to the lived experience of "the other". This experience is eloquently captured by Jonathan Smith (Smith, 2009, p.35) who writes:

> "I start with where I am at one point on the (hermeneutic) circle, caught up in my concerns, influenced by my preconceptions, shaped by my experience and expertise. In moving from this position, I attempt to either bracket, or at least acknowledge my preconceptions, before I go round to an encounter with a research participant at the other side of the circle. Whatever my previous concerns or positions, I have moved from a point where I am the focus, to one where the participant is the focus as I attend to the participant's story, facilitate the participant uncovering his/her experience. This required intense attentiveness to and engagement with the participant as he/she speaks".

During the analysis of the interview transcripts it is essential for the researcher, whilst still recognising their foreknowledge and its potential influence upon the analytical process, seeks to identify emerging themes and recurring patterns within each individual account. Although clear areas of overlap between "themes" are inevitable,

for the purpose of this research they will be defined as "recurrent and distinctive features of participants' accounts, characterising particular perceptions and/or experience, which the researcher sees as relevant to the research question" (King, 2010, p.150).

In acknowledging the symbiotic relationship between the researcher and participant, IPA accepts that accessing lived experience "is both partial and complex, in other words, the analytic process cannot ever achieve a genuinely first person account – the account is always constructed by participant *and* researcher" (Larkin, 2006, p.104). At this stage of the process, the researcher's role becomes central. Extending beyond the role of facilitator/interviewer, attempts are made to produce a theoretical framework "which is based upon but which may transcend or exceed the participant's own terminology and conceptualizations" (Smith, 2004, p.39).

Such an approach:

> "views the knower and the known as fundamentally interrelated and thus assumes that any interpretation necessarily involves an essential circularity of understanding – a hermeneutic circle in which the interpreter's perspective and understanding initially shapes his (sic) interpretation of the given phenomena and yet that interpretation, as it interacts with the phenomena in question, is open to revision and elaboration as the perspective and understanding of the interpreter, including his biases and blind spots are revealed and evaluated" (Tappan, 1997, p.651).

Such analysis and interpretations are central to the production of good quality phenomenological research; they transform the data analysis beyond a merely descriptive endeavour and into a detailed interpretation of the lifeworld of the individuals involved. When attempting to access and subsequently analyse the lived experience of social workers involved in fatal child abuse, my aim is to the facilitate the disclosure of the world as experienced by the participants; to capture the emotions, attributed meanings and sense making processes that occurred before, during and after the tragedy occurred. From a phenomenological perspective it is essential, that my own opinions and pre-conceptions are disclosed and their potential impact upon all stages of the research process acknowledged. This was achieved by initially declaring my own pre-conceptions and motivations for undertaking the research in the introductory section of my thesis and monitoring my thoughts and feelings through the use of a reflective research journal. As Brocki and Wearden (2005, p.92) state:

> "A focus upon researcher characteristics may not necessarily benefit the reader's interpretations of an analysis and might even represent a misleading diversion. However, it would perhaps represent best practice for researchers to present appropriate reflections on their role in the dynamic process of analysis where this might be argued to have had a significant impact on the final narrative account presented and in the course of the research itself".

In addition to recording my feelings in a reflective journal and in order to enhance the period of "active engagement" with the data, as advocated by Smith (2009, p.82), I replayed each recorded interview several times prior to transcription. In order to become as fully immersed as possible in the lifeworld of the individuals who were interviewed, whenever possible, I replayed the recorded interview in the environment in which the original interview was conducted. For example, one interview, at the request of the participant, was undertaken in my car in a rather remote car park, and I returned to the car park to replay the recording. Another interview I replayed (through headphones) in the hotel where the original interview occurred. During the replaying of the interviews, I made a series of notes of my own immediate recollections: "shock", "empathy", "fear "and "burden" for example. My rationale for undertaking this process was an attempt to "bracket" as far as possible my own feelings about the interviews, to acknowledge and disclose my own emotions, reactions and opinions and in doing so reduce the impact of such factors upon my subsequent data analysis. I wanted the analysis of the lived experience to be focussed upon the individuals involved and not clouded by my own reactions to their situation.

The advantages of declaring prior assumptions and "bracketing" fore-knowledge, are central to the IPA research process, it is essential that a balance is achieved between, immersing oneself within the research data, identifying and empathising with aspects of the interviewees' experiences and allowing an over-identification to cloud the subsequent analysis of events.

> "Identification can potentially cause problems in analysis: an over-identification with an interviewee on the basis of shared or

analogous experiences may lead the analyst to force the data to conform to his/her experiences or a negative disidentification with the interviewee can make it difficult to empathize (or at least sympathize) with the interviewee and thus attain as sort of "insider" perspective on the research topic that IPA aspire to" (Storey, 2007, p.54).

5.3 DATA COLLECTION: INTERVIEWS AND INTERVIEW STRUCTURE

Although IPA allows a certain amount of flexibility in relation to data collection, for example using questionnaires or the analysis of participants' diaries, semi-structured, in-depth interviews still remain a central method of data collection (Smith, 2009). Interviews, in various forms, have a long established tradition within qualitative research and are described by Kvale (2009, p.53) as "the production site of knowledge" and the attempt to "gather descriptions of the lifeworld of the interviewee with the intention of interpreting the meaning of the described phenomena" (Kvale, 1994, p.149). Despite their prominent status within qualitative research, interviews as a research tool have faced extensive criticism from predominantly objectivist-positivist epistemological orientations and research perspectives. Such criticisms often focus upon the absence of "hard" scientific testability, a lack of objectivity and inter-subjectivity and the perceived, predominantly explorative, nature of research interviews, as opposed to the hypothesis testing focus of more quantitative research traditions. Such charges are firmly rebuffed by Kvale (1994, p.151) who highlights the naivety of such assumptions in his declaration that " an automatic rejection of qualitative research as unscientific reflects a specific limited conception of science, rather than the meaning

of science being the topic of continual clarification and discussion" and by Polkinghorne (1983, p.3) who attempts to expand the perceived methodological restraints of positivism by promoting the use of research interviews in emphasising that:

> "Science is not seen as an activity of following methodological recipes that yield acceptable results. Science becomes the creative search to understand better and it uses whatever approaches are responsive to the particular questions and subject matters addressed. Those methods are acceptable which produce results that convince the community that the new understanding is deeper, fuller and more useful than the previous understanding".

The proposed area of investigation clearly meets the criteria for undertaking research interviews advocated by King (1994). King emphasises that qualitative research interviews are most appropriate:

- Where a study focuses on the meaning of particular phenomena to the participants
- Where individual perceptions of processes within a social unit – such as a workgroup, department or whole organisation – are to be studied prospectively, using a series of interviews
- Where individual historic accounts are required of how a particular phenomenon developed. (King, 1009.p.16)

Semi-structured interviews within IPA, are described by Marshall and Rossman (1995, p.82) as "a specific type of in-depth interview grounded in the theoretical tradition of phenomenology" which are designed to create an environment within which "the participants' descriptions can be explored, illuminated and gently probed" (Kvale, 1996). Through the use of such techniques as; open ended questioning, requests for clarification, prompts for examples, active listening and reflection, followed by the bracketed analysis of interview content, access to the lifeworld of the interviews is obtained and depth of interview is achieved.

The chosen format of questioning is constructed in order access the lived experiences of the workers in relation to several areas. Although there are elements of overlap between each area they broadly relate to: i) The social worker's perceptions of their relationships *with* and the assessments *of* the children and families involved in the study; ii) The feelings and emotions associated with hearing about the children's deaths and how events impacted upon the workers in both long and short term and personal and professional contexts; iii) The social workers' perceptions of the support and supervision they and their colleagues received post event; and iv) The social workers' experiences of participating in a review or inquiries into the children's deaths. These areas have been selected as, in keeping with the stated aims of the research, they attempt to provide a detailed, holistic insight into the workers' experiences and they address long and short term, personal and practice issues involved. It is envisaged that addressing such topics will subsequently inform several areas of social work practice. Such an aim is directly in keeping with the ethos of professional doctorates which stress "the importance of a connection with practice

through a research topic" (Lee, 2000) and also an "emphasis on developing professional knowledge but also [a] focus on developing practice" (Fenge, 2009, p.169).

The interview questions are designed to provide a detailed and as far as possible, sequential narrative of the lived experiences of the social workers involved in the fatalities. It is important to acknowledge however, that the recollections of the interviewees cannot be easily partitioned into distinct categories and there exists some areas of overlap between each section. It is must also be recognized that it is beyond the scope of this study (and perhaps any study) to capture *all* of the experiences involved and it is also possible that other researchers may chose different areas of focus and subsequently arrive at different conclusions following an analysis of the data.

In order to aid both the understanding of events and analysis, I decided to "start at the beginning" and discuss the social worker's initial interactions with the children and families involved in the study. Due to the potentially sensitive areas that are addressed during the interviews, I also consciously chose not to begin by directly questioning the interviewees about the child's death. Although the opening question is directly relevant to the study, it may be less emotionally difficult for the interviewees to address and may be used to establish a rapport before progressing to more challenging questions. I was also aware that as the interviews focused more and more on the events surrounding the children's deaths there was a need to redirect questioning at the end of the interview to more general areas. As a result the final interview question is an "open" question allowing the interviewees to discuss issues

of their choosing. It is envisaged that this will reduce the possibility of the interview concluding at a highly emotional stage.

The questioning begins by examining the social worker's initial perceptions of their work with the child and their family and their understanding of the reason/s why the family were referred to social services. This question is designed to explore the social worker's perceptions of the experience of working with the family and the events leading up to the child's death and then narrows the focus towards the discovery and immediate responses to the death. The questions then focus upon the interviewees and significant other responses to the tragedy, before moving to explore areas of support and supervision provided to the social worker. After discussing the perceptions of the investigatory processes involved, the interview concludes with an exploration of the perceived impact upon the social work both at a personal and professional/practice level. An opportunity is provided at the end of the interview to add any observations the social worker may have that have not been covered in the interview. Several prompts have been added to the questions in an attempt to add depth and explore the issues further.

Questions

1. **Could you tell me about your initial involvement with the family?**

Why do you think it was referred to your organisation? Was it family support or Child Protection?

2. **Could you say something about your relationship with individual family members before the child's death?** *Positives/negatives*
3. **What were your perceptions of the events leading up to the child's death?**

Did anything change? Within the family? You? Your organisation?

4. **Could you tell me about how and when you heard the child had died?**

How did you find out? Who told you? What did you do?

5. **Could you describe in as much detail as possible, your feelings when you heard the child had died?** *How exactly did you feel?*
6. **How would you describe your life experience in the days and weeks after the event?**

What did you do? Contact/support from others – colleagues/work/family/friends/media?

7. **How do you think other people, for example colleagues and your own family members reacted towards you after then event?**

Positives/negatives/support?

8. **Please tell me about your experience of the work based supervision you received after the incident**

Did supervision change, content/focus? What happened to other cases you were allocated? Did anything/one help with the situation?

9. **Were you offered any support or counselling following the incident?**

Who from? Did you access this? What were your perceptions of this? What worked/didn't work?

10. **Were any investigations or reviews carried out?**

Could you describe to me what this experience was like? What, if anything, would you change about this process?

11. **Do you feel that your social work practice has changed since the event and if so how?**

Examples? Positives? Negatives?

12. Do you think the experience changed you as a person and if so how?

If "yes" how? Provide examples?

13. Is there anything else you would like to add or tell me about?

5.5 RECRUITMENT

The research study involves semi-structured interviews with four social workers who have been directly involved in case of fatal child abuse. Interviewees were required to be qualified social workers (those holding a recognised social work qualification CQSW, Dip SW, B.A Social Work, M.A Social Work), who were practising social workers in the UK at the time of the child's death. In order to encapsulate the entire lived experience of the social workers involved, interviewees were required to have been working as the worker or co-worker with the child and their family, before, during and after the child's death. In order to obtain insight into the long and short term impact of the child's death upon social workers, no restrictions were placed on the timing of involvement with the child and family, or on the time that had passed since the child's death.

Although the child death review process and the lived experience of the social workers involved within the process are discussed during the interview, it was deemed not to be essential that all of the social workers who were recruited were involved in a review. Not all cases of fatal child abuse are subjected to review and potentially significant amounts of valuable information may be lost by the imposition of such criteria.

5.6 CONFIDENTIALITY AND ANNONYMITY.

Pseudonyms for interviewees and individuals mentioned during interviews are used during the interview, data analysis and publication stages of the research. Pseudonyms for interviewees were agreed between the participant and interviewer upon completion of the written consent form and prior to the undertaking of interviews. Pseudonyms for individuals, e.g. children or family members are provided by the researcher. No local authorities, service providers or specific agencies are identified within the research. All references were removed during the interview transcription process and where applicable alternative names are provided.

5.7 GEOGRAPHIC AREA

Local authorities were identified as the mechanism by which to approach volunteers to undertake the research interviews. Although as a result of undertaking the research on a part-time basis, it would be practical to approach local authorities who were geographically closest to Sheffield, I was concerned that in doing so I would obtain only a local perspective of events and also more importantly, increase the likelihood of either the social workers or the children themselves being identified. With this in mind, I chose which authorities to approach by placing the names of towns and cities throughout England in a bag and drew them out one by one. I then obtained the contact details of the chosen LSCB via a Google search and both telephoned and emailed the identified contact person.

A small number of the local authorities approached required research approval protocols to be completed as part of the research application process. The protocols consisted of pro-forma documents that required information concerning the aims,

objectives and ethical considerations of the research. Where relevant these were provided to each authority. Where no protocols existed, alternative methods of recruitment were attempted. Primarily due to the sensitive nature of the research, it was deemed inappropriate to attempt to contact social workers directly; therefore designated LSCB managers and development officers who were identified via LSCB websites were contacted and the aims of the research were verbally conveyed before permission was requested to send additional information via e-mail or hard copy to the local authorities involved. Following the discussions with LSCB officers, information sheets, participant information sheets and the written aims and objectives of the research (See Appendix one) were provided via e-mail or conventional postage. The named LSCB officers were then requested to distribute the research information to any social work practitioners whom they felt would meet the recruitment criteria.

An additional attempt to recruit participants was made via Community Care magazine (www.communitycare.co.uk) a national online magazine and discussion forum for social care professionals. Requests for research volunteers were placed on their "professional forums" page. All potential volunteers were provided via e-mail with the same information as that given to LSCB Officers and volunteers recruited via direct approached to LSCBs.

5.8 DURATION, TIMING, ENVIRONMENT AND RECORDING OF INTERVIEWS

A total of four interviews were undertaken, each lasted approximately 1 hour. In total the transcribed interviews generated a total of 26, 000 words. All interviews were conducted and transcribed by the researcher. In order to avoid any excessive emotional discomfort to interviewees, all were notified in advance both orally and via a written participant information sheet (see appendix one) of their right to terminate or seek "time-out" from the interview at anytime. All participants were allowed to choose a venue and timing of the interview. Additionally, all participants were offered the opportunity to undertake the interviews at Sheffield Hallam University in a private room provided by the researcher. All participants were required to sign the participant information sheet, acknowledging that they had fully understood the aims and objectives of the research and that they fully consented to the research interview being used under the terms stated by the researcher.

The interviews were recorded using the "QuickVoice" application for the Apple ipad and Casio digital voice recorder. All recordings and the subsequent transcripts were stored on a password protected computer and ipad. All transcribed interviews were stored in a locked cabinet accessible only to the researcher. Following transcription and analysis all recordings were erased.

6. ANALYTICAL METHOD

The following section outlines the processes involved in transcribing and analysing the research interviews. IPA recommends that the researcher seeks to become deeply immersed in the research data with the aim of producing a detailed account of the themes that may emerge. The section describes how this is achieved as well as providing an overview of the steps taken to enhance the validity of the analytical and interpretative processes involved.

6.1 Validity

In order to enhance the "validity" and overall quality of the research report, the completed data analysis sheets, the analysed narrative accounts and the theoretical discussion sections of the research were given to two social work academics who were also qualified social workers and who had extensive experience both in research and children and families social work. Neither of the academics had any prior involvement in any aspects of the research. Both academics were provided with written information regarding the overall aims and objectives of the research and asked to comment on whether the conclusions drawn from the data analysis were credible and had been extracted through a clear and logical process. It is essential to note at this stage that the objective of such an exercise is not to make or enhance claims that the research represents the absolute and only "truth", however it serves as a mechanism to "ensure that the account produced is a credible one, not that it is the only credible one...and that the concern therefore is how systematically and transparently this particular account has been produced" (Smith, 2009, p.183).

6.2 Transcribing, Immersion and Initial Noting

In order to immerse myself in the research I personally undertook the task of transcribing each interview. At this stage no attempts were made to analyse the data. Following transcription, all of the transcripts were subjected to hermeneutic analysis, "the art of reading a text so that the intention and meaning behind appearances are fully understood" (Dilthey, 1976, p.182). Such approaches "view the knower and the knowing a fundamentally interrelated, and thus assume that any interpretation necessarily involves an essential circularity of understanding – a hermeneutic circle in which the interpreter's perspective and understanding initially shapes his (sic) interpretation of a given phenomenon in question, and yet that interpretation, as it interacts with the phenomenon in question, is open to revision and elaboration, as the interpreter, including his biases and blind spots, are revealed and evaluated" (Tappan, 1997, p.651). The hermeneutic cycle is consistent with IPA's approach to familiarisation and immersion within the text and the view that "the closer one is to the source of the text the more valid one's interpretation is likely to be" (Robson, 2002, p. 197). In order to access and interpret the lived experiences of the interviewees, a process of reflective interpretation was undertaken. This process includes not only "a description of the experiences as it appears in consciousness but also an analysis and astute interpretation of the underlying conditions, historically and aesthetically, that account for the experience (Mostakas, 1994, p.10).

I began the process of analysis by transferring the original transcriptions of each interview onto a data analysis sheet. This sheet consisted of an A3 "Word" document set in "Landscape" format and divided into three sections. The original, unedited interview transcript was placed in the middle column and the left hand column was

given the heading "Exploratory Comments". This section was designed for undertaking the process of " Initial Noting", this serves to "examine content and language used on a very exploratory level (where) the analyst maintains an open mind and notes anything of interest within the transcript" and to "produce a comprehensive and detailed set of notes and comments" (Smith, 2009, p.83). During this stage I recorded any aspects of the interview that appeared to be particularly interesting, for example, descriptive comments, emotional responses, the use of metaphors and acronyms. To enhance the quality of this stage, I replayed each interview whilst reading a hard copy of the transcript and recorded any pauses, repetition, laughter and any particular changes to the interviewees' tone of voice. This process was repeated several times for each interview and resulted in the formulation of a comprehensive set of "notes" that were based on the interview data.

As has been previously stated a central aim of the research project is to analyse the lived experiences of social workers who have been directly involved in cases of fatal child abuse. In order to achieve this aim I chose to address a total of four interrelated areas, addressing both personal involvement and social work practice. These areas consist of:

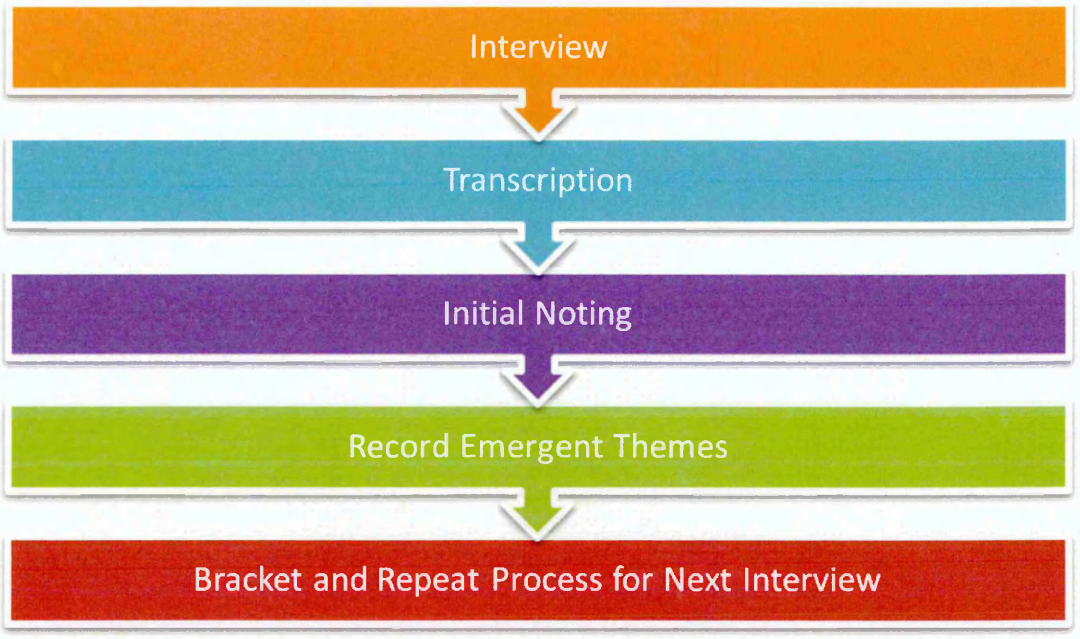
- The social workers' perceptions of their relationships with and the assessments of the children and families involved.
- The feelings and emotions associated with hearing about the children's deaths and how events impacted upon the workers in both long and short term and personal and professional contexts.

- The social workers' perceptions of the support and supervision they and their colleagues received post event
- The experiences of participating in a review or inquiries into the deaths.

Using the notes and transcribed interviews as data, the analysis progressed into establishing "emergent themes" within each category and each interview as a whole. Emergent themes consist of recurring thoughts, images, feelings, metaphors or statements made by the interviewee. Each emergent theme was highlighted in the interview transcription by using a different coloured highlighter pen for each theme. Each emergent theme was allocated a label, for example: loss, impact on self, professional identity, impact and anger. All of these labels were recorded in the right hand column of the data analysis sheet. The allocation of labels and colour coding enabled the visual identification of recurring themes; this facilitated the emergence of a collective of themes within each category known as super-ordinate themes. This collection of themes consists of grouping together emergent themes under a broader heading, for example: anger, loss, humiliation, which would be grouped under "Emotional Responses to the Child's Death".

Each interview and category was analysed individually and this process was then repeated for all four interviews. This is in keeping with IPA's idiographic approach. During this phase of analysis it is of paramount importance that foreknowledge of any preceding analysis is, as far as possible, "bracketed", in order to allow any themes particular to each individual case to emerge.

Fig. 2. The Analytical Process

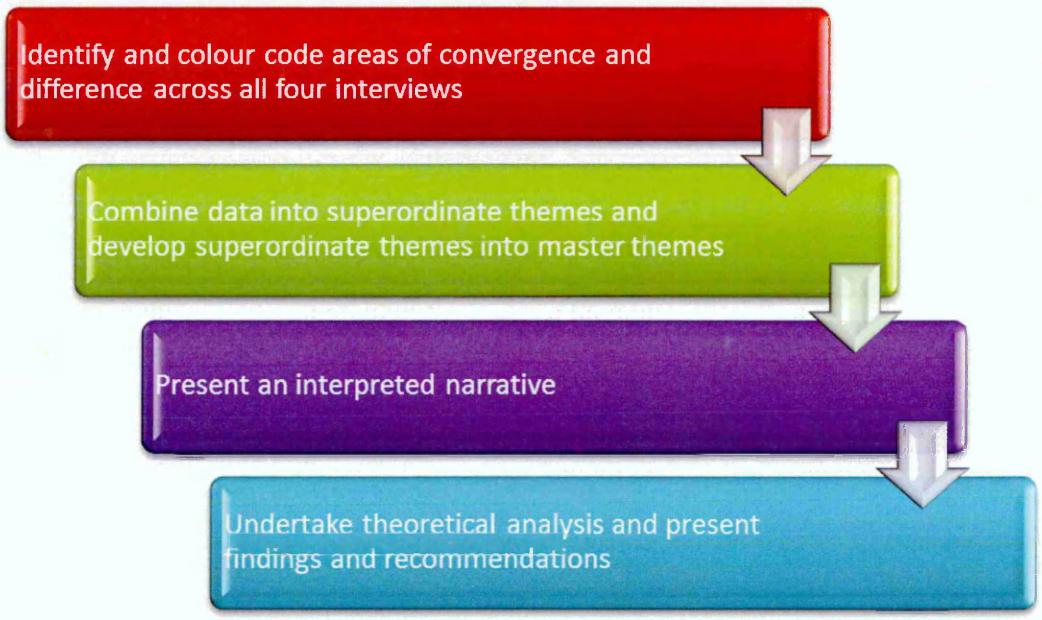


Upon completion of the analysis of each individual case the four cases were revisited collectively in order to identify areas of connectedness, convergence and polarization between each of them. Aided by the colour coding, any connections and similarities between themes and/or super-ordinate themes were abstracted from the main text and grouped together under a master table of connected themes. This task is highlighted by Smith (2009) as being an important step in the IPA process as it serves to

> "Help the analysis to move to a more theoretical level as one recognises, for example, that themes or superordinate themes which are particular to an individual case also represent instances of higher order concepts which the cases therefore share. Some of the best IPA has this quality, pointing out ways

in which participants represent unique idiosyncratic instances but also shared higher order qualities" (Smith, 2009, p.101)

Fig. 3 Analysis Across interviews



6.3 Presentation of Data.

The presentation of the analysis begins with an overview of the social workers and the cases that are referred to in the study. This section is deliberately brief and broad in nature and is included only to establish a context to some of the quotes and practice issues that were discussed during the interviews. As the study is designed to primarily focus upon the lived experiences of the social work practitioners involved and not the cases themselves, it is of little value and potentially detrimental to the focus of the study to provide extensive details relating to either the children,

practitioners or the local authorities involved. In addition, in order to safeguard the anonymity of all parties involved no reference is made in this section to the geographic location of the practice, specific agencies, individuals or services. All specific date references have also been omitted.

In order to aid understanding the emergent superordinate and master themes are initially presented in tabular form. There then follows a presentation of the research data which has been extracted from the analysis of each of the "raw" transcripts. In order to ensure that the voices of the participants are heard, this section is substantiated by direct quotes from each of the participants. During this section the researcher's own interpretation is applied to the process. Smith describes this as the "interweaving of analytical commentary and raw extracts" (Smith, 2009, p.110) that aims to provide a clear account of the lived experiences of the individuals involved. The result of such an endeavour is a comprehensive insight into events and in particular, the participant's perceptions and the researcher's interpretations of them. Following the commentary and analysis of each emergent theme, a summary of the key themes and issues is provided. In order to place the study within a wider theoretical context a detailed discussion takes place during which a number of different research informed perspectives are utilised in order to aid the interpretative process. Throughout this section the outcomes of the analysis are related to existing theories and literature already mentioned in the literature review but also any unanticipated theoretical concepts that may have arisen. The penultimate section of the study contains a detailed discussion of the research findings and makes a number of recommendations in relation to any potential areas for practice development or future research. The concluding section of the project consists of a reflective account

and critical evaluation of the entire research. This section will centre upon the learning gained from undertaking an IPA based study, its strengths, limitations and potential areas for development.

7. THE SOCIAL WORKERS, THE CHILDREN AND THEIR FAMILIES.

The following section provides a brief description of the social workers, children and families involved in the study. The section concludes with a brief vignette outlining the cases involved.

7.1 The Social workers:

- All of the social workers who were interviewed were white females who were working in statutory social work teams in England at the time of the child's death.
- All of the social workers were experienced workers with levels of social work experience ranging from 4 to 15 years.
- Three of the social workers who were interviewed were working in statutory children and families' referral and assessment or duty teams and one social worker was working in a generic neighbourhood team, with child protection responsibilities, at the time of the child's death.
- Three of the social workers involved first came into contact with the children and their families via duty visits, before adopting case responsibility, the remaining case was allocated via case load allocation.
- All of the social workers are still employed in social work related professions. Two of the workers are now in social work management positions and two are practising in none child protection social work roles.

7.2 The Children and their Families

- A total of five child deaths are referred to in the study (one social worker (Beth) had been directly involved in two fatalities).
- The ages of the children whose deaths were discussed ranged from 3 months to seventeen years of age.
- Four of the children died as a result of physical assault and one child died as a result of hyperthermia, although substance misuse was a contributing factor.
- The four children who died as a result of physical assault were assaulted by known care givers.
- All of the families of the children who died had experienced previous social work involvement in relation to their siblings, prior to the child's death. The families were known to social services as a result of incidents relating to neglect, extra-familial sexual abuse, substance misuse and domestic abuse.

7.3 Case Overviews

Anna

Four years ago Anna was the co-worker for a new-born female named Rebecca. The case was originally allocated to Anna due to concerns relating to maternal drug misuse during pregnancy. Following a s47 investigation, further concerns were highlighted in relation to on-going domestic abuse. As a result of those concerns and recognition by the mother of the impact of her drug taking upon Rebecca, she was voluntarily place into care.

Despite Anna and her co-worker expressing concerns to their managers about the quality of care that was being provided, Rebecca remained in the placement. She

died at the age of three months as a result of a physical assault whilst under the supervision of her new carers.

After Rebecca's death Anna continued to work with the family, she was involved in escorting the birth mother to view her daughters' body and assisting with funeral arrangements.

Beth

Kieran died ten years ago as a result of hypothermia. He was 17 years old. On the day of his death he had visited his local social work office and was interviewed by the Duty Officer who gave him £20 with which to buy food. Instead of buying food, Kieran purchased a small amount of drugs and the SCR revealed that this may have been a contributing factor in his death.

Beth had been Kieran's social worker during the year immediately prior to his death due to concerns relating to neglect and physical abuse by his birth parents who had an extensive history of social work involvement. Throughout her involvement with the family, Beth had persistently yet unsuccessfully argued for higher levels of support and protection to be provided for Kieran.

In addition to her work with Kieran, two years ago Beth conducted a duty visit to assess the safety of a six month old child whose mother was suspected of having contact with a violent ex-partner. After Beth's' assessment the case was allocated to a newly qualified social worker. Shortly after the social worker's first visit, the child was admitted to the local Accident and Emergency Department with serious

non-accidental injuries from which he later died. Beth attended the A and E Department and also supported the newly qualified worker throughout the review process.

Claire

Claire was the social worker for Sarah, a 6 month old child who was killed 13 years ago. Claire visited the family following concerns relating to the possible sexual abuse of Sarah's older sibling. During the visit Claire noticed what appeared to be burn marks on the soles of Sarah's feet and arranged for her to be physically examined by a paediatrician. The result of the medical examination concluded that the injuries were not suspicious and Sarah was returned to her mothers' care. She died as a result of a physical assault by the mothers' partner one month later. After her first visit to the family, Claire unsuccessfully attempted to seek a Place of Safety Order for Sarah and also presented evidence gathered from neighbours supporting her view that there were serious concerns about her safety. These concerns were not acted upon by any of the agencies involved.

Donna

Donna was the social worker who had the most recent experience of fatal child abuse. In 2012 she was involved in a duty visit assessing a family who had recently moved into the area. The family had a long history of domestic abuse; however the perpetrator of the abuse no longer had any contact with the family.

Concerns had recently been expressed by an ex-partner that the mother of the three children in the family was leaving them alone and without appropriate supervision.

The assessment of the family revealed no safeguarding concerns, however the children's mother failed to disclose that she had entered into a new relationship with a local man. Although any assessment of the new partner would have revealed that there was no indication that he posed a risk to the family, he physically assaulted and killed the youngest child who was aged 18 months.

8. DATA ANALYSIS.

The data analysis sheet below summarises the master and superordinate themes that emerged following the hermeneutic analysis of all the available data. Examples of quotes from the interviews have been added in order to directly link the themes to the experiences of the workers involved.

Fig.4 Table of themes

CATEGORY 1. Initial involvement, assessments and relationships with the children and families involved in the study. **MASTER THEME: Voices unheard.** **SUPERORDINATE THEMES:** • **Relationships** • **Decisions made but the doubt remains** • **Listen to me**	**SUPPORTING NARRATIVE:** **Relationships:** *She was a really nice mum as well and a really nice person and the children were lovely and they played lovely, I can still visualise them* **Decisions made:** *I did a good assessment and I do think I did a good assessment but I still wish I could have done something that could have stopped what happened. Like anybody would do somebody that perhaps saw a road traffic accident happening in front of them might have thought, if I had done something I might have...that's human nature* **The doubt remains:** *You were the last person who made any assessment of that family set up. Straight away you think what did I miss, did I miss something, did I ask because you can't look at the assessment as soon as the child dies that system is locked down"* **Listen to me**: *It really hit me hard; it really hit me hard because I tried so hard to get somebody to listen to me and they just wouldn't. He needed the support they acknowledged that, and they acknowledged that afterwards*
CATEGORY 2. The feelings and emotions associated with hearing about the children's deaths and how events impacted upon the workers in both long and short term and personal and professional contexts	**SUPPORTING NARRATIVE:** **Breaking the News:** *I got a phone call from my manager to say I just thought I would let you know before you come into work tomorrow that Sarah is dead. Basically, mother's partner had smashed*

MASTER THEME 2: The Pain of Knowing **SUPERORDINATE THEMES:** • **Breaking the news** • **What about me?** • **After all this time,**	*the baby against the wall and his skull was broken...and that's the circumstances of it.* **What about me?:** *You know it's a shame I wasn't a drinker, I didn't know what to do, didn't know where to go, I didn't want to go home, I didn't want to "put on" my colleagues anymore. I just took the dog for an incredibly long walk and cried for a long time?* ***After all this time I think about him:*** *I became the worker I am today because of Kieran but not through the support I got or the guidance from social services. I got it from the lessons learned, the things that wasn't done that should have been done and I am the worker I am today through no one else but my own practice because I make sure that I am listened to and I also make sure which is the way I started my career I always make sure I know my family. I ask the questions and I'm not afraid to challenge a family or individuals* **Rebecca:** *I cannot hear the name Rebecca, I cannot hear it, and this sounds bonkers. It sounds bonkers, there was something that happened on the news and they said her name I went cold, I went ohhh. We are talking 4 years later; I heard it on TV and..."* (long pause, silence, time out)
CATEGORY 3. The experiences of participating in individual management reviews or inquiries into the children's deaths. **MASTER THEME: THE BLAME GAME**	**SUPPORTING NARRATIVE:** **The cover up:** *Fascinating how the local authority became a self -protecting tool to look after itself.* **Resentment and anger:** *Blame culture in an LA is alive and well and thrives like the cockroach.* **The wrong questions, the wrong answers:** *We had a briefing err with*

SUPERORDINATE THEMES: • **The cover up** • **Resentment and anger** • **The wrong questions, the wrong answers** • **A glimmer of hope** • **The blame game**	*directorate that was around pretty much telling me what I could and could not say...the brief was about the corporate response not the emotional content...When there was the SCR, the questions were closed questions. This I found profound, I was angry, angry, angry, angry.* **A glimmer of hope:** *I thought it was very much a learning experience...at no point did I feel like there were questioning me like I had done something wrong. I felt it was very supportive. I really felt supported; I developed a really good relationship with the strategic manager over that, even when I left she sent me an e-mail saying "please doesn't go"* **The blame game:** *My last LA they were more interested in the blame and how to not be highlighted as a failing authority that should have done something"*
CATEGORY 4. The social workers perceptions of the support and supervision they and their colleagues received post event. **MASTER THEME: No Further Action** **SUPERORDINATE THEMES:** • **No Further Action** • **Peer support** • **Empathic understanding** • **Team dynamics**	**SUPPORTING NARRATIVE:** **Peer support, Empathic understanding, Team dynamics:** *We had a staff meeting in our team, to support the SW who was ripped apart, ripped apart, and err I think we got closer as a team, around it* **No Further Action:** *I can remember it, as well what my manager said, we were going through the cases, we got to Kieran and he said well this one we can NFA (No Further Action), get admin to put the closing date on the system.*

8.1 Master Themes and Rationale

Analysis of the research interviews resulted in the emergence of four master themes (see figure 4). The master themes are developed from the clustering of superordinate themes present within each interview. These themes are presented in the form of a

narrative, consisting of direct quotes from the research interviews and additional notes from the researcher, designed to aid clarity and understanding. During this section the experiences of the social workers involved in the study are interpreted. At the end of the presentation of master themes and their interpretation there follows a summary of the issues raised.

As far as possible, the narratives have been presented in their unedited form, however, in order to improve readability, some utterances and repetitions of statements and words have been removed. Sections of the transcript that have been removed are marked with "..." and in some instances, additional information designed to clarify individuals or events have been added in brackets.

The order of the presentation of the master themes is designed to capture, as far as possible the sequential process of events; as a result, there exists some overlap of subject matter between each of the themes.

At this stage, in keeping with the essentially interpretative nature of phenomenological research, the analysis consists entirely of the researcher's own interpretation of the participants' accounts. As has previously been stated, in order to add validity and rigour to the research process this section of the report has been shared with two social work academics who were asked to comment on whether the conclusions drawn from the analysis were credible and had been extracted through a clear and logical process.

8.2 Master Theme One; Voices Unheard.

The interviewees recalled very different experiences when working with the children and their families prior to the child's death. Their stories reveal many of the complexities and uncertainties involved in child protection social work practice, particularly around the areas of risk assessment. These issues are closely linked to the theme of assertiveness, which is explored in detail later in the narrative. At the start of their accounts Beth, Anna and Donna, describe their relationships with and their perceptions of the families involved.

Beth maintained a close and on-going relationship with Kieran, a 17 year old boy who had a history of familial physical abuse and neglect. Here she describes her relationship:

"He used to start talking, we did have a very good relationship and I think that is because I listened. I took the time, and you know, there wasn't a lot of time but I took the time"

Such was the nature and frequency of the meetings between Beth and Kieran that as his social worker Beth was able to notice the gradual deterioration in his mental and physical health:

He'd come in every now and again I'd make him a cup of tea, quite a lot of contact with him. I did see him, his mental health was really, sort of going down, he just wasn't himself and every time he'd come in he looked more and more dishevelled he looked more just, like he'd given up. You know, to me this was kind of all adding to the facts and raising my concern that we needed to do something.

Beth describes how agency concerns about the safety of her teenage client Kieran, dissipated following extensive, historical involvement with social services. Beth believes that perceptions of Kieran's needs became fixed in the belief that Kieran was a "child in need", potentially minimising the risks to his safety and ultimately his need for protection:

"It was child protection initially, because of the family breakdown and everything else, and then it went completely dysfunctional and completely, you know, he being one that was subject to plans and then not subject to plans, so it was one of those revolving door ones... It was kind of like, I don't know...a repeating pattern really right from when he was sort of like 11, 12, 13 and it just seemed to be deja vous all the time. Parents didn't engage so it kind of dwindled on and on and on"

During this section of her account, Beth repeatedly states her opinion that Kieran's situation was typified by a consistent lack of urgency by social services towards his needs. Her use of metaphors and descriptors such as: repeating pattern, revolving door, deja vous, on and on and on, create an image of the case of a vulnerable young person being allowed to "drift" without any decisive action being taken. An interesting aspect of Beth's account is that Kieran's "visibility" and regular contact with different agencies appeared to reduce, rather than exacerbate the level of anxiety for everyone involved apart from Beth. Through actively listening, developing relationships and by holding a detailed knowledge of Kieran's familial history, Beth was able to observe the decline in many aspects of Kieran's personal and social presentation.

Anna who had an on-going relationship with a substitute carer who later killed a child in her care describes her experience:

"We were picking up these concerns about this woman, she seemed quite brittle, babies were fed, they were well dressed... but...not a great deal of warmth I thought, not a nurturing mum, I'm not happy, she comes across as cold and steely and I asked for another placement for my baby. I was told "no".

Later in the interview:

This mum never smiled, she never smiled. That's one of the things I said to fostering, she has not got a smile in her that woman"

The metaphors and descriptors used by Anna in relation to the carer involved in the case are particularly interesting. Her use of terms such as *brittle, cold and steely, lacking warmth, never smiled,* emphasise how Anna perceived the personal characteristics of the carer as being the opposite of many of the attributes associated with a positive and nurturing parent/carer relationship. Her concerns were such that on several occasions she actively sought alternative care.

Anna's commitment to a child centred approach to her work and her feelings towards Rebecca are evidenced by the fact that throughout the interview she refers to Rebecca as "my child" or "my baby":

"She's too much on I want my baby to have... "

"She was not right for my child"

"If you are poorly resourced that is not my problem, and it's not going to be my babies' problem"

These terms are used when referring both to the care provided for Rebecca and also in relation to attempting to secure services for her.

Anna's approach allowed her to remain undeterred by the fact that on the surface everything within the family home appeared satisfactory. However, Anna believed that despite her personal anxiety regarding the quality of the care provided to Rebecca, the fact that family's house was clean and well-furnished distracted some professionals from acting on the concerns that were expressed.

"They might have got a John Lewis carpet but do they cuddle the child?"

"The Health Visitor had been going and because this was a family, a middle class family, who lived in a nice big house err I don't think there had been the scrutiny there needed to be"

"It was all about the house being lovely. The quality of life for this child could be afforded; the quality of life had been vile. This was a shiny middle class family."

The issue of social class is clearly evident within Anna's account. There are a number of examples during the interview where according to Anna, the perceptions by some professionals of the family being "middle class", served to reduce their concerns about their child care provision and reduce the amount of scrutiny the family were subjected to. Such a revelation raises a number of issues relating to not only the assessment, and communication processes regarding the family but also the value base and preconceptions of some of the individuals and agencies who were also involved.

In relation to the experiences of both Anna and Beth, it is possible that in addition to a "professional" child focussed outlook to their work, at a personal level, they projected their own maternal feelings and instincts upon the situation. Such a level of

emotional closeness, may partially explain the enormous sense of loss described by Anna and Beth following the children's deaths.

Anna and Beth both describe on-going concerns and display a strong sense of commitment towards safeguarding the children they were working with. When their cases are viewed retrospectively there are a number of instances where decisive action should have been taken. However, in relation to the experiences of Donna, there appeared no clear indications of risk and significant evidence that the family involved were intent on making a new, positive start together.

Donna's account illuminates the often unpredictable nature of "front line" child protection social work. Her descriptions highlight the likelihood that not all child deaths are preventable and that blame for the deaths cannot always be attributed to individual, professional or agency failures. Donna recalls how her initial involvement with the child who died involved a positive assessment of her family who had recently relocated into the area. The family had been experiencing severe and persistent domestic abuse. The perpetrator of the domestic abuse no longer had contact with the family and the care provided by the mother was now deemed to be of a good standard:

"She was a really nice mum as well and a really nice person and the children were lovely and they played lovely, I can still visualise them, I was there for an hour and a half, just an hour and half but I can still see them now"

Although Donna spent only a short period of time with the family her interaction clearly left a lasting impact upon her. This idealised image of the family held by

Donna clearly conflicted with the reality that the youngest child in the family would be murdered by the mother's new partner only a few weeks after her visit.

Donna describes how, unbeknown to social services, the mother had developed a new relationship with a male partner who had no previous criminal history and was not known to pose any risks to children. Shortly after starting the relationship he attacked and killed the youngest child in the family. In the first section below Donna, describes how she shared the positive feelings with the mother regarding her progress and the impact upon all concerned when the mother's trust in her new partner was found to be misplaced. In a later section of the interview, when discussing the same assessment, Donna revisits the issue of trust. Although any "official" checks would have revealed that there were no concerns about the mother's new partner, the fact that she did not disclose the relationship to Donna is also seen as a betrayal of trust within the social worker – client relationship.

I felt quite proud of her achievements and to feel that's the worrying thing for me that you can come out of assessing a family and feel that someone's really progressed in the way they can discuss the impact of things and discuss their progress and their thoughts for the future and then within a matter of weeks somebody that they feel they could trust, I believe that she did feel trust based on what she moved from, could then do something so tragic.

But I think I trusted them in a way that I got the stage where I had to say I could not have done anything else on that visit and actually, I did a good assessment and I do think I did a good assessment but I still wish I could have done something that could have stopped what happened. Like anybody would do somebody that perhaps saw a

road traffic accident happening in front of them might have thought, if I had done something I might have... that's human nature"

Throughout her account of the events surrounding the child's death, Donna frequently refers to her assessment of the family situation, she constantly searches for any omissions in her own assessment that may have prevented the tragedy happening. The significance of the "trust" issue is central to Donna's belief that even though she was totally exonerated of any blame she still feels that if the new relationship had been disclosed the outcomes may have been significantly different. Donna appears to empathise with the mother involved and in doing so internalise her later feelings of betrayal. In addition, Donna experiences her own sense of betrayal in the fact that the mother failed to disclose her new relationship. During the second part of her account Donna compares her situation to a bystander viewing a road traffic accident; this encapsulates her overriding feelings of being unable to influence events but personally searching for ways in which they may have prevented the tragedy happening.

Throughout her interview Donna spoke of her long standing frustration at being unable to identify any risks posed to the children within the family. Ironically, she recounts how the lack of a specific incident or area of concern and being exonerated of any blame *increased* her personal feelings of frustration and anxiety. Donna perceived that both for her own wellbeing and for her future practice, that however initially traumatic, the identification of an error in her judgement or an omission in her assessment would enable her to "move on" and end her on-going search for closure:

In some ways and this is going to sound really bizarre, I think I wanted to be responsible because a child had died and I felt like I needed to take some responsibility err I was making myself find responsibility I think... It was a bit weird and it is still a bit weird. Thinking I must have done something, I needed to find something that I didn't do right because surely we should be able to stop these things from happening

The account below graphically portrays the inner turmoil that Donna continues to experience.

"The outcome was that it could not have been avoided but you still think, if I had asked that question...could it have been? And I don't think I could ever know the answer"

She continues:

"Until I had beaten myself black and blue I could not go in (to work) *I could not do that. This was something that was for me and I felt so guilty about what had happened. You were the last person who made any assessment of that family set up. Straight away you think what did I miss, did I miss something? Did I ask? Because you can't look at the assessment as soon as the child dies that system is locked down"*

The sense of isolation and the issue of "locking down" case files will be addressed within master theme two and also in the discussion of research findings section of this study. Donna's feelings of being in some way personally responsible for the children's deaths are reflected in all of the interviewee's accounts. Despite consistently calling for protective measures to be taken in relation to the child, Anna still expresses her opinion that she was in some way responsible for Rebecca's death;

her revelations contrast sharply with her perceptions of other agencies responses who she perceived as being unwilling to accept that they too may have also been partly responsible :

"Everybody shot into "I'm not to blame". I think me and the (other) *social worker shot into "we are all to blame".*

Despite being completely exonerated of any blame in relation to Kieran's care, his death had a lasting impact upon Beth, who in line with the other social workers in the study also feels some responsibility for the tragedy.

"I will never ever forget Kieran, I will never forget him. I will never ever forget, the effect that the decision making within the LA had and the way I felt about it. I also feel partly responsible, because maybe I didn't shout loud enough. I also gave him the £20, so I also feel quite responsible for that"

Both Anna and Beth acknowledge that they are part of the wider systems designed to protect children but each of their accounts re-emphasise their feelings of being personally responsible. Beth refers several times within her account to the provision of £20 to Kieran, which served to provide him with food and shelter. On his final visit Kieran was given the money and purchased a small amount of drugs.

Anna Beth and Claire all described significant concerns relating to the risks posed and the levels of care provided to the children whom they worked with. When viewed retrospectively their disclosures highlight some of the problems associated single and multi-agency working, however, a strong recurring theme centres upon the issue of assertiveness.

All of the social workers who were interviewed spoke of their frustrations at being unable to convince other professionals, most notably managers, of the need to take urgent and decisive action in each of the cases. It became evident that for the workers involved, issues around the failure to secure protective action had left a lasting impact upon each of them in both a personal and professional contexts. As will be discussed in a later section of the research, each of the tragedies appeared to become a turning point in their careers and played a crucial role in shaping their current practice.

Claire provides insight into this area by voicing her frustration that what she (rightly) perceived to be burns to the soles of Sarah's feet were not recognised as such by a paediatrician. Despite the paediatrician's views, Claire still felt the need to take decisive action; unfortunately she was not supported by her colleague who was also involved in the assessment:

"I had a conversation with my colleague, probably about seven o'clock by the time we had got back to the office, everybody else had gone home obviously and I said look I'm not happy about this, I think we should seek a Place of Safety. Err...and we had this interesting conversation because, I said look you know I just want to go to the Magistrate and get that flipping place of safety order and he said, you might have done it like that in your previous job but we don't do it like that here".

Claire continued to assert her feelings at a later date with her team manager:

"I kept on and I kept going on and on and on about it saying look, you know, yeah ok, she (Sarah's mother) might not have done those burns but someone did, somebody did so, if it wasn't her, we need to know who it was and in any case, you can't leave a baby in those circumstances"

Claire's account reveals some of the issues associated with both single and inter-agency child protection practice. The paediatrician's assessment of the situation appeared to alleviate the concerns of Claire's fellow social workers and this potentially contributed to their reluctance to seek a Place of Safety Order. Claire's anger and frustration was compounded by the revelation that:

"Six weeks later the post mortem said that the baby had cigarette burns on its feet so they could tell six weeks later they were cigarette burns, why not then? Maybe he (the paediatrician) just had an off day?"

Despite being the lone voice in calling for Sarah to be removed, Claire still questions whether she could have done more to prevent her death:

"I was angry, angry, upset err...to be honest, it should not have happened, she should have been taken into care that very week, should have gone then...I still do think, if perhaps if I had said more, perhaps if I'd have gone right to the directors of SSD, before it happened and said "look you know, take this kid into care or whatever" (long pause) I don't know. I'm the one who thought this death was preventable; we should have done more. Everybody else was saying it wasn't preventable. Everything could have been done was done but I think they were deluding themselves, but then that's the only way that they can survive by trying to think, well I did everything that I could have done"

Beth initially attempted to secure a better standard of service for Kieran, believing his "Child in Need" status minimised the risks to his safety and welfare:

"It really hit me hard, it really hit me hard because I tried so hard to get somebody to listen to me and they just wouldn't. He needed the support they acknowledged that, and they acknowledged that after he had died"

Despite attempting to secure protection for Kieran, Beth begins to question the services he ultimately received and even her own complicity in his death:

"I was livid, really angry to start off with, I was really, really angry because, nobody would listen to me saying that he actually needed some help. He was only just 17 and we had been messing about deciding whether or not, from the age of 16, whether he was our responsibility, nobody could decide where he fitted. I just felt like we were just giving him twenty quid every week to say "right there, there, we are still trying to sort you out you know", I just felt that we had to accept that we had played some part in this. And ...I did just say to my manager: "You thought it was ok just to chuck him 20 quid and that last 20 quid probably killed him. So I hope you are happy" , kind of thing. I think that was more my anger and my grief talking then my professionalism because, that wasn't me... I still think exactly the same, exactly the same. We let him down and I told them that we had let him down. We let him down, his parents let him down, and everybody let him down, because there was no, collaboration between anybody. He was nobody's responsibility and we let that go on for a year"

Anna also argued vehemently for decisive action to be taken for Rebecca. Despite lengthy involvement with the child and her family and the support of her co-workers, Anna was unable to make her voice heard:

"We went down and raised it again and again... I said I want increased visits. I want more. I said I'm not happy about Rebecca being there, she's too much on. I wasn't

heard and there's little you can do, I can do a lot of decision making around child protection but in terms of placements I'm powerless... We asked them, we asked for a move, we documented it we documented we asked for a move, we documented that we'd been and said we had concerns about this carer. We documented that we had upped the visits. That never appeared in the SCR. Because I'd gone and asked for another placement and when I didn't get another placement I err (long pause) I didn't stay there and insist. I got into the social work mechanics of like there are no resources and those things".

All of the above accounts reflect a prevailing sense of powerlessness, anger and frustration for all of the social workers involved. In each of the cases, the workers were able to formulate informed judgements about the wellbeing of the children and particularly in the cases of Anna and Claire the concerns were sufficient enough for them to request alternative placements. The barrier to ensuring effective action appears to reside in the reluctance of managers and other professionals to accept and subsequently act on the social worker's concerns. During the final account provided by Anna, she begins to discuss her internalisation of some of the blame for her death and also the fact that her concerns were not addressed or reflected within the SCR. This will be discussed in more detail within Master Theme three.

8.3 Master Theme Two: The Pain of Knowing.

All four of the social workers who were interviewed were informed of the tragedy in different ways. Anna describes her immediate reaction to the news that Rebecca had died:

"We got a call to our one of our out of hours to say that this baby err had been admitted. She died (long pause) on the kitchen table...I think they might have resuscitated her, they got her to hospital and we got mum there straight away (The child was not residing with his mother at the time of her death and the mother was not involved in the child's death. Anna was directly involved in supporting Rebecca's mother following her admission to hospital and also escorting her to view Rebecca's body at the mortuary) *It's all a blur that bit. It's absolutely a blur. I couldn't breathe, I could not breath and I could not get any information, I wanted to know what had happened, it all happened at the weekend it was out of hours dealing with it. The police officer said "do you want a drink?" and I said I don't know, I don't know what's gonna happen? When I found out this baby had all those injuries... that's when I could not breathe."*

Throughout this section of the interview, Anna struggled to convey the full extent of her feelings. She recalled that the impact of hearing the news was such that she physically struggled to breathe. The account was interrupted by a long pause during which she was unable to speak and was clearly visibly upset. Anna was however able to clearly recall many of the visual images relating to the condition of Rebecca's body and provide a detailed account of the injuries she sustained (I have chosen to remove these from the narrative). Even though a significant amount of time has passed, these images and details have clearly left a deep and lasting impact upon

Anna and serve as a vivid and powerful reminder of the event. In relation to some of the other experiences associated with being informed of Rebecca's death, Anna's recollections are significantly less clear. Her statements continually reiterate the *"blur"* of confusion and powerlessness she experienced at not being able to obtain the full details relating to the tragedy. The fact that Rebecca's death occurred over the weekend and was handled by the Emergency Duty Team may also have reduced Anna's ability to access information.

Despite what was very clearly a traumatic emotional incident, an experience so intense that it physically impacted upon Anna, she immediately continued in her social work role, "shelving" her own inner turmoil and providing Rebecca's mother with emotional and practical support. There is little evidence however, of any support being made available to Anna, as will be discussed in Master theme four; any longer term support that ensued was either unplanned or provided by the social workers themselves.

Claire's recollection of how she was informed of Sarah's death is startlingly brief and dispassionate; her account reflects many similar experiences to those of Anna. Both workers had repeatedly called for protective action to be taken, both tragedies occurred over the weekend and both workers continued and were *expected* to continue in the work roles:

"I got a phone call from my manager to say I just thought I would let you know before you come into work tomorrow that Sarah is dead. Basically, mother's partner had smashed the baby against the wall and his skull was broken...and that's the circumstances of it."

LEE: How did this make you feel?

CLAIRE: "Well put it this way I was not surprised. I could see it coming. Unfortunately no one else could... I was angry, angry, upset err...to be honest, it should not have happened, she should have been taken into care that very week, we should have gone in then"

Claire was so convinced of the level of risk posed to Sarah that she recalled her lack of surprise upon hearing the news that she had died. Although, upon reading and if taken at face value, such a statement may appear dispassionate, this is clearly not the case. Claire, as well as using her own personal judgements to assess the level of risk, had spent a significant amount of time gathering information and statements from the families' neighbours. All of this evidence was disregarded following the intervention of a paediatrician who stated that prior injuries to Sarah were accidental. Claire's account refers to some of the issues relating to both power and status that operate within child protection practice. Ultimately, the opinions of paediatrician carried significantly more weight than the judgements of social workers and the information provided by the neighbours who knew the family:

It seemed to be this idea that the paediatrician was just not prepared to say "this is NAI" and everybody else's reason goes out of the window. If the Paediatrician says it's not NAI we can't then say it is, when clearly it was staring you in the face, what else could it be other than that? It couldn't have just happened! Yes the paediatricians have a lot of power don't they, what they say goes if they say it's not then it isn't and if they say it is , it is."

Sarah's death happened several years ago, yet for Claire the overriding emotion was still one of anger. She consistently recalled her anger and frustration at how almost every aspect of the case was handled. Beginning with the initial referral, through to the inquiry into Sarah's death, Claire clearly perceived a number of failings within the safeguarding and review process. The later section of her account conveys the additional human toll of the tragedy as Claire's colleague was so affected by events he left the authority and never worked in child protection again. Claire also provides a very interesting perspective in relation to the review process, believing it was (mis)used not only to mask deficiencies in practice but also inadvertently to reassure other professionals that the Sarah's death could not have been prevented.

CLAIRE: *"I think that the predominant feeling even now is anger"*

LEE: *At?*

CLAIRE: *"At, at the complacency, at playing it down, yeah well, I can remember them, yeah well, we'll get her in a few years' time, but they didn't have the opportunity to do that she was dead... "*

She continues:

"Well I know my colleague left, very shortly after that, because of what happened, he went to work in (area omitted), I think one of the things that got me is that, I can see it from their point of view, I'm the one who thought this death was preventable, we should have done more, but everybody else was saying it wasn't preventable. Everything could have been done was done but I think they were deluding themselves, but then that's the only way that they can survive by trying to think, well I did everything that I could have done".

Two of the social workers Claire and Donna, were both informed of the child's death by managerial staff, however they describe sharply contrasting experiences. Beth, who had established a long standing working relationship with her teenage client Kieran, acknowledges the unease she felt prior to his death after he failed to arrive for his weekly appointment.

"He used to come in every week and say to the receptionist can I talk to Beth...This Tuesday morning came and went, Tuesday afternoon came and went. The next day, came and went. I knew deep down something had happened"

Beth was later informed by a colleague that Kieran had died shortly after visiting the social services department. He had arrived unannounced on a day when Beth was taking annual leave. Here she recalls her initial reactions to the news:

"It was err word of mouth, I knew deep down something had happened...My colleague came in and told me that he had been found, the following weekend before the Tuesday he didn't come in. He had been in on the Friday before and my manager said basically "give him £20 and get him gone"....he didn't buy food, he didn't buy anything else, he didn't have anywhere to sleep, nowhere to go, and he froze to death. He fell asleep and the cold set in."

The issue of providing Kieran with £20 is a recurring theme throughout Beth's account. In total she referred to the amount ten times during the interview. Beth perceived that the provision of money was simply used as a means to pacify Kieran, to keep him away from the office, as the alternative would be to provide him with the much more expensive option of housing support or residential care. For Beth it is

possible that the figure of £20 is symbolic of the value that her agency appeared to place on Kieran's life and wellbeing.

"You thought it was ok just to chuck him 20 quid and that last 20 quid probably killed him. So I hope you are happy, kind of thing. I think that was more my anger and my grief talking then my professionalism because, that wasn't me".

"I also feel partly responsible, because maybe I didn't shout loud enough. I also gave him the £20, so I also feel quite responsible for that".

Once again, there appears to have been no structured or planned way in which Beth was informed of Kieran's death. She was informed of his death by a colleague and was not offered any immediate support or "time out" upon hearing the news. This once again resulted in an enormous sense of anger and frustration.

As with the experiences of Anna and Claire, the fatality occurred over the weekend period therefore it is possible that the full facts surrounding the incident may not have been available to the team manager. However, rather than providing Donna with a dispassionate, general, description of events (as in the accounts of the other interviewees) it is evident that the team manager is clearly familiar with the circumstances of Donna's assessment and aware of her possible involvement in the ensuing review. It appears that this initial, planned and personalised interaction set the tone for a sharply contrasting experience when compared to those of Anna, Beth and Claire:

"My manager rang me and said that this had happened over the weekend. She rang me to let me know that should it be in the news given that I had done the last assessment only six weeks before. It may well be something that I have a complete

panic over or would want to know so she gave me as much information as she had in regards to it so that I was aware...It was very good and she did say that there would be a full investigation and everything that was done with regards to my practice would be looked at and the department's practice but try not to stress too much but obviously you do don't you?"

Donna was the social worker in the study who had experienced the most recent death of a child. She spoke about how the events had impacted upon her as a social work practitioner but also in terms of her personal life and relationships. What is immediately evident from Donna's account is that she sees her personal and professional life as being interlinked. Social work for Donna is significantly more than a job, she accepts that there is essentially no clearly marked start and finish times within her role and as a result the emotional challenges and tribulations she faces must permeate into her personal life. Her recollections are both profound and moving, they echo of change, and transformation and they reflect the wide range of experiences and emotions she associates with the fatality. She encapsulates many of the complexities, the humanity, the uncertainty and the hopes and doubts she has for her profession. Her account reflects how she wrestles with the reality that despite her best efforts and faith in human and nature the tragedy still occurred. She is accepting of the possibility that the impact of the death will always remain with her and permeate many aspects of her personal and professional life. In an attempt to convey the full impact of events they are presented here in their entirety:

"You could not be the same person...to experience working in an environment where you have had a link with a family that has tragically, horrifically lost a child, and to carry on doing what we do. It's not a job is it? You cannot call social work a job.

You don't log on and off. Yes, it has changed me; I think yourself as a person and your own relationships as well changes. Strangely enough I'm not in one (laughs) I now have my own barriers up around things so it does change you as a person, but how could it not change you? If it didn't change you then it would be worrying really. You do think about it, it does come back to you. It is something that will never go away. I think about how people can seem quite nice, quiet approachable and friendly, you cannot define someone that could kill a child. You cannot say that's somebody who could kill a child or my assessment of you is that I think you could do that. If people knew why they did it they wouldn't do it. I didn't think anybody intentionally sets out to kill a child, but maybe they do. I hope they don't otherwise I would lose faith. It is something that will never go away, that's for sure...It might be beneficial to draw out all the issues for that particular case and resolve some practice or communication issues and maybe we do stop them but we will never know will we, we will never ever know. We may stop them all of the time, daily in this country but how would you ever know? How do you measure that? No one really cares about the ones we stop do they?"

Anna speaks of the isolation she experienced, whilst coming to terms with the fatality. The account reflects the fact despite the clear impact of events, she felt reluctant or unable to turn to her friends and colleagues for support:

You know it's a shame I wasn't a drinker, I didn't know what to do, didn't know where to go, I didn't want to go home, I didn't want to "put on" my colleagues anymore. I just took the dog for an incredibly long walk and cried for a long time?

It is evident from the research interviews that the deaths of the children had a profound and lasting impact upon all of the social workers involved in both personal

and professional contexts. At a personal level both Anna and Beth, several years after the death are still clearly affected:

ANNA: *"I cannot hear the name Rebecca, I cannot hear it, and this sounds bonkers. It sounds bonkers, there was something that happened on the news and they said her name I went cold, I went ohhh* (At this point of the interview Anne visibly shuddered and place her hands over her eyes) *We are talking 4 years later; I heard it on TV and I..." (Long pause, silence)*

BETH: *"You just think I will never ever forget Kieran, I will never forget him. I will never ever forget the effect that the decision making within the LA had and the way I felt...It was horrendous, absolutely horrendous, he was just broken, he was just broken, he passed away, he died. Those sorts of things kind of, stay with you."*

In addition to the impact upon themselves each social worker described at length the impact of the fatalities upon their work colleagues. For some of the social workers involved the events were career changing and even potentially career ending. Beth who was directly involved in two child fatalities recalls the potentially lasting impact of one of the children's deaths upon the career of a newly qualified social worker:

"The poor worker with the young baby...her cards are marked, you only have to see people's reaction when you mention her name, oh! Is that the worker that had Adam and you think she will never get on in her social work career but was that her fault? No!"

What is apparent, and will be discussed in more detail in Master Theme four, is that within the interviews there are numerous examples of how, following the death of a child, many of the social work teams involved developed a strong bond and united in

their support for their colleagues. Anna cites a co-awareness of the emotional and practical challenges of social work practice as providing the foundation for the support that was offered:

"Immediately we had a staff meeting in our team, to support the SW who was ripped apart, ripped apart, and err I think we got closer as a team, around it... Err your conscious of, of ... (we were) conscious of each other's needs, you're conscious of how each other is feeling. You're conscious of, you know you're empathic to each other."

What is perhaps surprising is that for all of the workers involved, the deaths of the children proved to be a catalyst for some positive changes in their working practice. It is evident that as a direct result of the deaths, the workers felt much more able to assert their judgements (although this was not perceived to be an entirely positive attribute by the local authorities in which they worked!). The interviewees also describe how personally experiencing the fatalities and witnessing the effects of the deaths upon their colleagues, instilled in them the need to for such things as assertiveness, good record keeping and accountability in others:

CLAIRE: *I suppose when I think up to leaving that LA, I'd more or less been quite, what's the word? I'd behaved myself, towed the line because, I know in some organisations if you don't you are in trouble. But as I then started my career in Mental Health, I think I did certainly speak out a lot more, often to my detriment, if I may say, but I did speak out,*

LEE: *Would I be right in saying that you are now much less likely to take no for an answer? Do you think you'd be more prepared to force the issue?*

CLAIRE: *Yes, absolutely*

Anna who was still involved in child protection practice, also worked as a practice educator, assessing undergraduate and post-graduate social work students. She begins by describing how Rebecca's death impacted upon her own practice but also discusses who she uses the experience in a positive way to inform and benefit the practice of her students. Her views are echoed by Donna, who emphasises how the continuing awareness that another death may occur, informs the need to question the decision making process and to effectively record actions:

ANNA: *"I'm more assertive in saying "no that's not what is happening for this child"...I think it's bred into you as a social worker, early on about being constantly culpable, constantly responsible. You know the words we throw at students, responsible, accountable, culpable, blame (emphasises this word). Blame culture in an LA is alive and well and thrives like the cockroach. It's changed my practice in how I manage people, how I train students, err you know I am constantly saying things to them in my own colloquial way, that it could come back and bite you on the arse this, make sure you have done, de der de der. Talk about a heightened awareness".*

DONNA: *"I do think my practice has improved because I think any social worker knows this could happen to them. Any social worker is aware that it does happen. And so don't be scared of asking any questions and always ask more and more and more questions and I am pretty good at it, but just recording as well, make sure you record everything and on duty if you were to record absolutely everything you would stop working you would not get anywhere"*

Beth, also cited a number of improvements in her practice as a result of Kieran's death, however her belief is that the developments evolved as a result of a self-reflective process, rather than as a consequence of external support systems:

"I became the worker I am today because of Kieran but not through the support I got or the guidance from social services. I got it from the lessons learned, the things that wasn't done that should have been done and I am the worker I am today through no one else but my own practice because I make sure that I am listened to and I also make sure, which is the way I started my career, I always make sure I know my family. I ask the questions and I'm not afraid to challenge a family or individuals".

As will be discussed in more detail in Master Theme Four, none of the social workers involved in the study received any planned or structured supervision or counselling following the children's deaths. Largely they were left alone, unable to speak to or find comfort in their own families. They were expected to immediately continue in their work roles, they felt blamed and vilified by the processes that were designed to learn from the tragedies and continued to practice in the full knowledge that the next tragedy may lurk just around the corner. They were expected to support and protect others, despite the fact that the agencies in which they worked largely offered little of the sort in return. It is possible therefore to conclude that rather than emerging as a result of the cathartic processes associated with supervision or counselling, the learning and the changes to practice that have taken place, are directly born from the painful self-reflection upon bitter experience. Their origins reside within the lonely, tearful periods when Anna walked her dogs and in the impassioned and frustrated attempts by Beth and Claire to secure services for the children deemed to be under their protection. Such changes are maintained by a sense of passion and commitment

and a deep seated anxiety to prevent a re-occurrence of the events. The fact that for all of the workers involved, the research interviews represented their first opportunity (outside the review process) to discuss and openly share their true feelings is an indictment of the some of the practices within the agencies in which they operate.

Despite some positives, all of the social workers who were interviewed portrayed a bleak vision of the current social work profession. Although, their personal attempts to learn from the events and share their learning with other professionals had resulted in some actual improvements to child protective systems, it was the stated opinion of all of the interviewees that the profession of social work and the ability to safeguard children had been seriously undermined as a result of understaffing, underfunding and a culture of target setting and deadlines. The closing two accounts reflect the participant's passion and commitment to their roles but also a deep rooted anxiety that the rise in managerialism, typified by meeting targets and deadlines has eliminated the very core elements of their working practice:

BETH*: This is a dying profession and we are all becoming admin workers. I never thought I would every say that, I've always loved social work...It's all down to deadlines now, it's stats that's all you hear nowadays it well done we got 90%...so what? We have not* ***seen*** *those families but we've been in so tick the box. That is what it's about now, you know all that came out of the Munro things and yet, it's all complete lip service, err the whole ten months I was there all you would hear is (makes typing noise) I never heard people talking about a child. I heard them talking about processes, procedures and deadlines but I never heard them talk about a child. Believe me in the last 10 months I saw some scared social workers, really, scared social workers. People are afraid, they are scared to challenge now as they are seen*

as incapable. Pull yourself together, get in to work tomorrow, you have a conference. You are in court tomorrow, tough. There's just nothing there.

ANNA: *I'm much more cynical, I've worked in LA's for 37 years and the cynicism is a defence mechanism I think, err an accepting and an acknowledgement of being damned if we do and damned if we don't and the...there's too much going on, I'm on leave today but I'm going in for two meetings, I've got a statement to write 'cos the social worker is on her knees. There's always too much and it impacts on home. Because you are scared of not doing things ok, you know, it a case of, and I don't know if this is relevant to it Lee but I wait until my old fella falls asleep in the chair at 9 o'clock so I can cautiously get my laptop out to do work. I want to see my families; I don't just want to see them at conferences. I don't just want to see them when it's a LAC review. I don't want to just see them when we pull them in because we are too scared to go to the house. I want to be able to go round and do the visits and stuff.*

8.4 Master Theme Three: The Blame Game.

This master theme explores the experiences associated with the Serious Case Reviews and inquiries into the children's deaths. This section is designed to provide insight into participant's experiences of the local authorities' responses to the tragedies. For three of the social workers, participating in the reviews was a largely negative and even traumatic event; however, one worker, Donna, describes a number of positives that emerged, largely as a result of feeling included and listened to during the review.

In order to contrast the experiences, the predominantly negative views of Anna, Beth and Claire will be discussed initially before turning to the vastly different opinions voiced by Donna. In the opening section Beth recalls how, in her view, the administrative processes and the overall needs of the local authority during the review took precedent over her personal needs and feelings. From her point of view the local authority did not engage her in the review process until they felt the need to address perceived errors in her assessment. In the second section of her account, Beth also describes how she perceived that Kieran's needs were only recognised by the local authority after his death:

BETH*: My last LA they were more interested in the blame and how to not be highlighted as a failing authority that should have done something. It seemed to me it was more like they were more interested in making the good bits look good and the bad bits to be watered down...It's all procedural now, but what about the social worker, that's had to deal with this? It's all procedural. At the end of it all we are people. You are a real person, I'm a real person and they just seem to have forgotten...It's all corporate... That happened and they expect you back at work they next day. Get on with the next lot. Until they decide they want to talk to you about*

something that you did not do. I don't think that will change, I don't think that's ever going to change. Stats and procedures and performance has sadly overtaken, the sort of practical things.

Anna also perceived that the undertaking of reviews into the children's deaths actively sought to cover up bad (mostly managerial or service manager) practice and mask deficiencies in service provision. In two remarkably similar accounts, both workers describe how the needs of the local authority were prioritized during the reviews. Beth in particular, recounts how individual social workers who had been directly involved in the cases bore the brunt of the blame, whilst a number of "higher level" practice failings were omitted from the reviews and importantly, those who were responsible for the failings were exempt from blame:

ANNA: *Fascinating how the local authority became a self -protecting tool to look after itself.*

BETH*: As an authority ...it was almost hush, hush...it was looked into, reviewed and stuff because of his age. Funny enough, once that actually happened, it became somebody's problem. But again for me it was more ...they were talking about the way in which they could get themselves out of it rather than learning from it...Blame was pinned believe me, it was pinned, yes, yes, funnily enough you know, you look through the case notes, there's no supervision, no action on there, but the managers still get to stay in post, how is that? How does that work? Where's the accountability for them not offering what they should be offering to the ground workers?"*

They were speaking to the right people but not the correct people, if they wanted to learn from it. This is 8 years' worth of us knowing this family.

LEE: *You would have something to say...*

BETH: *Yes, yes*

LEE: *What would you have wanted to say, did you want to tell them anything?*

BETH: *I thought that it would, because he was not the only one in that age gap, there was huge, huge resource issues, huge practice issues, huge kind of, we seem to always concentrate on the...physical and sexual abuse of children and I always think kind of, the neglect or the ones that do not fall in anyone's category.*

Use of terms such as "tool", "machine" and "cockroach" encapsulates the workers sense of the cold, impersonal nature of the local authorities during the reviews. Each of the social workers who presented a negative view of the SCR process, emphasised how, in their opinion, the local authority, appeared to ignore their individual needs and distress and did very little to negate or minimise their feelings of alienation and isolation. The final section of Beth's account reveals how her involvement with Kieran's family, which lasted for a significant number of years, provided her with a number of valuable insights into social work practice, particularly around working with teenagers who are experiencing neglect, were lost as a result of the procedurally driven format of the reviews. Beth's account is supported by Anna and Claire. They describe in detail how the formal nature of the inquiries also nullified their contribution,

ANNA: *We had a briefing err with directorate that was around pretty much telling me what I could and could not say...the brief was about the corporate response not the emotional content... When there was the SCR, the questions were closed questions. This I found profound, I was angry, angry, angry, angry.*

CLAIRE: *I can remember going, it was like a going in a big room, there were all these people there and they didn't really ask me, never really asked me anything much to be honest.*

LEE: *Did you want to be asked?*

CLAIRE: *I suppose I would have said what I wanted to say but I didn't really feel able to say that much, I had only been working there a few months and I didn't really know, any of these people, I didn't know all of the procedures etc. I know what I would have wanted to say was "you know this should not have happened" and I suppose I was also aware that if I had said something like that, I don't think the outcome would have been any different, which was nobody was to blame and we did all we could and this man, this nasty man killed him, he killed this baby, and* **he** *did it, we didn't do it. It's not our fault kind of thing but we didn't save him and I guess they wouldn't necessarily want the outside world knowing that certainly their procedures were inadequate.*

Both of the previous accounts encapsulate the feelings of anger and frustration experienced by the workers involved. In addition they support the premise that a significant amount of "real" learning potentially remains unheard.

During and after their participation in the reviews Anna, Beth and Claire highlighted several deficiencies in the work based supervision, guidance and support they received. Not only were the interviewees unprepared for many of the practical tasks they were expected to perform but also their need for emotional support was largely ignored. As Anna was involved in one of the fatalities in a case management capacity she was extensively involved in the review process. During the review she sat

through the entire coroner's inquest and also escorted the child's mother to view her baby's body. Anna had not been informed that during the post-mortem the coroner had removed several of the baby's body parts and this only became apparent when the body was presented for viewing. Anna had not been briefed or received any support or information prior to undertaking such duties. Her meeting with the coroner brought back many of the images and feelings she experienced after viewing Rebecca's body:

"We were called to interview as individuals, there was no group debriefing and after we had met with the coroner I could have done with that, I really could, when he sat and read out the child's injuries... The post mortem revealed that the child had got a torn fraenulum and broken ribs; multiple fractures of her ribs and some that had been healed and re-fractured. I felt like I had been hit by a train."

Where support was offered during the review process, in Claire's experience, it was somewhat surprisingly only offered to her colleague:

"There was an internal investigation they didn't have an external one or anything else. That seemed to go on quite a long time, really there was counselling provided for my colleague, I felt a bit miffed because no one came to me and said how you feel about it?"

The aforementioned experiences contrast sharply with those of Donna. Earlier, she had described how sensitively she had been informed of the child's death and this template appears to have been followed throughout her involvement in the serious case review:

"It was very structured to be fair; it didn't take a lot of my time and it didn't drag me down or anything because the way it was dealt with right from the beginning. The Service Manager was very supportive but not to the point where she would have covered up any bad practice or anything; she was perfectly just on the ball, really right with the level...very compassionate but appropriate. I think it was very well done and a much needed process because regardless of anybody's level of responsibility it needed doing and if there is a responsibility for you and the way that you practice you need to know that so that you can do something about it"

Donna's positive experiences are maintained throughout the review even during the inquisitorial section of proceedings.

I thought it was very much a learning experience...at no point did I feel like they were questioning me like I had done something wrong. I felt it was very supportive. I really felt supported; I developed a really good relationship with the strategic manager over that, even when I left she sent me an e-mail saying "please don't go".

Donna was offered briefings and debriefings, relating to the review process, these were available to all of the agencies involved in the child's case. Donna is able to perceive how the review facilitated an open exchange of information between herself and the service manager which directly changed practice in relation to IT and case recording:

"It made the LA look at the system that they'd got and how they worked and how unhelpful they were at the time to produce the proper assessment for the family's situation...I think because she (The Service Manager) did not understand our system, because she did not understand the IT she wanted to know, how it looked to me when

we were inputting data and when we were getting things and she learned quite a lot. She was learning quite a lot from how the system actually stops you doing your job properly"

Donna also firmly believes that the multi-agency debriefing sessions were crucial in establishing a complete picture of events leading to the tragedy and

"What was interesting at that point was seeing how they had done things and seeing where things were missed and seeing that if we had been aware of this or if that would have happened...maybe this would have stopped or you would have gone a degree this way or that way. I think just seeing the beginnings of it from the other L.A to coming to here was quite useful"

What is interesting when viewing the different experiences of the reviews is that the workers who were not briefed, prepared effectively or felt included in the process, perceived them to be a means by which to attribute individual blame and to disguise bad practice within the authority. For these workers the experience has been one of alienation and trauma, resulting in long lasting feelings of resentment and anger. In contrast the experiences of Donna are typified by the view that the review was a learning process that was transparent, inclusive and used to develop good practice. For example, there is clear evidence in Donna's interview that following a one to one meeting with the author of the SCR, positive improvements were made to the local authority's computerised case recording systems. Such accounts contrast sharply with the wider recollections of closed questioning and guidance on what can or cannot be said during interviews. Clearly, Donna's experiences offer a model of good practice that could be utilised for enhancing both practice and the experiences of the workers involved in serious case reviews. It is perhaps an interesting footnote

that the local authority in which Donna worked were more than happy for her to partake in the interviews.

8.5 Master Theme Four; No Further Action.

Following notification of the children's death no immediate support or counselling was offered by the local authorities to any of the social workers involved. For all of the interviewees the research interviews served as the first opportunity to discuss the children's deaths outside the review process. The following accounts raise serious questions about the level of care and support available to social work practitioners who experience similar traumatic episodes.

It is possible, that as a consequence of not being offered support in the workplace many workers turn to their friends and families for support or to informally offload their thoughts and feelings. In relation to their own experiences both Anna and Donna recall how for a number of reasons they felt unable to do this. In her account, Anna describes how she perceived that her involvement with children and families in the workplace was often replicated in her home life:

"Your own family don't understand...I think you go home sometimes with the trauma of what is happening at work and you walk in and real life hits you. And they don't understand that real life is happening for you at work"

Despite Donna clearly finding significant emotional support from her mother, issues of confidentiality limited the amount of information that she could discuss with her and therefore limited the amount of support and empathy that her mother could offer;

"I was devastated, at that point luckily for me I had moved, I was between moving house...I had moved in with my mum for the six weeks so fortunately she is very supportive and I have a lot of emotional support from her so at night time when the kids had gone to bed we could sit and obviously it was confidential but for me I needed to have that support"

All of the social workers who were interviewed spoke at length of the different forms of managerial input the received. Interestingly, Beth who had been involved in two child abuse fatalities voiced her opinion that the support provided by her manager was linked to the fact that she had previously been exonerated of blame:

"I had a phone call from the service manager and an email from the manager because they wanted to make sure I was ok because obviously, it was horrendous, absolutely horrendous, he was just broken, he was just broken and he passed away and he died. Those sorts of things kind of, stay with you...but I don't think I would probably got that support had I had not done a good job on the write ups, and the fact that I had done everything right"

This recollection contrasted sharply with Beth's experience of an earlier tragedy in which she perceived the care and protection offered to the child was severely lacking. This section of the interview addresses several areas of practice, most notably relating to supervisory processes, accountability and staff support. Beth begins by voicing her frustrations at the inappropriate support was initially made available to her. Several years after Kieran's death:

"I've never really spoken to anybody about this and I've never really been offered anything apart from the counselling but that was more to do with bereavement than anything. That wasn't what I really wanted"

As Beth had not received the support she felt she needed after Kieran's death, I questioned whether any additional support was offered via supervision. Here she describes her first supervision session with her team manager following Kieran's death:

BETH: *Kieran had a two minute slot, the same as any of my other cases*

LEE: *Even after his death?*

BETH: *Even after, even after, it was not to be spoken about because there were practice issues, there were accountability factors and at a level that was higher. They needed to work all of that out, cover their own backs. At the end of the day we were giving this kid ten or twenty quid a week just to shut him up and to go away. That's how I saw it and it was literally a two minute, supervision the same as any other case. I can remember it, as well what my manager said, we were going through the cases, we got to Kieran and he said "well this one we can NFA (No Further Action), get admin to put the closing date on the system".*

LEE*: Was that after he had died*

BETH*: Yes...NFA it!*

LEE*: That's it?*

BETH*: Yes, no further action, NFA it...nothing else no... nothing*

LEE*: How did that feel?*

BETH*: Ohhh...when I came back off the wall? (laughs)...It was after that I think I gave up. I gave up really talking about it, after that. ..it just fell on deaf ears, and I thought, NFA it? That's it?*

Claire shared a similar experience to those of Beth. During the interview she voiced her frustration that after she had been informed of the child's death she was expected to attend work the following day and continue with her work schedule. Claire maintained the belief that the focus of an assessment that was undertaken of the baby involved, centred upon the likelihood of her being sexually abused rather than at risk of physical harm. The baby was murdered shortly after the assessment. Eight years after the event, Claire's frustration at the outcome and the lack of support she received is evident:

CLAIRE: *I just had to get on with it, I tend to be sort of person who internalises a lot of things and stuff and it simmered but I just had to try and get on with it...*

LEE: *Were you offered anything*

CLAIRE*: No, no, nothing...*

LEE*: If it had been offered would you have wanted it?*

CLAIRE*: Yes, yes I would. Cos I think that the predominant feeling even now is anger*

LEE*: At?*

CLAIRE: *At, at the complacency, at playing it down, yeah well, I can remember them, yeah well, we'll get her in a few years' time, but they didn't have the opportunity to do that (long pause) she was dead...*

Anna, Claire and Donna all cited their line mangers and social work colleagues as playing key roles in providing support and comfort following the children's deaths. Anna and Donna shared very similar experience in relation to support from their line managers. Here Anna begins by describing how her line manager, whilst acknowledging the emotions experienced by Anna, also addressed some of the issues relating to her practice. During her account Anna describes how the reassurances and guidance provided by the line manager were shared with other members in her team:

ANNA: *My line manager was amazing, she was amazing, she looked after me and then I was able to look after the team. I had a debriefing with my line manager who looked after my feelings and helped me to realize that I hadn't killed this baby and we looked at what could we have done different, I took a lot on board. People were telling me this woman (the child's carer) was no good and she was saying "but you did go and ask (for a placement) three times, you did three times"...and I said "but I didn't do my best. I did something but I did not do enough", and my co-worker I could see was feeling the same. That helped me because I was saying to her "you did your best, you have 30 other cases".*

Donna describes in detail, how, after a very stressful briefing session relating to the SCR, instead of picking up the keys to her new home, she decided to speak to her manager about her feelings. Donna's manager acknowledges the complex emotions associated with the situation but maintains a realistic perspective in conveying that a resolution to Donna's inner turmoil may be difficult or even impossible to find:

"I went back to the office and sat with my Manager because there were things that were flagged up to me at that point that provoked more questions inside me, so I had to go back and sit and talk to her she gave me that time, we had a good hour and a half just discussing the impact of that meeting so... I do value the way that she supported me, because she was saying "when you get to one question you get to another question". She was saying that it doesn't matter how much you ask yourself these questions you will never come to a conclusion, and I think we bled it dry to be fair, we got no further; there was nowhere I could go"

Despite Donna's initial assertion that after speaking to her manager; "we got no further", and her use of the metaphor "there was nowhere I could go" she did feel able to enter her new home. It is possible that the manager, in acknowledging Donna's grief and listening to her disclosure facilitated this process.

It is evident from the interviews that the children's deaths impacted significantly upon both the individual social workers involved and the teams in which they worked. A recurring theme emerged that the empathic understanding of co-workers played a pivotal role in improving some aspects of social work practice as well as providing networks of support for those affected by events. Both Anna and Beth recount how the children's deaths served as a catalyst to develop support networks for the social workers involved and how team dynamics were positively altered in response to events. In both accounts, the importance of a shared understanding of the practical and emotional challenges of social work practice is evidenced as being crucial to the healing process:

ANNA: *"We had a staff meeting in our team, to support the SW who was ripped apart, ripped apart, and err I think we got closer as a team, around it. I've known*

that before when we've had children die...the team becomes like a family. Your conscious of, of each other's needs, your conscious of how each other is feeling. Your conscious of, you know your empathic to each other"

BETH: *"My colleagues were supportive, but I think that's more so because they come across that sort of thing, we work together so closely every day that we would all bounce off each other"*

DONNA: *Yes they were very useful, very supportive, and very useful. Fortunately there were a few characters in there, myself included and another manager that I got on really well with so there was a bit of appropriate banter going on just to keep everybody calm*

For Anna, the support needed for herself and her team following Rebecca's death was multi-faceted in nature and consisted not only of the practical solutions needed to continue to function as a team but also emotionally attuned interventions, which allowed practitioners to talk about, actively reflect and share their feelings and experiences

"We did a lot more group supervision around supporting each other, that took the form of allowing people to talk about how they felt, it took the form of pragmatic stuff, practical like people doing visits for the SW while she was coming into work and barely functioning. We stayed together as a team and people rang at night and asked if you were alright and we were ringing each other and just that I think is what made our team really strong. Err adversity made us think "right what do we need to do? How do we need to deal with this?" Talking and reflecting more on this case or

this case and I think it made people more err more thorough. It impacted on practice it made people more cautious"

The above accounts provide evidence that a number of positive developments to several areas of social work practice may emerge from the initial stress and trauma associated with the death of a child. Importantly the peer support that was offered extended beyond work role and provided peer contact to social workers in their homes. Such measures potentially reduce the anxiety and isolation described by some of the interviewees in master theme two.

Despite positive changes in the social work team following Kieran's death, Beth perceived that management structures within the authority remained largely inert and continued to remain detached from the process:

"I think we came together more as a team to be heard after that. We are the people that deal with these people. When they come in we are the people that know these people. I found it really supportive, also found it frustrating, because again it was on the ground level that we were talking about it, we were dealing with it, we were trying to make the changes but the middle bit, middle management bit never changed, and they still didn't accept or talk to us about it"

Although each of the social workers provided positive examples of how practice improved following the children's deaths, it is possible, given Beth's account that these changes only occurred on the "coal face". Although such improvements are undoubtedly welcome it is possible to assert that unless they are incorporated within a wider systemic change their overall efficacy is significantly reduced.

9. INTERPRETATION AND CROSS REFERENCING OF THEMES.

The section consists of an attempt to extract the central features contained within each master theme and to apply a structure to those experiences. The overall intention is to formulate a detailed, holistic exploration of the life world of each social work practitioner, identifying both commonalities between, and differences within each experience. The bracketed sections of the text refer to the specific areas where supporting evidence for the summary can be located.

The social workers recollections of their direct work with the children and their families demonstrate the employment of both tacit and evidence based approaches to assessing the needs and risks involved (pp.100, 103, 104,107). There are clear accounts of how following the assessments their demands for protective action were not addressed in either single or inter-agency contexts (pp.107, 108, 109, 109). The result of the failure to secure action clearly impacted on all of the workers and although in the immediate aftermath of the children's deaths there were many negative experiences, from a longer term perspective all of the workers felt that they had ultimately become more effective and assertive practitioners (pp.120, 121, 122).

It is difficult to envisage a scenario where informing a colleague of the sudden, unexpected death of a child whose welfare they were largely responsible for, can be anything other than a deeply emotive and personally distressing duty. Whilst acknowledging the unenviable and challenging aspects of such a role, there appears to be a distinct absence of compassion or awareness of the impact and wider implications that the breaking of the news may have upon the workers (pp.111, 112, 114, 115). Whilst it is to be accepted that those individuals responsible for communicating the news may not have possessed all of the relevant details regarding

the circumstances surrounding the children's deaths, in relation to the experiences of Anna, Beth and Claire the receiving of only partial information undoubtedly contributed to their increased their levels of stress and anxiety (pp.111, 112, 113, 109,115, 116,117). In the case of Donna, who was informed of the context and possible actions that were to follow, the experience although traumatic contained some positive elements.

It is evidenced within the study that each death left a deep and lasting impression upon the workers involved, affecting them in both personal and professional capacities (pp. 103, 104, 105, 108, 114,117, 118, 119). The accounts gives insight into not only the personal feelings associated with the children's deaths but the impact upon each practitioner's social work practice and their perceptions of the systemic responses that followed. What emerges sheds light not only on the perceived failings and inadequacies of child protection systems but evidences some areas of practice that have potentially been strengthened and improved as an indirect consequence of the tragedies (pp.120,121,122,130,131) It is possible to conclude from the accounts provided that in relation to the lived experiences of the social workers, several interrelated factors contributed to their overall feelings of anxiety and frustration and in addition, the children's deaths played a central role in shaping several aspects of their actions in both personal and professional capacities.

What is apparent is that after hearing of the children's deaths the fear of breaching confidentiality and an unwillingness to "burden" or subject their own families to additional stress, resulted in an internalisation of emotions by the workers involved (pp.117, 118,132,133,). When viewed in conjunction with the lack of formal support they received in their workplaces, it appears that the workers became trapped in a

"double bind", unable to discuss or offload their feelings in either personal or professional contexts. Such negative emotions are further exacerbated by the process of "locking down" case files, denying the worker the opportunity to examine their professional involvement with the child prior to his or her death. Donna, in particular describes the lasting pain of not being able to check from the case files whether she had questioned the child's mother about her relationship with her new partner.

Three of the social workers involved in the study expressed negative views relating to their involvement in the serious case reviews that followed the children's deaths (pp. 125, 126, 127, 128, 129). The perceptions of a procedurally driven, impersonal and alienating process emerges in which wider managerial failings and local authority underfunding issues are ignored in favour of a willingness to locate the reasons for the children's deaths at the level of individual, usually social worker, practice errors. Crucially, the interviewees spoke of their frustration at being denied a "voice" within the serious case review process. This resulted not only in the potential loss of valuable insights into the work they had undertaken but due to the nature of the "closed" questioning and the urge for "corporate" responses to be provided, the outcomes of the review skewed away from possible systemic failures and towards individual culpability. Importantly, where, as in the case of Donna, practitioners were consulted and informed of the processes involved, direct, positive improvements to social work practice were made.

One of the most striking features to emerge from the accounts centres upon the lack of structured support the workers received both in the immediate aftermath of events and during the review process that followed (pp.135,136,137,139). What is perhaps equally concerning is the fact that even though the workers received little or no

support there was a clear expectation that they would continue in their roles and in the case of Anna, the assumption that despite receiving no structured support following Rebecca's death, her ability to deal with future deaths had somehow increased.

Before, during and after the reviews were undertaken, the level of support offered to each practitioner appears to be both inappropriate and inconsistent. Where support was offered by the local authority, in the form of bereavement counselling, it was viewed as failing to meet the wider needs of the workers involved and rather alarmingly offered to some of the workers and not others who were involved in the same tragedy. Where formal supervision was provided, in most of the cases, it also failed to address both the emotional and practice related issues arising from the children's deaths.

Anna, Claire and Donna cited their line managers as playing a crucial role in providing one to one support (pp.136, 137, 138). What is described emphasises the provision of an appropriate balance between listening, providing practical advice and acknowledging the emotional and practice issues that have arisen since the events occurred. The lack of structured support and supervision is evident and resulted in the development of informal peer support systems; it is here that many of the interviewees found significant solace and assistance.

Overall, the general perception of current social work practice described by the interviewees portrays a bleak and somewhat depressing image of a system overwhelmed by bureaucracy and enforced deadlines (pp.123, 124, 127). Despite this situation all of the workers involved continue to practice as social workers or in social work related roles. They do so in the full knowledge that the consequences of "failure" are high, that many of their "successes" will pass unnoticed and that there

remains a distinct chance that they may once again be confronted by the death of a child in their care.

10. THEORETICAL ANALYSIS OF THE RESEARCH FINDINGS

The following section relates Nagel's theory of "moral luck" and Doka's concept of disenfranchised grief to the workers' experiences. The central outcome of the theoretical analysis is the development of a concept known as the Personification of Systemic Failure. This concept explores the possibility that a combination of political, procedural, media responses, managerial behaviours and interpersonal relationships, combine to exacerbate the negative impact of the children's deaths upon individual workers and the social work teams in which they practice. The section concludes by providing insights and analysis of the practice developments and learning that has emerged as a direct result of the experiences of the social workers within the study.

10.1 Social Work Practice in Context.

The research interviews reveal how, following the sudden, unexpected death of a child under their protection, social work practitioners are confronted by a myriad of emotions and practice related issues that have a profound and lasting impact upon them in both personal and professional capacities.

As a starting point, the psychological investment required to undertake "everyday" social work practice with children and their families, provides "the potential for social workers to experience strong, even disabling feelings given the demands of the diverse, and often deeply traumatized, individuals who make up our caseloads" (Weinstein, 2008, p.154). As a result, effective social work practice necessitates the requirement to "draw extensively on our own personal resources when striving to understand and support the personal, social and emotional needs of service users"

(Hafford-Letchfield, 2006, p.108). Such emotional challenges may be sustainable in both the long and short term if the individuals concerned were to operate within a secure and supportive working environment. However, several authors and the social workers within the study describe a child protection setting where "practice itself has increasingly been dominated by bureaucratic, procedural approaches and a child protection discourse characterised by rationality" (Ferguson, 2005, p.792) and in addition "the effect of continuous reform has been to intensify the high levels of anxiety that permeate the child protection system" (Munro, 2011, p.134). Such views are supported by BASW chief executive Hilton Dawson who stated in May 2012 that:

> "The government pledged in 2010 to protect front-line social workers, yet by axing support staff they have turned social workers into glorified typists. We cannot afford to wait any longer for urgent action from government. Lives that could be helped will be neglected and lives that could quite literally be saved will be lost unless the response is swift and total. Social workers are facing an administrative overload and as a result are spending less and less time with vulnerable children and adults. Caseloads are quite simply unmanageable, posing imminent and serious risks to the people who need services"

(http://www.bbc.co.uk/news/education-18033540).

Within such a climate it is evident that the ability to cope with the challenges of providing effective "everyday" social work practice is significantly impaired. As a result of such a situation, it is reasonable to question how individual social work practitioners and the teams in which they operate are able to accommodate the

additional emotional and practical challenges that result from the death of a child deemed to be under their care and protection.

This combination of psychological stresses and organisational uncertainty are reflected in varying degrees within the research interviews and it is from such a starting point typified by uncertainty, anxiety and heightened stress levels that each practitioner began the process of coming to terms with the children's deaths.

10.2 Undertaking Assessments

Any theoretical analysis of the interviewee's experiences of assessing the children involved and their perceptions of local authorities' responses to their deaths must begin with recognition of the context in which such assessments were made. It is widely acknowledged that in relation to child protection practice there are no guarantees of complete certainty when making practice judgements. As emphasised by Munro (2008, p.40) "there is an unavoidable chance of error. It is impossible to identify infallibly those children who are in serious danger of abuse, or other harm. Professionals can only make fallible judgements of the probability of the undesirable event occurring". Munro rightly acknowledges that in the field of social work solid evidence based judgements and "text book" interventions can never totally ensure against potentially tragic outcomes. Although such perspectives are widely acknowledged by social work practitioners and academics, according to Macdonald (1990, p.525) when viewed within the wider context of media and inquiry reports there is the established assumption that "the ultimate measure of competence is that of particular outcomes and that the responsibility for such outcomes can be traced back to individuals, or groups of individuals, with who it is rightly placed.

Accordingly, a bad outcome is presumed to indicate a bad decision or negligent action".

What becomes apparent from the accounts provided is that whilst recognising the degrees of uncertainty surrounding the making of professional judgements, all four of the social workers interviewed, provided clear descriptions of "solid", evidence based, assessments of each situation. For example all of the children involved were "visible" to professionals up to the time of their deaths. Although the existence of partial or disguised compliance is evident: (the) "*babies were fed, they were well dressed", "She was a really nice mum as well and a really nice person and the children were lovely and they played lovely",* none of the children were actively hidden from professional scrutiny and none of the families entered into partial or terminal closure prior to the fatality. As a result, Anna, Beth, Claire and Donna were able to make both intuitive and evidence informed assessments, judgements and decisions about each child's situation and the potential risks to their safety.

In relation to actuarial forms of assessment, all of the children and their families would have, to varying degrees, been highlighted as presenting many of the "risk factors" associated with the need to take protective action (Dalgleish and Drew, 1989). For example in the case of Kieran: parental child management skills, his perceived challenging behaviour, family history, poverty and social isolation would have contributed to general undesirable outcomes for him. In the case of Rebecca, parental substance misuse, developmental history, attachment issues and domestic abuse would raise the level of risk posed to her wellbeing. All of these factors were described within the interviews.

In addition to actuarial assessments being used to inform decision making there is also evidence that "tacit" or "intuitive" approaches were also utilised. Such approaches often emanate from "life experiences both as a child and an adult that are often subconscious (which) with professional training we might more consciously draw on a knowledge base that includes such areas as human growth and development, psychology, law and sociology...with experience we can draw on our experiences of similar cases, transferring knowledge to new situations by analogy" (Taylor, 2010, p.74). Therefore, while statements such as "*she has not got a smile in her that woman"* and "*she comes across as cold and steely"* would not ordinarily feature as factors contributing to posing heightened risks towards children, when viewed in the context of observing the interaction between a caregiver and a vulnerable baby and when voiced by a qualified and experienced children and families social worker the connotations are evident.

Within the study there is evidence to suggest that the interviewees were allowed access to all of the children involved and through the use of both evidence based and intuitive knowledge, the risk factors posed to the children were recognised and used by the workers to form the basis of their calls for protective action to be taken. The decisions they reached were based upon the evidence available *at the time* and in the context that such decisions carry degrees of uncertainty. Yet, despite what may be regarded as "sound" professional judgements being made, the outcomes for all concerned were clearly unfavourable and ultimately it appears that the individual social work practitioners responsible for those "sound" judgements perceived themselves to bear the brunt of the blame and the long lasting negative experiences that were to follow.

Based on the interview transcripts, it is possible to suggest that ultimately the initial failings lay not in the social workers judgements in themselves but in the inability to assert those judgements in either single or inter-agency contexts. What is not implied here is any criticism of the individual social workers involved, many of the citations included in the narrative clearly evidence their frustrated and impassioned attempts to secure services for their clients; what is suggested is that ultimately it is the failure of protective *systems* to trust the social workers' judgements and ultimately to respond to their concerns appropriately that is at fault.

When viewed in the context of the review process, there exists the underlying (and incorrect) assumption that because the child has died, the wrong decisions were made. Such a viewpoint is supported by Macdonald (1990, 526-527) who asserts:

> "That a child died is generally deemed to be evidence that a wrong decision was made. Such a judgement is the application of a common everyday response; from gardening to matrimony, we readily read, bad outcomes as evidence of bad decisions", she goes on to state that "poor outcomes are neither necessary nor sufficient indicators of wrong decisions. Bad outcomes may signal the need to review pertinent decisions, but the criteria for assessment should not be the outcomes, but the appropriateness of decisions given the information available at the time".

It is Macdonald (1990) who first begins to relate the allocation of blame in social work to Nagels' (1979) concept of "Moral Luck" and such findings are directly relevant to aiding the theoretical understanding of the experiences of the social

workers in this study. Nagel notes that "identical actions can have dissimilar outcomes due to events outside of the control of the person concerned" (Nagel, 1979, p.30). Nagel uses the analogy that the act of leaving a bath running with the baby in it, would be judged as either an awful negligent act or someone being merely careless may ultimately depend on whether or not the child comes to any harm. He develops his analogy further by describing how the driver of a car that accidently runs over and kills a child may not merely feel bad about the accident but blame him/herself for the child's death even if they were only slightly negligent, for example not having the car's brakes recently serviced (Nagel, 1979).

To relate Nagel's concept to the social workers in the study, had the children not died, the outcome may purely have been that the workers became increasingly frustrated in their roles and the children continued to receive a poor or inappropriate level of service. For example, Kieran would continue to be pacified by the provision of twenty pounds per week and Rebecca would remain in her substandard placement. Such "cases" are not untypical and in fact constitute many aspects of "everyday" social work practice; more often than not they pass largely unnoticed by the media and escape the attention of most people with the exception of the individuals directly involved. However, when a child or young person in such a situation dies as a result of abuse or neglect, the outcomes for all concerned, particularly the social worker involved, are considerably different.

If we are to accept Nagel's concept of moral luck it is possible to understand how, although the social workers were not directly responsible for the children's deaths, they were involved in the surrounding events, and as a result were judged as being culpable for the undesirable outcomes that followed and as individuals internalised

their own feelings of culpability. In the case of Anna, she described the self-blame she associated with failing to secure an alternative placement for Rebecca. Donna blamed herself for not directly asking of the mother of the child if she was in a new relationship. Claire's guilt appeared to stem from her inability to convince the paediatrician and other colleagues to request a Care Order. Beth who also believed that she had simply "fallen in line" by providing Kieran with £20, also described her feelings of guilt as she believed that he had purchased a small amount of drugs with the money, which may have partially contributed to him falling asleep and succumbing to hypothermia. Such issues in themselves would hardly seem to represent drastic failures or omissions in social work practice. It is possible that each of the workers has acted in the same or similar ways when working with a number of clients in similar situations. However, in relation to the concept of "moral luck" the unfortunate outcome enormously exacerbates the feelings of failure and responsibility.

Geraldine MacDonald's paper "Allocating Blame in Social Work" (1990) centres upon a stinging rebuttal of Hollis and Howe's (1986) publication "Child Death, Why Social Workers are Responsible". Although originally published in 1986, it is possible to draw direct analogies between Hollis and Howe's assertions, the interviewee's experiences and present day assumptions regarding social work practice, in particular the SCR process. In rejecting Nagels' theory,

> their argument rests on four main moves: first, deaths are preventable and predictable and accordingly represent culpable failures; second social workers *choose* their profession and in becoming social workers accept the

> responsibility for outcomes, some of which will be bad; third, social workers have a duty to prevent death and protect children and when they fail, the responsibility rests with the individual; and finally, underpinning all these, is the claim that the social worker is the effective decision-maker, responsibility shared is not responsibility shed"
>
> (Hollis and Howe, 1986, p.20).

Although to the author such claims may seem absurd, it is in relation to such criteria that the actions of the social workers in the study appear to have been judged.

10.3 The Consequences of Loss

Any theoretical analysis concerned with examining the consequences of a child's death within the aforementioned contexts, must do so in the recognition that "despite the wealth of research that exists in the area of death, grief, and loss, the scarcity of literature examining the impact upon social work practitioners is troubling" (Simpson, 2013, p.36). However, although, significant amounts of the related literature and research around this subject centres upon working in palliative care, hospital or older adult social work settings, it is still possible to relate many of the central theoretical concepts involved to the experiences of the social workers within the study.

10.4 Disenfranchised Grief

"The literature on grief has typically used an interpersonal level of analysis, exploring psychological reactions to loss" (Bento, 1994, p. 37) Such pioneering examinations

of the grieving process, as professed within Kubler-Ross' (1969) five stage typology, have received criticism from such theorists as Doka (1989), Durall (2011) and Simpson (2013). Such criticisms centre upon the perceived individualistic nature of previous approaches and emphasise how such models largely ignore or understate the roles played by societal responses to grief and importantly how such factors may potentially serve to both facilitate and/or impair the grieving process. Whilst acknowledging individual responses to grief, Doka (1989) "extended the idea of how grief is resolved, when he emphasised its fundamental and indispensible interpersonal aspects in his theory of disenfranchised grief" (Hazen, 2003, p.80). Whilst not specifically concerned with social worker responses to the death of a client, it is the work of Doka (1989) and its subsequent adaptation by Corr et al (2002) that are best situated to provide detailed theoretical insights into the lived experiences of the social workers involved in the study. Beginning with the acceptance that "the death of an individual has a profound impact on those left behind, all are touched in one way or another by grief and loss" (Simpson, 2013) and that "societies have sets of norms, in effect grieving rules, that attempt to specify who, when, where, how, how long and for whom people should grieve" (Doka, 1892, p.4). The concept of disenfranchised grief explores the psychological, organisation and cultural contexts in which grief occurs and examines how the "disenfranchisement" of the grief impacts upon individuals, social groups and the organisations in which they practice. Doka's typology has been chosen as a central means by which to analyse the losses experienced by the social workers in the study as it locates their experiences within its wider social context and also provides a framework by which to analyse those experiences. Such an approach is also in keeping with the phenomenological philosophical orientation of the study as it recognises how personal experiences,

reactions and perceptions of events are shaped once an individual interacts with his/her environment.

It is important at this stage to acknowledge the theoretical distinction between "grief" and "loss". "Loss" is defined by Weinstein (2008, p.2) as "any separation from someone or something whose significance is such that it impacts on our physical or emotional well-being, role and status", whilst "grief" refers to "one's reactions, both internally and externally, to the impact of the loss" (Corr, 2009, p.213). Grief is likely to manifest in a number of ways and due to a number of factors affect people in varying degrees. It is generally accepted that loss typically impacts upon individuals both physically and emotionally and particularly in relation to the care workers who experience the death of a child, grief is likely to provoke "feelings of guilt, anger, vulnerability, emptiness and helplessness and may lead to crying, withdrawal and recurring thoughts of the death of the child. Caring for a dying child in pain and the unexpected death of a child are factors that can be highly distressing" (Papadatou et al, 2002, p.372)

Defined by (Doka, 1989, p.4) as "the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported" and as a result "the appropriateness of the grief is contested by the individual or by the social system to which he or she belongs" (Bento, 1994, p.38). Disenfranchised grief becomes the assumption "that a particular individual does not have the right to be perceived or to function as a bereaved person. The important point here is that disenfranchised grief is not merely unnoticed, forgotten or hidden; it is socially disallowed and unsupported" Corr, et al (2009, p.257).

Originally consisting of three broad categories but later extended to five, Doka's typology of disenfranchised grief provides a framework upon which to analyse the experiences of the social workers involved. The five categories, consisting of instances where following death: the relationship (to the deceased) is not recognized, the loss is not acknowledged, the griever is excluded, the circumstances of the death and the way individuals grieve will now be analysed in detail.

"The presumption that the sense of loss can only be experienced by a closeness or traditional relationship, normally with spouses, family, or lifelong friends" (Corr, 2002, p.40) potentially contributed to the disenfranchisement of the grief experienced by the social workers in the study. In relation to the experiences of Beth, the relationship with Kieran had been long- lasting. She had known Kieran and his family for a number of years and had been involved in a number of ways: caring; as his case worker she had been directly responsible for his safeguarding and protection, supportive; Beth had been central to providing and co-ordinating the support he received and personal; Kieran always referred to Beth by a pet name he had given her. Further evidence is provided relating to the closeness of the relationship between the social workers and their clients is provided by Anna, who several times during the research interview referred to Rebecca as "my baby". Despite this, the relationships remained outside the traditionally prescribed boundaries in which the need to grieve would be recognized. Ultimately, whilst the existing relationship is acknowledged in principle, it is defined primarily within the parameters of a "professional" relationship, negating the emotional context and the perceived acceptance of the need for Claire and Anna et al to grieve.

When viewed in the context of organisational culture, Eyetsemitan's (1998) study of grief in the workplace acknowledges that "work is organized to provide services and products and in most cases, for profit making, therefore, anything that will disrupt work is likely to threaten the survival of an organization" (Eyetsemitan, 1998, p.471). In addition, "each environment has its own work-style which includes an explicit and implicit system of beliefs, values and assumptions about the goals of care. Based on this, a number of rules are developed that prescribe the role and behaviour expected of care providers confronted with death and dying" (Papadatou, 2009, p.28). When applied to a social work context, it appears that the needs of the organisation to continue to function as "normally" as possible were placed above the individual needs of the social workers involved in the children's deaths.

Significant factors that contribute to the inability of organisations to acknowledge loss are noted by both, Doka (2002, p.8) and Stein and Winokuer (1989). Whilst both theories centre upon the prevailing need for organisations to continue to function as effectively as possible, Doka links his organisational analysis to his insights regarding kin relationships and loss. He believes that "by limiting the acknowledgement of loss to family members, organisations avoid confusion and potential abuse, affirming a single standard and eliminating the need to assess whether this loss or relationship is entitled to recognition". In their study of "death" related absence from work Stein and Winokuer revealed that many policies and procedures within the workplace define for whom it is acceptable to grieve for and for how long. The social workers within the study would clearly fall outside the "traditionally" acknowledged definition of "grievers" (usually spousal, close blood relative or sibling) and subsequently further excluded from the grieving process. In addition, the imposition

by such policies of acceptable timescales in which grief is officially sanctioned (usually three days) further compounds the issues. As Stein and Winokuer emphasise "grief research indicates that people are initially in a state of denial and disbelief after a loss and most manifestations of grief do not begin to show until weeks or months after the event. The timing, pace and pattern of grief are intensely personal, and one's ability to repress its expression in the workplace may vary widely from one day to the next" Stein and Winokuer (1989, p.93). Within the study the social workers are undoubtedly dealt a double blow by such policies; as a result of their loss not being officially recognised or sanctioned, no time, real or even procedurally defined was allowed for their grief to manifest. When viewed in the context that all of the workers were expected to continue in their roles immediately, largely alone and unsupported, there is little surprise that many of the individuals involved appeared to be greatly affected by events.

It emerges within the study that at an interpersonal level, significant others, namely service managers and line managers also failed to recognise or acknowledge the loss and the need to grieve of the workers. Each of the social workers involved in the study provided examples of when their grief or their need to grieve was not acknowledged by their managers and the organisations within which they practiced. Such a situation has previously been demonstrated, particularly in relation to social work and nursing contexts by Bento (1994, p.40) who suggests that within such professions workers are "required to keep their grief under tight control in the workplace. The rationale for this is that their grief emotions, if manifested or even consciously experienced might jeopardise the performance of their work" and ultimately "contaminate" the workplace. In such situations it is possible that

"disenfranchised grief will be present as the organisational practices and culture deliberately ignore the grief and loss being experienced by social work practitioners in favour of more immediate pressing issues related to financial constraints and lack of resources" (Simpson, 2013, p.4)

Anna, Beth and Claire all describe how, following their children's deaths, the general expectation within their organisations was to continue to practice in much the same way as before. In the case of Beth, it appears that the decision to "N.F.A" the case of Kieran following his death was used as a means by which the organisation clinically and insensitively marked his passing. This decision to "officially" close the case appears to represent an ending of any acknowledged obligation towards supporting or recognising the loss of those who were involved in his care and protection. Rather than acknowledging the grief experienced by Anna, the organisation in which she worked chose to not only expect her to function in much the same way but she was also asked to take on additional duties in relation to future child deaths.

It is possible that the negative feelings experienced by some of the interviewees were further compounded by their organisations "locking down" of computer systems and case files which contained information relating to the children involved. Although in terms of the serious case review process, it is understandable why such actions may be necessary, it is also possible that preventing the workers reviewing their actions and decisions may be perceived as the organisation further distancing itself from acknowledging and accepting the worker's loss and subsequent need to grieve.

In addition to the lack of acknowledgement of their loss within the workplace, both Anna and Beth felt unable to share their grief with their own families or significant others. Unable to find an external outlet for their feelings, many of the emotions and

frustrations that were experienced were internalised by those involved. It becomes apparent particularly in relation to the study that; "the overwhelming expectation is that social work practitioners are to carry on working, in spite of the emotional turmoil within, in order to demonstrate their competence as self-assured professionals, which means that there is little or no room to admit the "shameful" truth that such a sense of self-assurance might not in actual fact exist. It can be argued that the social work profession, by its very nature, has a predilection for self-disenfranchised grief based upon a suppression of negative thoughts and feelings by the individual practitioner" (Simpson, 2013, p.3). The potential negative consequences of such a situation are discussed in detail later in this chapter.

In an interesting departure from many of the negative experiences of her fellow workers, Donna provided many examples of her loss and grief being recognised and acknowledged by her organisation. Donna was contacted by a service manager following her client's death and was provided with a detailed overview of the situation and any possible courses of action that were to follow. In addition, she was offered a face to face meeting with her service manager, giving her the opportunity to discuss her feelings as well as highlighting possible inadequacies in the organisation's case recording system. Donna described how regular debriefing sessions which were provided to her own and a number of other agencies involved, helped her to come to terms with her loss. Fortunately, prior to the tragedy, Donna had also arranged to take a six week period of absence form work in order to move home and as a result she was not subjected to the allocation of an "official" grieving period in by her organisation. During this period Donna lived with her mother, with whom she had a very close relationship. Whilst acknowledging the need to observe

the boundaries of confidentiality, Donna spoke of how her mother's acknowledgement of her grief was particularly comforting and supportive.

It is distinctly possible that the enfranchisement of Donna's experience; the recognition of her loss and grief by her organisation and significant others, contributed to her more positive recollection of events. Although, Donna was negatively affected by some of the events relating to her client's death , it is possible that the single and multi-agency briefing and debriefing sessions that were provided, also served to depersonalize her experiences and reduce the internalization of the blame she felt.

The fourth and fifth components of Doka's taxonomy explore the hypothesis that certain types of death, the circumstances surrounding a person's death and the different ways in which people grieve may contribute in varying ways to the disenfranchisement of grief. Originally focussing on deaths from AIDS and suicide, Doka believed that "the nature of the death may constrain the solicitation of the bereaved for support as well as limit the support extended by others" (Doka, 2002, p.14). When viewed in the context of the experiences of the social workers involved in the study, it is possible to see how such issues were enacted. Many of the workers, despite evidence to the contrary, felt in some way responsible for the children's deaths. As has been noted, such feelings of self-blame were further reinforced by the negativity of the SCR process and the organisation responses to loss. It is possible to recognize how such factors may reduce the "solicitation of the bereaved" for support. The possibility exists that Anna, Beth and Donna in particular, perceived themselves as being undeserving of the right to grieve and to ask others for their support throughout their grieving process. It is feasible that at an inter-personal level, the

inability of family members to hold full knowledge of the issues involved, role expectation and the organisational need to continue to function effectively, all served to regulate the amount of support that was offered by significant others.

In a later development of Doka's theory, Rando (1993, p.14) asserts that in addition to the abovementioned factors, "deaths that provoke anxiety (e.g. suicide, mutilating loss, the death of a child), especially those that incur media notoriety or involved other family members, are likely to be disenfranchised". The experiences of the social workers contained all of these factors in varying combinations. All of the deaths involved children and young people and were clearly anxiety provoking for each of the workers. In three of the four cases family members were directly involved in the deaths. In the case of Anna, Rebecca's death attracted a certain amount of local media interest and Rebecca's mother later sold her story to a tabloid magazine. Both of these portrayals provided graphic accounts of Rebecca's death and were damning of the social workers and the local authorities involved.

Doka also noted that grief is potentially disenfranchised when the way in which individuals grieve falls outside traditionally accepted norms.

> "Because each human being is both a particular individual and a social creature, mourning has two complementary forms, or aspects. It is both an outward, public, or interpersonal process (the overt, visible and characteristically shared public efforts to cope with or manage loss and associated grief reactions) and an internal, private, or interpersonal process, a person's

> inward struggles to cope with or manage loss and the grief reactions to that loss" (Corr, 2002, p.51).

Interestingly, apart from Anna, who recalled how following Rebecca's death, she cried alone for long periods, none of the participants described exactly how their grief was expressed. Due to a number of factors (role expectations, circumstances of the death) the social workers within the study, were denied access to many of the traditional means that facilitate the expression of grief. They were not present at the funerals of the children or allowed to participate in the established mourning rituals; they were not able to "share" their thoughts and experiences of the lives of the deceased with relatives and family members. As a result it is feasible that for some of the social workers involved, their grief has yet to be fully expressed. In such situations not only is personal grief denied an external expression but the workers also felt the need present an outward persona of coping and surviving the loss. As Turner (1995, p.126) notes "many workers feel they must appear to be coping well within their work at all times. What they see as their less acceptable thoughts, feelings and actions are supressed, denied and avoided, for fear of being seen as not a good enough worker".

There is evidence of the disenfranchisement of the grief of the social workers who participated in the study. Such a situation, where the grieving process is disrupted, denied or stifled has potentially serious, detrimental consequences for the individuals involved. Doka emphasises how the presence of disenfranchised grief "can be expressed in a paradox, the very nature of disenfranchised grief creates additional problems for grief, while removing or minimising sources of support" (Doka, 1989, p.7). In such situations " the survivor is thrust into an even more complex and

difficult cycle of mourning that can delay resolution, make the process more severe, result in pathological responses or all of the above" (Bento, 1994, p.38). Such issues are potentially further exacerbated by the acceptance by the participants that due to their work roles there were no guarantees that similar events would not be repeated and that elements of their practice placed them similar circumstances to those in which the children died. Within this context not only has grief been disenfranchised but there exists the distinct possibility for further or even multiple disenfranchisements.

Stewart (1989, p.28) describes how "the absence of, or intolerance toward bereavement behaviours generally produces an intensification of grief, feelings of abandonment from and resentment towards non-supportive significant others and a potential devaluation of the self". Anna, Claire and Beth all spoke of the isolation they experienced following the tragedies and how they felt resentment towards both the organisations and some of the individuals with whom they worked. In addition, despite being exonerated of any wrongdoing, each of the workers questioned their own practice and decision making, believing that they had somehow "failed" the children involved.

Within the study all of the participants described feelings of anger, frustration and guilt following the children's deaths. It is generally accepted that such feelings are "typical" of the emotional reactions to loss; however, the disenfranchisement of grief often complicates and intensifies such reactions (Doka, 2002). Bento (1994) also emphasises that the disenfranchisement merely postpones the grieving process and ultimately grief will be expressed in a number of different, usually negative ways by the individuals concerned, ultimately, "the longer it takes (to grieve) the higher may

be the cost to the total personality" (Bento, 1994, p.38). Both Anna and Beth, provided examples of how two of their colleagues' careers were effectively ended following child abuse fatalities, Claire and Donna also ceased to practice as children and families social workers. However, there are a number of clear examples of how despite their grief being clearly disenfranchised, the participants have continued to function socially and in some instances thrive in their work roles following the children's deaths. Anna, Beth, Claire and Donna have lived with their disenfranchised grief and continued to practice as social workers for a number of years following the tragedies. They have been promoted into managerial and senior managerial roles despite a clear lack of "official" support and acknowledgement of their loss. Whilst, the detrimental impact upon the workers can never be underestimated, it is a testament to their commitment and resilience that they continue in their profession.

10.5 Support and Supervision

Social work supervision is long established as a central vehicle for ensuring effective social work practice. In 1996 the Association of Directors of Social Services identified supervision as one of the five elements of good practice (ADSS/NCH, 1996) and in 2007 Providing Effective Supervision (CWDC, 2007) became "the first national policy statement on the need for organisations in England to have robust arrangements for supervision" (Morrison and Wonnacott, 2010). Perhaps the most vociferous calls for effective supervisory arrangements have originated from the recommendations within public enquiries and serious case reviews undertaken following child abuse tragedies. Rushton and Nathan (1996) highlight how many of the child abuse inquiry reports undertaken since 1974 "in focussing on shortcomings

of professional, mostly social work, practice have consistently called for improvements in professional support systems to reduce the risk of errors or omission or commission".

Responses to the most recent public enquiry undertaken in 2003 into the circumstance surrounding the death of Victoria Climbie have consistently emphasised the need for the appropriate and effective supervision of social workers. Amongst the most influential has been the author of the report Lord Laming who stressed "It is vitally important that social work is carried out in a supportive learning environment that actively encourages the continuous development of professional judgement and skills. Regular, high quality, organised supervision is critical" (Laming, 2009, p.32).

Julia Phillipson's review of supervisory practice methods (2009), notes that despite a recent reiteration of the importance of effective supervision in enhancing social work practice its recorded functions have remained largely unchanged as the profession of social work has developed. It is recognised by Kadushin and Harkness (2002), that supervision in social work requires an appropriate balance of supervisory, administrative and educational elements. Publications such as Salaman's (1995) analysis of the managerial function of supervision have attempted to refine aspects of Kadushin and Harkness' model, yet such attempts offer only a fragmented insight into supervisory practices. Although first published during the late 1980's, it is perhaps the model provided by Hawkins and Shohet that still provides the most comprehensive model of social work supervision:

The Primary Foci of Supervision (Hawkins and Shohet, 1989)

- To provide a regular space for supervisees to reflect upon the content and process of their work (educational)
- To develop understanding and skills within the work (educational)
- To receive information and another's perspective concerning ones work (educational/supportive)
- To receive both content and process feedback (educational/supportive)
- To be validated and supported both as an individual and a worker (supportive)
- To ensure that as a person and a worker one is not left to carry unnecessary difficulties, problems and projections alone (supportive)
- To have space to explore and express re-stimulation, transference or counter-transference that may be brought up by the work (administrative)
- To plan and utilize their personal and professional resources better (administrative)
- To be pro-active rather than re-active (administrative)
- To ensure quality of work (administrative/supportive)

The above model when used in conjunction with the definition provided by Browne and Bourne (2002, p.9) emphasises that "supervision is the primary means by which an agency-designated supervisor enables staff, individually, and collectively; and ensures standards of practice. The aim is to enable the supervisee(s) to carry out their work, as stated in their job specification, as effectively as possible. Regular arranged

meetings between supervisor and supervisee(s) form the core of the process by which the supervisory task is carried out. The supervisee is an active participant in this interactional process". Such models combine both the *content* and *procedural* aspects of social work supervision and locate its position and purpose as an integral element of effective social work practice. Unfortunately, despite such assertions, in relation to the social workers in the study, there is little evidence to suggest such models of good practice were effectively employed.

Despite experiencing significantly stressful events, which had clear implications for their social work practice and their emotional wellbeing, the support offered to the workers by their organisations via supervision, was largely uncoordinated, and inconsistent. To apply the key components of Hawkins and Shohet's model to the experiences of the participants is to reveal that amongst other things, they were offered little time or space to reflect on their experiences and the provision of another perspective (particularly in the case of Beth) only served to reinforce the negativity she already felt. Beth's account typifies how the supervisor's instructions to "NFA" Kieran's case denied her the opportunity to discuss her feelings and receive guidance and support regarding how to address the issues that arose. In addition, it possible that the decision to NFA the case, without any pre-amble or discussion of the context and emotional challenges faced by Beth, reinforced the prioritisation of the agency needs above those of the individual worker. At this point it is important to acknowledge that the needs of the organisation and the prioritisation of cases and caseloads clearly needs addressing, however, the central issue must surely be one of striking a balance between agency needs and the welfare of the individuals involved.

One of the most sobering findings in the study is that each of the workers spoke of their need and desire to discuss and share their experiences with others. Interestingly, for three of the four social workers involved in the study, participating in the research interview was their first opportunity to do this and they cited supervision in particular as failing to provide a means by which to access support. Such a situation is sadly reflected in the study undertaken by Simpson (2013, p.4) who concluded that following a loss "few social work practitioners will be able to use supervision as a tool to find meaning in the midst of the loss and grief they experience. This is because managers are more likely to have been affected by the organisational priorities and culture, thus leading to the subversion of the supervision process by making it a mechanism to control and or instruct staff". There is evidence within the study that some forms of support were offered to the workers. Claire recalls how (inappropriate) bereavement counselling was offered to her colleague but not to her, and each worker describes the benefits they derived from peer support and ad hoc meetings with their managers. Although such provision is to be welcomed its random, inconsistent and unfocussed nature is clearly concerning and raises a number of questions regarding an employer's duty of care towards the individual workers involved.

It is possible, that the provision of effective supervision could serve as a means by which the grief of the participants could be enfranchised, however, given Simpson's assertions and the recollections of the workers involved, two key factors need to be considered: In such situations are line managers best placed to provide the supervision? And, if by focussing on the issues is there the potential that the supervisory process could merely serve to reinforce the internalisation of blame and

isolation felt by the workers? It would not be feasible to suggest that such provision could address *all* of the needs of all of the workers; however, when provided by an appropriate person who adopts an informed and balanced approach, it could potentially serve to facilitate the organisational acknowledgement of the workers loss and in addition provide a means by which to deliver, appropriate, targeted support to meet the worker's emotional needs. The provision of such supervision also potentially provides the opportunity to directly reflect and critically analyse the practice context of the case and inform any future practice developments. As Bento (1994) suggests, such practices provide an ideal opportunity "for people to learn about the grief process and what can be expected, then the role ambiguity, conflict and overload can be attenuated if the organisation supports the grieving employee".

Although there are many examples within the study of low levels of support and supervision being provided to the participants, there are also a number of factors that made positive contributions towards aiding the healing process. All of the social workers in the study were eager to stress the positive role that the actions of some of their colleagues and line managers played in facilitating the accommodation of their grief. The supportive actions ranged from simply taking time to listen to the workers or actively including them in office "banter", through to forming peer supervision groups and buddying systems for those affected by the loss.

One of the reasons why the peer to peer support and informal "off the record" discussions with team managers were deemed to be so beneficial by the workers involved, could be that they served to represent a less official, less judgemental and more emotionally attuned and shared response to the individual's needs. To speak to manager outside the structured format of supervision or review process may enable

the practitioners to disclose their true feelings and opinions in the knowledge that they are not being personally and professionally evaluated or having their practice methods scrutinized.

It is possible that due to the lack of "official" support on offer, the teams were left with little alternative other than to seek their own solutions to the issues they faced. Such a supposition would be supported by Weinstein's (2005) study which revealed that due predominantly to poor management and supervision:

> "More often than not, social work practitioners are likely to find coping mechanisms that enable them to either avoid or manage powerful emotions associated with the loss and the grief they come into contact with. Some social work practitioners will seek solace informally from other colleagues; others will draw on their own experiences from the past and there will be those practitioners who will lean on their religious faith" (Weinstein, 2005, p. 123).

It has already been established that alternative forms of support for the social workers in the study were severely restricted due to the fact that they felt unable to confide and seek solace from family members.

It is unclear from the study whether the combined team actions were a "natural" consequence of responding to the distress of a fellow human being, team dynamics or an *espirit de corps* shared by social work practitioners. It is possible that the team togetherness that developed following some of the children's deaths may be a result

of not only an empathetic understanding of the individuals needs but also recognition that "there but for the grace...". To contribute to the care of a fellow professional in such a way is to communicate both to one's self and to all of those affected by events that they too would be supported in their time of need.

11. THE PERSONIFICATION OF SYSTEMIC FAILURE

As the study has provided a holistic overview of the lived experiences of the workers involved and placed those experiences within their personal and organisational contexts, it is possible to analyse how and in what ways the interplay between intraneous factors, consisting of individual judgements, decisions and emotions associated with the event and extraneous factors, consisting of SCRs, managerial actions, the disenfranchisement of the social worker's grief and media and political responses to the event, have impacted upon the workers involved. It is proposed that the amalgamation of such intra and extraneous factors has resulted in what will be termed "the personification of systemic failure" (PSF). This concept refers to the possibility that the negative impact of the children's deaths upon the workers has been exacerbated by a combination of the abovementioned factors through a process that creates or at least passively endorses the assignation of individual. Using examples from within the study and supporting literature from a variety of sources, this process will now be described and analysed in more detail.

11.1 The Role of the Media in the PSF

It is important to recognise that the largely negative media portrayal of some elements of child protection practice is by no means a new phenomenon, restricted to cases of fatal child abuse or exclusive in its focus upon social worker practice, neither is such negativity entirely British in nature. In terms of the media portrayal of social work in other countries an Australian study by Mendes (2008,p.30) revealed how a national newspaper *The Herald Sun* "used the headline "Snatched" to depict a child protection case where protective workers allegedly removed a baby from the operating table within minutes of the birth". Other reports from Western Australia describe

newspaper articles depicting social workers as "out of control, unaccountable, pariahs of social ills - feeding on the distress of society" (Meemeduma, 1998, p.12).

In relation to other professions, Sue Richardson's' reflections of the Cleveland sexual abuse "scandal" in 1987, describes how:

> "The paediatricians were at the centre of a national storm of outrage - the parents of the 121 children taken into care were lionised for their courage or portrayed as the victims of a monstrous which hunt, Their voices (and) sometimes their faces dominated newsstands and television bulletins. When the courts seemed to be returning all their children to them, the nation seemed to breathe a sigh of relief, while simultaneously demanding the scalps of the paediatricians and social workers" (Richardson, 2003, p.18).

Lord Laming in his public inquiry into the death of Victoria Climbie in 2009 was also critical of senior managers and councillors in Haringey as well as the roles played by paediatricians, the police and voluntary sectors. More recently, the death of Peter Connelly in 2007, provoked media criticism of a number of professionals and services involved. Despite such examples, it is possible to argue that the unexpected often violent death of a child and the perceived failings of the social workers charged with their care and protection holds a particular attraction to the media. As Ivory and Snell (2003, p.32) highlight "whenever there is a child death inquiry, the popular press reaches for its dictionary of contempt in a ritual display of disgust at the "incompetence" of social workers". Although, other professions and agencies are by no means immune from criticism "the language is more temperate, the attention to

systems failures sometimes more rigorous, but the professionals in the spotlight are usually the practitioners who had day to day contact with the client" (ibid). The consequence of such media attention is by no means limited to creating psychological discomfort for the workers involved. The social work profession and front line practitioners in particular, have a lengthy history of bearing the brunt of disciplinary action following the death of a child. As the experiences of Diane Dietman, Gun Wahlstrom, Lisa Arthurworrey and Sharon Shoesmith, et al, will testify.

In relation to the experiences of the social workers in the study, Anna provides an account of how the local media and a popular tabloid magazine conveyed lead stories in relation to the circumstances surrounding Rebecca's death. Anna clearly perceived the articles to be inaccurate, personal and hostile to social work in nature. She recounts her feelings of powerlessness, frustration and anxiety at being unable to respond to the public, highly visible, criticism of her practice and describes her co-worker being "ripped apart" in the process. Anna's and her co-workers feelings are potentially compounded by the unwillingness of their local authority to challenge the publications on their behalf. Beth also described how the name of a newly qualified social worker was now synonymous with perceived poor practice following the publicity surrounding her involvement in a child abuse fatality.

Anna's and Beth's feelings have been replicated by a number of other social work practitioners who have themselves been directly involved in case of fatal child abuse. Martin Ruddock, the allocated social worker for Kimberley Carlile who died in 1986, recalls his "conflicting emotions" at the media and public inquiry response to his involvement in the case. His impassioned and deeply moving account describes the isolation and anxiety he experienced amidst the "tabloid clamour for personal blame

and revenge" (Ruddock, 1987, p.14). The extent of the vitriol aimed at Ruddock was so severe that his image

> "Appeared on the front page of The Star under the headline: "Kim: It was murder" Her stepfather Nigel Hall's photograph was captioned: "He killed her". Next to it came Ruddock's photograph: "He let her die" and finally Pauline Carlile:" She betrayed her baby". At this photographic show trial, the social worker was more guilty than the child's mothers, who had been found guilty in court"

There are examples within the study and supporting evidence from a number of additional sources that support the assertion that the media plays a central role in contributing to the personification of systemic failure. The naming and shaming of individual social workers and their practice detracts from the wider issues involved and ultimately provides a human face to represent the sum of all perceived failings. As noted by Franklin and Parton (1991, p.15): "Social workers have become a flagship or symbol for the entire public sector and are seen "to personify in caricature form, all the shortcomings which the political New Right assumes the public sector possess".

11.2 Politics, The Review Process and the PSF

It is suggested here that in conjunction with the negative media portrayal of social work, a combination of political factors linked to the review and policy contexts of fatal child abuse, play a significant role in relation to the personification of systemic failure. In relation to these issues, it has been suggested that rather than addressing

wider learning or systemic issues, and in order to pacify any perceived moral panic, inquiries:

> "Serve to appease public disquiet. They demonstrate that government (central or local) is not being passive; they symbolize the reassertion of moral order; and they serve to define the nature and causation of child abuse in ways which detach it from wider social processes and responsibilities. Politicians, policy makers and the public may thereby feel satisfied that their duties towards children are being fulfilled. At the same time they are reassured that these duties may be carried out by changing a small number of individuals (abusers and welfare professionals) rather than requiring alterations in social and socialization processes which would touch us all" (Parton, 1981, p.391)

The views of Parton emphasise how, within inquiries, both the demonization of child abusers and the highlighting of the practice errors of individual welfare professionals, serve to detract from many of the more complex and challenging issues associated with the wider societal recognition and responses to child abuse. He describes how the death of Peter Connelly "impacted on the highest level of politics and was stoked by certain sections of the media" to an extent that "many aspects of the case and concerns about child protection dominated the media and political discourse for the remainder of 2008 and into 2009" (Parton, 2014, p.72). The willingness to individualise the blame within this case as clearly evidenced by the public admonishment of Sharon Shoesmith by the then Secretary of State for Children, Ed

Balls and the leader of the opposition David Cameron, who affirmed that "We've had a raft of excuses and not one apology. Everyone says they followed protocol to the letter and that the fault lies in some systemic failure. But we cannot allow the words "systemic failure" to absolve anyone of responsibility. Systems are made up of people and the buck has got to stop somewhere" (Cameron, 2008).

In connection with the views Parton, several authors (e.g. Reder, 1993, 2004, Van Heugten, 2011) have emphasised how child abuse inquiries and serious case reviews in particular, also focus upon areas of individual, usually social worker malpractices, that are perceived as directly contributing to, or at least fail to prevent the deaths of the children involved. Although writing primarily about inquiries into the abuse of adults with learning disabilities, Paul Cambridge also highlights that "failings in care" cases of abuse are easy to attribute to an individual or group of people and their particular actions or inactions, suggesting a degree of individual culpability. However, such contradictions are potentially naïve and even dangerous, in that they can distract attention away from more fundamental learning points for organisations. Blaming someone can be used as an excuse for not making broader systems level improvements, for example in relation to inter-professional working or care-management" (Cambridge, 2004, p.236).

Cambridge's assertions are evident within the study; from the perspective of the interviewees they either personally felt responsible or perceived that they were made to *feel* responsible for failing to prevent the deaths of the children involved. In addition, the interviews provide several examples of individual social work practitioners being directly blamed for the children's deaths. It is reasonable to suggest however, that the "individualisation" of blame in relation to both the

perpetrators of the abuse and the workers, served to detract from the wider systemic issues involved. For example, Anna firmly believed that the substitute carer for Rebecca was becoming overwhelmed by the number of children in her care and isolated from the systems that were put in place to support her; the perpetrator of the abuse towards the child in Donna's care had become part of a large reconstituted family that had experienced on-going domestic abuse; and in Beth's opinion a place in residential care for Kieran was preferable from the cycle of physical abuse and neglect he faced. In the case of Claire the home situation within the family was typified by domestic abuse, drug use and prostitution.

From the perspective of the social workers, Beth describes how one newly qualified social worker undertook a complex s47 inquiry without adequate support and supervision. As the child who was the subject of the inquiry later died, the blame for the tragedy was firmly pinned upon the worker involved. To place the blame for such tragedies at the feet of parents in poverty, violent men, drug users, inadequate social work training and ineffective practice is to minimise the underlying aetiology of child abuse tragedies. Although such factors may contribute to the deaths of children they cannot be clinically disassociated from the wider societal factors that are involved. The challenge for Inquiries and reviews is to recognise and address the forces that create social deprivation and poverty, which disempower and isolate parents and carers, in particular, women. Although there are clear lessons to be learned from the inquiry process, a real danger exists that in many ways they provide only a superficial "comfort blanket" of a response, they supplicate the public calls for justice and create the illusion of governmental concern and reaction.

Anna, Beth and Claire provide a number of instances where, in their opinions, the local authorities in which they practiced used the SCR process to mask deficiencies in such things as service provision, supervisory process and managerial accountability in favour of attributing blame to failures within individual practice. For all of the workers the needs and the media image of the local authorities were prioritised above the needs of the individuals or the necessity to learn from the tragedies. Anna and Beth describe a process in which the local authorities, via the SCRs became "*a self-protecting tool*", willing to allocate individual blame, or willing to allow blame to be allocated, to the individual workers involved.

The interviewees provided examples of how, in preparation for the review, rather than being advised to openly contribute to the process, they were told by senior managers of what they *should* and *should not* say to the reviewers. The advised responses were described as being "corporate" in nature. Both workers described how they were interviewed alone and by a panel consisting of people who they did not know, further adding to their feelings of isolation. Following the interviews Anna, Beth and Claire were not offered any form of debrief. Anna was not offered the chance to debrief even after she had attended the coroner's inquest and listened to the evidence including graphic accounts of Rebecca's injuries. It is little wonder, given such occurrences, that the review process was highlighted as being a particularly traumatic experience for the workers involved.

The format of the reviews themselves, in the cases of Anna and Claire consisted only of "closed" questioning and prohibited them from providing their own personal accounts and experience of events. There is evidence in the interviews that within the SCR review process, some of the workers were simply asked such (closed) questions

as whether certain assessments and case recording had been completed on time? Or if the appropriate number of statutory visits had been undertaken? Such questions do not then seek to elaborate upon the quality, context or the inter-personal dynamics that were in operation during those visits and assessments. The interviewee's perceptions are of the "wrong questions" being asked during the reviews and with the exception of Donna; they describe their anger and frustrations at being unable to highlight how such things as the lack of supervision and managerial failings contributed to the failure to protect the children involved. It is suggested here that those who are viewed as directly responsible for the "bad" outcomes and who are lowest in the organisational hierarchy: social work practitioners, that suffer most as a result of such assumptions.

11.3 Interpersonal Relationships and the PSF

Any discussion relating to the personification of systemic failure must also address the inter-personal relationships that may also serve to reinforce the feelings of blame experienced by the social workers. At a personal level, the social workers describe how there emerged a professional distance between the social workers directly involved in the events and some service and team managers within the authority. Along with the aforementioned lack of support and supervision a number of other factors were described, for example Beth conveys how her team manager only reinitiated contact with her and offered her support after the review had been completed and she had been fully cleared of any wrongdoing. Anna and Claire believe that ultimately the decisions of the senior managers not to remove the children and act on the social worker's advice played a crucial part in the tragedies.

Anna firmly believes that the guiding factor underlying her manager's decision was based largely on resource issues rather than the actual needs of the child.

Anna, Beth and Claire perceived that managers and management system were exempt from the attribution of blame following the reviews, thus creating further "distance" between the individual practitioners and their organisations. They question why the lack of staff support and supervision, reduced training opportunities and poor or no decision making from management was not highlighted within the reviews and how no managers or senior managers were deemed to be accountable for their actions and inaction. Such a situation is in sharp contrast to their accounts of individual workers, who experienced reviews being *"ripped apart"* of operating within a *"minefield of blame"* and a *"blame culture that thrives like a cockroach"* existing in some local authorities.

11.4 Conclusion

When viewed collectively, a media-fuelled public clamour for "justice", an inability or reluctance on behalf of the government to acknowledge and address issues of underfunding and understaffing, an alienating and stigmatising review process and detached and insensitive management systems, potentially combine to either deliberately or inadvertently create a process by which individual social workers are apportioned blame and scapegoated in relation to child abuse fatalities. Within the study, and at all stages of the process, there are clear examples of how the "real" voices of the practitioners have remained unheard.

SCRs are now firmly established as *the* means of providing a resource for reviewing, learning from and hopefully reducing the deaths of children and young people. The

executive summaries of cases are readily available on most LSCB websites; they provide a publicly accessible and detailed account of each individual case. The question must be asked however, is what new learning and information is emerging from the reviews? Whilst failures in communication, inter-agency working, record keeping and inadequate assessments are frequently recounted, how many of the reviews reflect the experiences of the workers involved in the study? How often are such factors as poor supervision, ineffective management, lack of funding, deficits in preventative services, understaffing and newly qualified social workers holding too many and too complex cases cited as contributing to the deaths of the children involved?

The accounts of the individuals involved represent only a small fraction of the numbers of social workers who have been directly involved in SCRs, and even though all of the workers recounted a number of instances where colleagues have endured similar experiences it must be acknowledged that the representative sample is still very small. As a result care needs to be taken before making any broad practice analogies however; those interviewed describe their experiences of a review system that in some instances asks the same largely irrelevant questions to the wrong people. Potentially the voices of those individuals who are able to make the most telling insights and contributions to our learning are denied a voice. In addition, the interviewees describe instances where they remained largely unprotected from professional scorn and the public admonishment. Based on the experiences of the social workers involved in the study, in some instances the SCRs created only the illusion of action; detracting from the wider need to address the underlying aetiology of a deeply serious and emotive social issue.

Eileen Munro recognised some of the above issues as early as 2005, and emphasised that:

> "Inquiries have typically ended once professional mistakes have been found. Social workers failed to interview the child; the health visitor misinterpreted the evidence she had been give; the doctor did not share crucial information with other professionals. The cumulative results of thirty years of child abuse inquiries have created traditional solutions: psychological pressure to avoid mistakes, increasingly detailed procedures and guidelines, strengthened managerial control to ensure compliance, and steady erosion of the scope for individual professional judgement through use of standardized protocols, assessment frameworks and decision making aids" (Munro, 2005, p.533)

The above quote contains a number of parallels to the experiences of Anna, Beth and Claire and potentially reflect many of the "systems" that were in place at the time of their involvement in the children and families in the study. In the same article Munro argues for a "systems" based approach to reviewing child deaths and as such makes a potentially significant step towards both recognising and preventing the Personification of Systemic Failure. Such an approach:

> "Looks for causal explanations of error in all parts of the system, not just within the individual. When a traditional investigation identifies human error as a cause, it is assumed that the person who erred "could have acted differently" - that her or she can be

> held responsible for omitting a crucial step or misinterpreting a vital piece of information. The systems approach has a more complicated picture of causality. The human operator is only a factor; the final outcome as a product of the *interaction* of the individual with the rest of the system. It has been found that human errors are not usually random but can be understood and predicted by seeing them in this wider context" (ibid, p.535)

It is possible that if such a system was to be used in relation to reviewing the involvement of Anna, Beth, Claire, Martin Ruddock and Lisa Arthurworrey et al, the personal and public and perception of their roles may be significantly different.

As a result of Munro's suggestions and in conjunction with the Social Care Institute for Excellence (SCIE), a number of recommendations for new systems for reviewing child death has now developed. The proposed format centred upon the principles that:

- The 'systems' model helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely.
- It provides a way of thinking about frontline practice and a method for conducting case reviews.
- It produces organisational learning that is vital to improving the quality of work with families and the ability of services to keep children safe.

- The model has been adapted from the systems approach used in other high risk areas of work, including aviation and health.
- It supports an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken.

- It involves moving beyond the basic facts of the case and appreciating the views from other agencies and professions

- It is a collaborative model for case reviews - those directly involved in the case are centrally and actively involved in the analysis and development of recommendations. (SCIE, 2012, p.1

In January, 2013, The Welsh Assembly in its guidance; Protecting Children in Wales (Llywordraeth Cymru, 2013) outlined its own system for undertaking "Child Practice Reviews" and incorporated many of the elements to Munro's and SCIES's recommendations. From an English perspective there are also examples within this research study of some positive practice developments containing elements of these proposals. Donna was the social worker who had directly experienced the most recent child death. She provides a number of examples during her interview of how, despite being clearly affected by events, her inclusion in the SCR review process not only alleviated some of the stress she experienced but also directly contributed to changing social work practice. The actions that contributed to her more positive experience, involved such simples acts as being personally introduced to the chair of

the review panel, meeting directly with them and the provision of regular single and multi-agency briefing and de-briefing sessions. Donna describes how the chair person actively sought out Donna's opinion to the extent of sitting together in front of a computer and highlighting the technical flaws that existed within the case recording system. The local authority in which Donna worked attempted to include her in all stages of the review process; starting with an informative but sensitively conducted telephone call and concluding with a positive and inspiring email when she left to begin a new post.

In the cases of Anna and Donna the organisation and development of buddying systems, peer supervision and multi-agency briefings were all cited as being beneficial in helping their recovery process. Not only were such initiatives instrumental in dealing with the emotional losses experienced by the individuals and teams involved, there were several examples of how they had directly contributed to enhancing social work practice. Anna recollects how following Rebecca's death, case recording in her team significantly improved, whilst Donna's disclosure to her team manager directly contributed to enhancing electronic recording systems in her authority.

At a personal level identified improvements centred on such areas as: case recording, assertiveness and developing relationships with the children and families with whom the workers were allocated. Each worker also described how their involvement in the tragedies had also engendered a deep understanding of the personal processes and emotional challenges associated with protecting children. When viewed holistically, such a combination of knowledge, practice skills and emotional intelligence potentially provides an excellent resource through which to inform and develop

several important aspects of social work practice. Such potential is recognised by Thompson (2009) and also emphasises the necessity to not only possess knowledge but to provide a means by which it is effectively integrated into practice. His, *Select, Integrate, Reflect* model recognises that a clear understanding of the context within which specific areas of knowledge are required and applied, the integration of different forms of knowledge and the ability to reflect on our actions and their consequences, if communicated effectively, provide a solid basis for practice development. Importantly, Thompson's assertion that "social workers are human beings dealing with emotionally demanding situations and so we should not underplay the importance of understanding how emotional issues apply to us as workers" (Thompson, 2009, p.85) recognises the wider context in which practice is conducted. The value of combining knowledge and emotional intelligence is also supported by Howe (2008) who stresses:

> "Our knowledge base, then should not been seen as something hard and solid, to be distinguished from softer, more uncertain issues of feelings and emotional responses. These two sets of factors, thinking and feeling need to be integrated, as they will often influence each other and indeed, they will both influence our actions. Consequently, it is imperative that we take on board the emotional dimension of practice in addition to the cognitive elements of knowledge and thought".

As a result of their experiences the social workers in the study have in their possession a plethora of skills and knowledge relating to a number of extremely important areas of social work practice. It must also be acknowledged that they

represent only a very small fraction of workers who have been directly involved and affected by cases of fatal child abuse. Unfortunately, despite the fact that all of the workers in the study had continued to work in social work or social work related professions following the children's deaths and had progressed positions which involved both senior managerial, managerial and practice education elements, there appears to have been very little opportunity for them to share the knowledge and experience they had gained. Every worker in the study described how taking part in the research interviews was for them, the first opportunity outside the review process to share their thoughts and experiences in an open and personal manner, free from the fear of being blamed or judged by the quality of their answers.

Although, there are no sweeping solutions that will negate all of the stresses experienced by the workers, it appears that simple acts of inter-personal communication: listening, empowering, valuing, including, when displayed by managers and those undertaking the reviews, played a key role in enabling the workers to address and learn from her loss. Ironically all of these skills are intrinsic to effective social work practice but do not seem to have been replicated consistently in the experiences of all of the social workers in the study.

It is possible that if the positive experiences of Donna were to be replicated, more workers would potentially feel more valued, empowered, supported and secure within the workplace. In addition SCRs would potentially provide more insightful, informed and detailed information about each tragedy. The wider undertaking of such an inclusive approach creates the potential for the perception of SCRs to change. Rather than being viewed by the workers as an externally enforced mechanism that isolates and compounds the blame and self-recrimination they already feel, the have the

potential to become an inclusive process and a means by which real learning and organisation change could be achieved.

Within the study there is clear evidence of how each of the workers attempted to instil their acquired knowledge in the practices of their peers, managers and social work students. Such efforts are clearly commendable but potentially make only localised, piecemeal changes to social work practice. SCRs are now established as the central means by which "learning" from child deaths can be achieved. However, there are examples within the study where the potentially valuable contribution of social workers who have directly experienced such tragedies appears to remain a largely untapped resource. Evidence within the study identifies the workers as being able to provide valuable insights into both the emotional and practical issues involved. However, predominantly due to the atmosphere of negativity, the quest for blame and the corporate focus of SCRs, their contribution is nullified and their voices remain unheard.

12. DISSEMINATION OF FINDINGS RECOMMENDATIONS

Two of the aims of the research project are: to locate the experience of social workers involved in cases of fatal child abuse within its organisational context in order to identify and inform potential areas of practice development and to contribute to further research and development initiatives relating to cases of fatal child abuse and the child death review process. Such aims are in keeping with the stated philosophy of the Professional Doctorate programme which centres upon the "acquisition of knowledge and research skills, to further advance or enhance professional practice" (Lee, 2009, p.6). It is therefore essential that the research project and its findings should be made available to social work practitioners, and managers, social work teams and LSCB's who may be able to integrate some of the learning into their working practices and also to fellow researchers and academic bodies who are best positioned to undertake any potential further research in this area. With such issues in mind the following approach to research dissemination will be undertaken:

- Applications will be made to LSCB and University conferences and practice learning events throughout the UK to present the research findings via keynote speeches and seminars.
- A paper has already been accepted for presentation at the New Buckinghamshire University Safeguarding Conference in May 2014.
- Presentations of the research findings will also be undertaken via the Sheffield Hallam Research Café, Research Seminar Series and Sheffield Hallam University Research Conference.

- In order to facilitate wider geographic dissemination of the research findings it has been agreed that upon successful completion of the Professional Doctorate Programme, meetings will take place between the author and the Media and Public Relations department at Sheffield Hallam University.

In order to disseminate the research to fellow academics and researching practitioners, applications will be made to present the research findings at a number of conferences:

- A presentation of the research has already taken place at the 13th ISPCAN European Regional Conference on Child Abuse and Neglect, 15th - 18th September 2013
- Application for presentation at 9th BASPCAN Congress, 12-15th April 2015
- Application for presentation at the Sheffield Hallam University Faculty Research Day in June 2014.
- It is proposed that several papers centered upon different aspects of the research will be submitted to peer reviewed journals (Child Abuse Review, Qualitative Social Work Research, British Journal of Social Work) for consideration for publication.
- In order to explore possible international applicability of the research a proposal will also be sent to the ISPCAN journal for consideration for publication.

When considering any recommendations from the research, it must be acknowledged that the project consists of a small scale study highlighting the lived experiences of four social work practitioners. Although within the study there are examples of how other practitioners have shared similar experiences, it is essential that any recommendations are kept within the context and potential limitations of the research.

In conjunction with the aforementioned method of dissemination, it is envisaged that the availability of the research to LSCBs will enable a number of localized practice developments to emerge. It is feasible that future larger scale projects, stemming from the original research, may facilitate the development of national or international practice developments. In keeping with the doctorate's stated aims it is envisaged that distribution of the research findings will contribute to enhancing and developing professional practice in the following ways:

- The dissemination of the research will contribute to a number of practice initiatives and future research projects in relation to social worker experience of fatal child abuse.
- The possibility of applying the research findings to different agencies (nursing, midwifery, social care, residential care workers) is explored.
- LSCBs will use the research findings to develop systems of support to address the personal and professional needs of social workers who have been directly involved in cases of fatal child abuse.
- LSCBs will explore means by which social work practitioners could be more effectively included in the SCR or IMR process.

- LSCBs will recognize that the social workers may be significantly affected by the death of a service user and those policies and procedures are reviewed in order to acknowledge each worker's potential need to grieve.
- Managers and Senior Managers will review supervisory practice in order to address the additional needs of social work practitioners who have been affected by their involvement in cases of fatal child abuse. It is suggested that in particular attention is given to the emotional impact of case of fatal child abuse upon social work practitioners.
- LSCBs consider means by which practitioners, managers and senior managers may receive appropriate training, development and support in order to address both team and their own needs in relation to supporting staff that have been affected by cases fatal child abuse.
- Local Authorities take steps to recognize the impact of negative media responses to social workers who have been involved in cases of fatal child abuse and respond accordingly to supporting those who are identified.
- Where applicable, Local Authorities develop procedures and processes to enable researchers to submit research proposals and discuss the undertaking of research projects.
- Local Authorities develop systems by which research findings may be publicized within their authorities in order to enhance and develop practice.

13. CRITICAL REFLECTION

This section is designed to provide insight into my own personal and practical experiences associated with undertaking the research. The opening section aims to reflect upon my own personal feelings throughout my "research journey". The second section primarily focuses upon the more practical issues associated with conducting and writing a doctoral level research thesis. The undertaking of the Doctorate in Professional Studies programme has marked a significant step in my "learning journey". This journey began when at the age of twenty-five, having no qualifications and no formal schooling after the age of twelve, I enrolled on a "TOPS" Introduction to English and Mathematics course at Barnsley College. Prior to my enrolment on the course, my academic "record" consisted only of several court appearances (for my parents) due to my persistent truancy from school. Twenty five years later, I can still clearly remember standing outside Barnsley College physically shaking at the prospect of returning to learning. Taking those first steps back into a classroom environment represent one of the most significant challenges I have ever had to face. It is not unreasonable to say that I have since developed a thirst for knowledge and understanding. My studies progressed through to a University Access course, the Diploma in Social Work and BA and Masters level courses. My embarkation on a course of doctoral level study represents the undertaking and culmination of a personal and professional challenge and desire to test my abilities and hopefully succeed at the highest academic level.

I have found the modular format of the Professional Doctorate programme particularly beneficial in relation to developing and enhancing my academic practice. I have employed several aspects of the programme into my own teaching and

professional development. Since beginning the course, I have successfully completed the Sheffield Hallam PhD Supervisors course and I am currently involved in supervising M.A and doctoral level supervisions.

It has however, been the undertaking of the research module of the course that really brought the learning experience to life. Although I had undertaken a small scale research project as part of my M.A in Child Protection, the subject area and format of the research had been chosen by my employer and overall I did not fully embrace the learning experiences involved. My current research project has provided me with a previously unknown level of intellectual and creative freedom. Choosing a subject area, selecting a research paradigm and conducting the research interviews has been both a challenging and immensely rewarding experience.

It is difficult to encapsulate the range of emotions that I have experienced since undertaking the study. Long periods of frustration, self-doubt, anxiety, and dejection have been mixed with bouts euphoria and elation. My behaviours have fluctuated between long periods of silence to enthusing wildly about the research to anyone willing to listen. I can only imagine the impact that my tantrums and tears have had on my wife and sons. So many feelings are associated with seeing an initial idea develop into a research project that has already been presented at an international conference and received offers of publication. The positive feedback I received after presenting a paper about the research at the ISPCAN Conference in Dublin in Sept 2014, confirmed for me that not only is the research of academic interest to a range of different professionals both nationally and internationally, but its findings may in

some way directly contribute to enhancing the welfare and protection of some of the most vulnerable children in our society.

It is not an exaggeration to reveal that the research project was in danger of never getting started. Despite being accepted by the SHU ethics panel and having all the desired "paperwork", my attempts to obtain research participants by the means stated within the recruitment strategy failed miserably. In total I contacted a total of fifteen LSCB's. Only two replied to say they would not take part, one actually changed their mind after attending an overview presentation of the research aims but later withdrew their offer on the morning we were due to meet. They did however, inform me that they would be interested in hearing the outcomes of the research should I wish to share them. The response from the other thirteen LSCB's, was non-existent. My attempts to recruit participants were met with only unreturned emails and telephone messages. Even individuals in areas where I had previously worked and who I knew personally, did not respond. The nearest I ever got to an official response was from one local authority who repeatedly forwarded my enquiries to the council tax department!

Prior to undertaking the project, I was under no illusions that I would be overwhelmed with social workers willing to share such intimate and challenging experiences. I did however (perhaps naively) assume that even in these hectic and challenging times, LSCB's would be interested in the study and provide a means by which to access and discuss its aims with potential volunteers. My investigations revealed that only one of the local authorities I approached had a research protocol which provided a means to submit research requests (this local authority actually

refused to even consider my proposal). All of the other authorities had no process in place, hence the recommendation in section sixteen.

I cannot help feeling, based upon my experiences, that the processes or lack of them, were largely irrelevant and that the subject matter within the study was the main reason for the LSCB's none engagement. In total an additional four social workers contacted me "off the record", each one recalled experiences that closely mirrored those of the participants in the study; however all were reluctant to participate for fear of the consequences of being identified by their employer. As a result of their concerns, I actively discouraged them from participating in the study.

Whilst I can fully understand why individual practitioners, without the backing of their employers were reluctant to participate in the study, I struggle with the blanket reluctance of LSCBs to even *begin* to engage in the learning process. I can understand that for a local authority or an LSCB the revelation that some of their employees at times of often acute distress remained unsupported and unsupervised may not portray them in an entirely positive light and that often as a result of systemic process the *real* learning children's death may be ignored, yet this does not justify prioritisation of image over learning. If we are to accept that the reluctance to engage may be even *partially* attributable concerns about "bad press" we are to acknowledge that as in the study, the needs of employees and the opportunity to enhance the safeguarding of children comes second to the perceived needs of the authority involved. Although the findings from the research may make difficult and uncomfortable reading for everyone involved, the potential long term learning from

its findings should far exceed the short term discomfort of senior managers and LSCB representatives.

The undertaking of an Interpretative Phenomenological Analysis has provided me with the opportunity to use a relatively new research paradigm and apply it to an under researched area of social work practice. As a starting point the guidance provided by Jonathan Smith (Smith, 1999) is an excellent resource; however to attempt to "know" exactly what phenomenology is, is to be confronted with a range of literature that overall is often confusing and contradictory. Although, I feel that as a result of my research I have developed a clear understanding of the central facets of phenomenological philosophy, a detailed understanding of the concept as a whole still remains for me somewhat illusory.

As a result of its epistemological starting point, IPA may always remain on the periphery of "hard" science and as a consequence, be open to criticism from more positivist orientated research methods, this situation reveals both IPA's the strengths and limitations. On the negative side, it is possible that for some academics the lack of "hard" data and testable hypothesis reduces the overall efficacy of the research. It must be acknowledged that the very nature of the study also reduces the ability to make any wide scale recommendations or sweeping generalisations. However, when evaluated as a means by which to gain insight and depth of understanding into the lifeworld of the individuals within the study, the choice of this paradigm has personally been enormously beneficial. What the philosophical underpinnings of phenomenology recognise is that individual experiences are interpretative in nature and form part of a sense making processes that emerges as a result of person's

interaction with their environment. As a result, perceptions of events are essentially multi-perspectival and may differ depending upon both the individual involved and the context of each experience. IPA provides a means by which to analyse, interpret and record such experiences but does so in the acceptance that this action is in itself also interpretative in nature. If we are to accept that IPA strives for depth and understanding at the expense of scope and transferability, we are presented with a process through which the lived experiences of participants are brought to the fore and presented for our interpretation and understanding.

In terms of my own future learning and development, in addition to publishing and publicising the research findings, I would like to examine the ways by which some issues raised within the study may be addressed and further developed. For example developing support packages for social workers who have been involved in cases of fatal child abuse or enhancing social worker involvement in the review process. In addition it is possible to develop the themes further by exploring the applicability of some of the research findings to different occupations and agencies.

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APPENDICES

APPENDIX ONE PARTICIPANT INFORMATION SHEET

PARTICIPANT INFORMATION SHEET

"Social Worker Experience of Fatal Child Abuse; an Interpretive Phenomenological Analysis"

About the research:

- My name is Lee W Pollard; I am a Senior Lecturer in Social Work at Sheffield Hallam University. I am conducting a research project as part of the Doctorate in Professional Studies programme at Sheffield Hallam. The research aims to provide a detailed exploration of the lived experience of social work practitioners who have been directly involved in cases of fatal child abuse. Its key objectives are:
- To enhance the understanding of how involvement in cases of fatal child abuse may impact upon social work practitioners both personally and professionally
- To locate the experience of social workers involved in cases of fatal child abuse within its organisational context in order to identify and inform potential areas of practice development
- To contribute to further research and development initiatives relating to cases of fatal child abuse and the child death review process.

Why have I been asked to volunteer?

- The research is seeking to interview qualified social workers who have been directly involved in cases of fatal child abuse.

Do I have to take part?

- Participation in the research is entirely voluntary.
- You have the right to terminate your involvement in the research project at any time up to the point of data analysis
- During the interview, you have the right to decline to respond to any questions or prompts that you may cause you distress or discomfort.
- You will be offered to opportunity to take "time out" during the interview should you experience distress or discomfort.
- All data will be anonymised and pseudonyms used in relation to interviewees, professionals and service users. The names of specific services, agencies and geographic locations will also be anonymised.

What do I have to do?

- As a participant you will be asked to take part in a one to one, semi-structured interview with the researcher. This will last for approximately 1 hour.

- The interview will be conducted at a time that is convenient for you and at an appropriate venue agreed between you and the interviewer.
- The interviewer will ask you questions relating to your experience of being involved in a case/s involving fatal child abuse.
- The interview will be recorded.
- At the end of the interview all participants will be provided with information about the sources of support available should the content of the interview prove distressing.

What happens to the information I give at the interview?

- The interview will be recorded using password protected digital recording equipment.
- The interview will be transcribed either by the interviewer or by University approved transcription services
- The transcript will be stored on a password protected computer and also on a password protected file site.
- The transcribed interview will be analysed and the analysis will be used to contribute to wider research project.

What will happen to the results of the study?

- The research study will be submitted in line with the requirements of the Doctorate in Professional Studies award.
- One permanently bound (i.e. hard-bound) copy of the thesis shall be sent to the University Learning Centre and a loose copy of the title page, list of contents and abstract which will be sent to the British Library.
- The whole or parts of the thesis may be used for publication and/or conference or educational purposes.
- A summary of the research findings and recommendations will be provided to all research participants

Contact details for further information:

If you would like further information about the research project please contact:

Lee W Pollard
Room 504 Robert Winston Building
Sheffield Hallam University, Collegiate Crescent Campus
S1 1WB
Tel : 0114 225 5652
Mobile 07958198389
e-mail: l.pollard@shu.ac.uk

Thank-you for reading this information sheet and considering taking part.

APPENDIX TWO PARTICIPANT CONSENT FORM

Social Worker Experience of Fatal Child Abuse and Interpretative Phenomenological Analysis"
Name of researcher: Lee W Pollard

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information , ask questions and have had these answered satisfactorily ☐
2. I understand that my participation is voluntary and that I am free to withdraw without the need to give a reason, up to the point of data analysis beginning ☐
3. I have been informed that the interview will be recorded and I give my consent for this recording to be made ☐
4. I understand that the information will be treated as confidential and will be anonymised ☐
5. I agree to the use of anonymised direct quotes from my interview in publications and presentations arising from this study ☐
6. I agree to take part in this study ☐

Name of Participant Signature Date

Name of Researcher Signature Date

Adapted from King, N (2010) Interviews in Qualitative Research, Sage, London