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Allegations against people working with children: a study of initial decision making.

A study submitted in part fulfilment of the requirements of Sheffield Hallam University for the degree of Doctorate in Professional Studies (Health and Social Care)

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Abstract

The study explores the initial decision making of managers within services for children when faced with an allegation of abuse against a member of staff. Much has been written about thresholds for intervention in response to abuse of children within their families. When the alleged abuse or poor childcare practice is by professionals, the initial decision making is equally complex, but the thresholds for inclusion in the formal safeguarding processes have received less attention. The study responds to the gap identified by practitioners in determining the appropriate level of intervention to reported behaviours across a range of children's services. It makes available summary descriptions of nine allegations reported between March 2008 and February 2009, in two Local Safeguarding Children Board areas. Descriptive accounts from the participants, obtained through semi structured interviews, provide insight into the actions taken and approach to decision making including the role of relationships. The descriptions included systematic information gathering and consultation with others, conducted within a tight time frame, which was not dependent on knowledge of safeguarding children procedures. The findings suggest that awareness of specific safeguarding procedures for the management of allegations did not enhance practice or decision making, and could operate to blur responsibility for decision making. Further data was drawn from semi structured interviews utilising vignettes constructed from the anonymised real cases to explore the levels of incidents reported across agencies. The finding that practice varied more between areas than between agencies suggested that responses were attuned to local interpretation and implementation of the national guidance. The comparison of responses across the study suggests that in some situations the current processes for managing allegations may not serve either the welfare of the child or the best interests of the worker.

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CHAPTER 1: Introduction

1.1 Introduction

The media reporting of Peter Harvey's acquittal on charges of attempted murder and grievous bodily harm with intent, in April 2010, was unusual in the sympathetic reporting it attracted of a serious physical assault by a professional. The science teacher had admitted causing grievous bodily harm without intent, after hitting a fourteen year old pupil in his class with a three kilogram dumbbell. The young person sustained a fractured skull. The media reporting focussed largely on the misbehaviour and disruption of a group of young people in the classroom, in the process casting them as the villains. Peter Harvey, portrayed in a fragile state of health, receiving treatment for stress and depression, became the victim of the story.

The absence of concern for the physical injury and any long term emotional harm to the pupil victim from such an attack by a trusted adult, or the welfare of the pupils who witnessed the attack, was notable within the popular media. It raised important questions about children's rights to be protected from abuse by people who are expected to act in their best interest, in the context of some public and professional support for a return to corporal punishment within schools[1]. During the period between the incident and the trial three websites were initiated in support of Peter Harvey. The websites propagated critical messages about unruliness, violence and intimidation experienced by teachers. Similar messages could be found in the election campaigning of the same period with notions of "restoring discipline and order in the classroom" (Conservative Manifesto, 2010). The subsequent Coalition Agreement included a commitment to giving heads and teachers the powers to ensure discipline, along with anonymity for teachers facing allegations of abuse, and extended powers for head teachers to search pupils (HM Gov, 2010a). These measures found expression in the Schools White Paper *The Importance of Teaching* published on the 24th of November 2010 (DfE,

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[1] Sources of information include national newspapers, government funded consultation, and parenting advice websites. See Guardian Newspaper 03/10/2008; Times Educational Supplement 10/10/2008; The Telegraph Newspaper 23/02/2007; Daily Mail Newspaper, 01/12/2004; Child Alert, 07/01/2001; UK Youth Parliament Poll, October 2008; The Guardian Newspaper, 08/01/2000

2010a) and feature within the Education Bill laid before Parliament on the 26th of January 2011 (DfE, 2011a).

The care and control contradictions in the responses to children are one of the issues that emerge when considering allegations against people employed to provide for their education, paid care and supervision. The construction of images of unruly young people, short of effective discipline, committing anti social behaviour is one side of the argument. This exists alongside images of childhood as a time of vulnerability, with increased social anxiety about risks to young people and their protection in an uncertain and unsafe world (Buckingham, 2000; Parton, 2006, H.M Gov, 2010a). The majority of allegations arise due to some form of physical intervention (DCSF, 2009). Some occur within the context of restraint which young people in care report as provoking emotions of panic, humiliation, stress, and resentment against the staff members doing the restraining (Morgan, 2004a). Unpicking issues of appropriateness of the physical response, the level of force used, and the intent on the part of the worker towards the child can be problematic for managers when faced with contradictory, inconsistent or ambiguous accounts.

Allegations of a sexual nature equally attract polarised responses. The media portrayal of paedophiles and demonstrations of public anger at the actions of professionals such as nursery worker Vanessa George, who was convicted of sexually abusing pre-school age children, generate a vocabulary of the behaviour as 'monstrous', 'vile' and 'evil'. This is in stark contrast to the counter narrative that some sexual abuse allegations made by young people in residential care and schools are malicious (Webster, 2005; Sikes and Piper, 2010) and motivated by compensation (Webster, 2005), or retribution (Sikes and Piper, 2010). Webster, and Sikes and Piper, accept that sexual abuse of young people in care and school settings does take place. Sikes (2006, p.266) however also tells stories of "attraction and consensual sexual relationships" between female students and their male teachers and questions the "blanket prohibition" of pupil teacher sexual relationships enshrined within the Sexual Offences Act, 2003. An estimated fifteen hundred teachers are involved in relationships with pupils in any one year (Revell, 2002; Sikes, 2006). The awareness within schools of consensual relationships between teachers and pupils, and pupil infatuation, serves to add to

the complexity for managers faced with an allegation of sexually motivated behaviour or sexualised language which may have arisen in a private space, un-witnessed, and for which there may be no other physical or supporting evidence.

The ongoing revelations of historic abuse in relation to church based institutions and other establishments provide a reminder of how difficult reporting abuse can be, particularly when the alleged abuser is in a professional role or position of trust. The twelve victims of Derek Slade who experienced physical and sexual abuse while at private schools in Wicklewood, Norfolk and Great Finborough in Suffolk did not make complaints for more than twenty years. Derek Slade was convicted and sentenced to twenty one years imprisonment by Ipswich Crown Court on the 6th of September, 2010. It was only as adults that the victims reported to police the abuse they had experienced between 1978 and 1983.

1.2 Reasons for the study

In April 2006 the management of allegations against people who work with children received a higher profile. This was the outcome of a series of developments. The Children Act, 2004, had changed the status of the child protection mechanisms that had existed for the previous thirty years. Statutory Local Safeguarding Children Boards replaced the previous voluntary arrangements for cooperation. Part 1 of the *Working Together to Safeguard Children* practice guidance had been issued as a statutory document (HM Gov, 2006a). At central government level there had been a transfer of responsibility for children's social care from the Department of Health to the Department for Education and Skills. At a local authority level there had been the amalgamation of education and children's social care under a single Director of Children's Services. As a consequence of these changes of landscape, particularly the shift in central government departmental responsibilities, issues that had commanded attention within the education and schools agenda took a more central position in the safeguarding arena. Key amongst these was the process for the management of allegations against staff.

From the beginning of the decade there had been two guidance documents about allegations management produced for schools (NEOST, 2002; DfES, 2005a) in

response to concerns expressed by the teaching associations. These sought to bring consistency of process and timely conclusion for what were perceived to be escalating numbers of allegations against school staff (NASUWT data, Hansard, 18th July 2006, column 1263). It was a generic version of the guidance developed for schools (DfES, 2005a) that appeared as an appendix within the revised *Working Together* (HM Gov, 2006a) for a multi agency audience. A network of advisors had been recruited by the Department for Education and Employment during 2001 to work with clusters of Local Authorities. Their objective was to reduce the time taken to resolve allegations against school staff. With the introduction of the processes across all partner agencies of the Local Safeguarding Children Boards, a new network of advisors was appointed to promote the requirements, and encourage compliance. Limitations identified in the evaluation of the education based network (Baginsky, 2005) were addressed with the central government department management of the new network of Allegations Management Advisers (AMA), based at the nine regional Government Offices. The direct lead provided from the central government department with responsibility for safeguarding provision served to raise the profile of what had previously been for many organisations a human resources and complaint issue, to one of safeguarding children.

My appointment as one of the Allegations Management Advisers (AMA) in 2006 gave a focus to my work over the next two years, to contribute to improving policies, procedures and practices in managing allegations against staff and paid carers. The role also involved providing feedback to the central government department on barriers to progress, and facilitating data gathering on allegations as part of a national review of progress (DCSF, 2009). Through regular direct contact with the lead officers, entitled 'local authority designated officers' within the *Working Together* (HM Gov, 2006a) guidance, the challenges at a local level became apparent. This study developed from questions raised during the process of supporting their activity of promoting the requirements and receiving, recording, monitoring, and reporting on allegations against staff in all services for children. For the officers, applying processes which had been requested by the schools sector but which were not welcomed by all service sectors raised fundamental questions about what should be, and what should not be, referred into the multi agency processes for managing allegations. For local authority

children's care services delivering residential and foster care the processes were less contentious. The local authority designated officers were located in child protection or safeguarding units and therefore regarded as an 'internal' contact, rather than an external overseer. For the many other diverse organisations with different types of involvement with children, and their own internal processes for responding to concerns raised by children, the procedures were not always welcome. Some professional groups challenged the legitimacy of the arrangements which involved providing information about employees to another organisation at a threshold below the broadly understood child protection threshold.

1.3 Approach to Defining the Research Problem

Strauss and Corbin (1990, p. 34) in identifying the sources of research problems, collate them under three headings. Their categories are "suggested or ascribed" research problems, those that emerge from "technical literature", and those from "personal and professional experience". The source of motivation for this study was the last of these, based on my professional activity at that time. As a newly appointed regional adviser supporting the introduction of allegation management arrangements across children's services I was steeped in the subject matter. As I promoted the requirements, discussions with managers and members of Local Safeguarding Children Boards repeatedly returned to the issues about the types of allegations against staff and levels of seriousness that should be included within the recorded cases.

The questions that the study set out to explore were developed and refined in conversation with the local authority designated officers. The objectives emerged through working backwards from their descriptions of the contextually situated challenges of receiving and responding to allegations from the breadth of agencies that provide services to children. In co-creating the objectives of the study the local authority designated officers' priority was to understand a perceived difference between agencies in the thresholds for referral, and differing patterns of agencies reporting of concerns. Regardless of how prescriptive the guidance may appear to be, the decision about whether an allegation meets the criteria for referral in accordance with *Working Together* (HM Gov. 2006a, 2010b) is a matter for individual professional judgement.

This focus of interest for the practitioners mirrored the professional dialogue around thresholds, eligibility, and interpretation of bureaucratic procedures which dominate the safeguarding agenda when the focus is on familial abuse and neglect. A literature search identified considerable material on thresholds for intervention into families when the threshold is that of significant harm (see, for example, Birchall and Hallet, 1995; Dartington Research Unit, 1995; Jones and Gupta, 1998; Brandon, Thoburn, Lewis and Wray, 1999; Joint Chief Inspectors Reports, 2002, 2005; Brandon, Belderson, Warren, Gardner, Howe and Dodsworth 2008). What was less in evidence was research literature which explored the notion of degrees of harm when the behaviour is that of a professional, paid carer or volunteer.

The *Working Together* (HM Gov, 2006a, 2010b) guidance in relation to allegations of abuse against people working with children states that:

> "The scope of inter-agency procedures in this area is not limited to allegations involving significant harm, or risk of significant harm, to a child."
> (H.M.Gov, 2006a, p. 153, para 6.25; 2010b, p.200, para 6.37)

This suggests a potentially lower threshold of harm for inclusion within the safeguarding processes for situations when allegations are made against a member of the children's workforce. The consequence of a threshold that captures too many low level cases has already been well documented (Birchall and Hallet, 1995; Dartington Research Unit, 1995) in relation to familial abuse and welfare concerns. There are no similar studies of the implications of this when the alleged abuse is by people working with children in paid and voluntary roles. Messages from professional associations, Government Select Committees and House of Lords Debates (Hansard, 30.10.06 Column 136) however argue that the consequence includes the "wrecking of lives".

Much of the literature in relation to abuse of children from people in professional and non familial caring roles has emerged from inquiries of physical and sexual abuse of children within residential institutions (Utting, 1991; Brannan, Jones and Murch, 1992; Smith, 1992; Warner, 1992; Kirkwood, 1993; Utting, 1997; Waterhouse, 2000; Frizzell, 2009). While these provide detailed and valuable analysis of large scale abuse scenarios they do not relate directly to the single incidents and less severe allegations of abuse which make up a large part of those reported under the multi agency *Working Together* (HM Gov, 2006a,

2010b) requirements. What the inquiry reports do provide is an understanding of the barriers to recognising and reporting abuse of children by colleagues, and children's difficulties in raising concerns.

The literature includes studies that have explored the impact of being the subject of an allegation (Wilson, Sinclair and Gibbs, 2000; Sikes & Piper, 2010), and the anxiety and uncertainty allegations can generate within a staff group and service as a whole (Lindsay, 1999). Studies with offenders who had held professional roles (Colton and Vanstone, 1996; Beech and Sullivan, 2002; Erooga, 2009) contributed an understanding of how some offenders target particular settings, and how some organisational cultures allow abuse to occur and go unchallenged. The literature search also reports research with individual professional groups (Hicks and Nixon, 1989, 1991; Wheal, 1995; Wilson, Sinclair and Gibbs, 2000; Minty and Bray, 2001; Howarth, 2000; Phillips, 2004) much of which focuses on abuse in care settings, both residential and foster care. Studies in relation to sports settings (Brackenridge, 2001), health settings (Clothier, 1994; Kendrick and Taylor, 2000) and clerics from religious settings (Langevin, Curnoe and Bain, 2000; Nolan, 2001; Doyle, 2009), provide a broader perspective while being focussed on a single organisation or professional group. There is no evidence of studies which have approached the subject from a multi agency perspective. Studies of professional groups predominantly address the stages beyond first recognition and attend to the stages of notification, investigation and beyond. This study while small-scale, local, short term and practitioner owned contributes a multi agency dimension. It explores the initial stage when a concern about behaviour is first raised with a manager and considers the categorisation of behaviours from a variety of professional perspectives. In so doing it responds directly to gaps in knowledge identified by practitioners with responsibility for this area of safeguarding activity.

The literature review includes sources identified through electronic databases and references identified and located from those source texts. This process captured inquiries and studies which also related to safer recruitment in organisations working with children (Warner, 1992; Bichard, 2004; Erooga, 2009). This is a closely aligned area and involves substantial policies which have sought to prevent potential abusers entering organisations, or roles working with children

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(Home Office, 1986; HO, 1993a; HO, 1993b; HO, 1994; HO 1996; HO, 1999; HM Gov, 2000: DfEE, 2000; DfES, 2002; HM Gov, 2003a; DfES, 2005b; HM Gov, 2006b). Gallagher (2000) makes a distinction between those policy and legislative responses to abuse of children by professionals that have addressed child care practice, and those which attempt to control abusers. The focus of this study on decision making when allegations are made against people working with children places the emphasis on the former. The study does therefore not consider safer recruitment practices and the barring of individuals from working with children, although recognising that barring may be the outcome of an allegation investigation. The study, in confining itself to the interpretation and implementation of guidance for children's services, excludes consideration of abuse of vulnerable adults by staff and volunteers in adults' services.

1.4 The Questions the Study Set Out to Explore

The key question that the study was designed to explore was that of the behaviours and incidents which were referred under the Local Safeguarding Children Board procedures, and which could be dealt with internally by the organisations. The *Working Together to Safeguard Children,* (HM Gov, 2006a) guidance specified that from October 2006 all allegations against people who worked with children that fell within one of three categories were to be reported to the local authority designated officer. The three criteria were set out as being any allegation that a person who works with children has:

> *"behaved in a way that has harmed, or may have harmed a child*
> *possibly committed a criminal offence against, or related to a child; or*
> *behaved towards a child or children in a way that indicates s/he is*
> *unsuitable to work with children."*
> *(H.M.Gov, 2006a, p. 153)*

A positive decision that any of the criteria have been met leads onto the behaviour of an employee or volunteer being reported outside of the agency or organisation, and opens internal practice to external scrutiny. It also initiates a record of an allegation being made which is maintained until the person retires or for ten years, whichever is the longer (HM Gov, 2006a, 2010b). Alternatively the manager can decide that the alleged incident is a matter of poor practice which requires advice, training, amendment to internal procedures or no action. In those circumstances the allegation does not need to be referred to the local authority designated officer.

Senior managers within employing or contracting agencies and organisations who are identified to receive allegations have the operational responsibility for determining the behaviours which are referred to the local authority designated officers. These managers thereby determine the threshold of behaviours which are included within the allegations arrangements. The local authority designated officer has a role in providing advice on alleged behaviours and actions to employers and voluntary organisations, liaising with other agencies, including the police. From the point of referral the local authority designated officer monitors the progress of cases, including those which the organisation will progress through their disciplinary processes. *Working Together* (HM Gov, 2006a, p.242) states that it is important that even "apparently less serious allegations are seen to be followed up" and identifies the independent examination that the local authority designated officer provides of all allegations fitting one of the three criteria.

Allegations may be brought to a manager's attention from a variety of sources. A young person or parent may make a direct report. A colleague or other member of staff may express a concern to the manager, or another agency may pass on information they have received. A member of the public may report behaviour, or the information may be provided anonymously. The concern may be generated through the employment relationship and the observations of the manager themselves. Regardless of the source of the allegation, and whether it is current or historic, the requirement if it appears to meet the referral criteria, is that the manager will refer to the local authority designated officer.

The response to an allegation can be fourfold. The senior manager and local authority designated officer decide whether the behaviour requires a safeguarding response, which may or may not include a criminal investigation, a disciplinary response, internal action by the line manager, or no response. It is not however this investigative or disciplinary process that is the focus of the study. The focus is on the period prior to this when the manager considers the three criteria of harm, a criminal offence or behaviour which suggests the person is unsuitable to work with children and decides if they apply.

1.4.1 Harmed or may have harmed a child

The most familiar of the criteria for referral in relation to protecting children is that of behaviour which has "*harmed or may have harmed a child*". This derives from the *Children Act, 1989,* Section 31(9), as amended by section 120 of the *Adoption and Children Act, 2002.* 'Harm' is defined as 'ill-treatment or the impairment of health or development, including for example, impairment suffered from seeing or hearing the ill-treatment of another' (HM Gov, 2002). 'Ill-treatment' includes sexual abuse and forms of ill-treatment which are not physical'; while 'development' refers to physical, intellectual, emotional, social or behavioural development'; and health refers to 'physical or mental health' (HM Gov, 1989). Brandon, Thoburn, Lewis and Wray (1999) draw attention to the meaning of harm as referring to the impact of the actions of maltreatment rather than the acts of maltreatment themselves. The criterion of 'harmed' incorporates many different forms of behaviour and action by adults and is generally applied to children within their families, when the threshold for compulsory intervention is that of 'significant harm'. *Working Together* guidance (1991, 1999 and 2006a) has provided increasingly detailed definitions of neglect, physical, sexual, and emotional abuse which are the subject of child protection (Section 47) investigations when the threshold of significant harm is thought to have been reached. Situations in which it is identified that a professional, paid carer or volunteer had, or may have, caused physical, emotional or sexual harm or neglected a child's welfare would fall within this category of referral. While physical and sexual abuse are incident based and single occurrences would be expected to meet the referral criteria, emotional abuse and neglect are generally regarded as part of a pattern of behaviour located within a relationship. For managers this adds to the complexity in determining if the criterion is reached in relation to professional conduct.

1.4.2 Possibly committed a criminal offence

The second criterion of, '*possibly committed a criminal offence'* initially appears the easiest to determine, but senior managers in organisations may have limited knowledge of the range of behaviours to which this could apply. In many circumstances only after an investigation has been undertaken and issues of interpretation and intent are unravelled will it be possible to decide if the

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behaviour falls within the definition of a crime. Adults working in many children's services are permitted to use physical intervention in situations of perceived harm to children, either the individual concerned or others. Restrain is also permitted in relation to damage to property in some situations, for example in schools (HM Gov, 1996; HM Gov, 2006c). The authority of school staff to use 'reasonable force' and undertake random non-intrusive searches of young people, including searches without consent, and searches of whole groups, for weapons (H.M Gov, 2006d) brings them in to physical contact in situations of conflict and heightened emotion. The level of force that is deemed 'reasonable' by the adult in that situation may be at odds with the perception of the young person. Faced with an allegation in the context of a search or a possible injury to a child following a permitted physical intervention or restrain, the senior manager's decision making has to balance the responsibility to safeguard children and young people with the need to support staff in handling difficult situations.

The *Sexual Offences Act, 2003*, increased the range of possible sexual offences by extending the range of abuse of trust offences within the Sexual Offences (Amendment) Act, 2000. It also introduced an offence of meeting a child following sexual grooming, and voyeurism, and amended the definition of a child in relation to indecent photographs from sixteen years to eighteen years of age. These offences are not without their challenges for senior managers making judgements about staff conduct. A staff member only a few years older than the sixth form pupils or residents of a children's unit, or member of a senior sports team may engage in the same social activities as the young people. Yet forming a close or social relationship could raise questions about their intentions and naïve practice could bring them into the range of 'abuse of trust offences', or their conduct being interpreted as 'grooming'. Public anxiety about paedophiles and sex offenders prompts suspicion of motives fuelled by media reporting of the constant stream of instances of sexual abuse by adults in positions of trust. Managers making judgements about the actions and activities of staff which could fall within the multiplicity that could constitute 'grooming', will be mindful of the need to be seen to be taking appropriate action, and the need to make a 'defensible' decision (Howe, 1992; Dingwall et al., 1995); one that evidences attention to policies and procedures.

1.4.3 Unsuitable to work with children

The third category of behaviour which may indicate the person is unsuitable to work with children incorporates a wide spectrum of poorly defined behaviours occurring within the context of diverse relationships. It could arise within formal relationships with health or teaching staff, in failures to understand or appreciate how actions could impact on the safety and welfare of children. It could occur within highly tense situations of restraint or arrest when proper processes or procedures are not followed. It could be within informal settings where young people engage in sporting or recreational pursuits when an adult acts in an irresponsible manner or demonstrates an inability to make sound professional judgements. It may be an incident which arises in the community when a worker fails to recognise the need for personal or professional boundaries; or within poorly conducted or inadequate caring activities undertaken by foster carers[2] and child minders.

The notion of 'unsuitable' derives from the Department of Health Consultancy Index. This was superseded by the *Protection of Children Act* (POCA) list following the passage of the Act in 1999 which required that the Secretary of State maintain a list of people "unsuitable to work with children". For those from the education sector 'List 99' had existed since 1926 (Education Code 856) detailing those considered 'not fit and proper persons to work with children' (DoH, 2000a, p.5). There is no legal definition provided of 'unsuitable' and the guidance notes accompanying the *Protection of Children Act, 1999,* warned against inclusion of 'incompetence' and 'youthful indiscretion'. Instead it refers to 'misconduct' which is described as ranging from:

> "....serious sexual abuse through to physical abuse which may include intentional inappropriate restraint and /or poor child care practices in contravention of organisational codes of conduct which results in harm or risk of harm to children."
> (DoH, 2000a)

This remained unchanged when the guidance was revised in September 2005, with an expectation that organisational codes of conduct would define the behaviours expected of staff. The criteria of 'unsuitable' therefore became that

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[2] Issues of suitability, and unsuitable conduct, in relation to foster carers and the decision making process of the fostering service's panel and decision maker are governed by the Fostering Service Regulations, 2002, as well as the *Working Together* guidance in relation to allegations against foster carers.

which was contrary to an organisation's code of conduct. The *Safeguarding Vulnerable Groups Act,* which superseded previous legislation in 2006, included within the consultation document preceding its implementation (DfES/DoH, 2005) the dilemmas in setting a threshold for barring. It noted that a high threshold, one which only included those convicted or cautioned for a serious offence would not have identified Ian Huntley (Bichard, 2004) and would not prevent some applicants who were 'unsuitable' to work with children from gaining employment. On the other hand:

> "A lower threshold would consider a wide range of offences and
> allegations and use a broad range of evidence to inform judgements.
> This would identify more borderline cases ....."
> (DfES/DoH,2005)

The consultation document identified that the system already in place captured such evidence. Within Schedule 3, Part 1 of the Act, the 'relevant conduct' about which the Independent Barring Board make decisions to bar individuals is: "conduct which endangers or is likely to endanger a child; conduct involving, or possession, of sexual material relating to children; sexually explicit images including images of violence; and conduct of a sexual nature involving a child' (HM Gov, 2006b). A person's conduct is defined as 'endangering a child' if it involves attempting to harm, harming, causing a child to be harmed, inciting another to harm or putting a child at risk of harm. This includes acts of commission and omission and behaviours which may be carried out by a third party. Within the Independent Safeguarding Authority's guidance notes for decision making it identifies "action or inaction by others that causes mental anguish; any physical contact that results in discomfort, pain or injury; any form of sexual activity with a child under the age of consent; and failure to identify and/or meet care needs (I.S.A., 2010, p.10). Within this some aspects have clarity while others remain a matter of interpretation and individual perception.

1.5 Overview of Report

The three criteria each present challenges for managers when faced with reported allegations. The alternative of managing the response 'in house' is also not without difficulty if inappropriate staff conduct is seen to be minimised and the decision making subsequently questioned. There is a need not only to make a rational decision that can be articulated to others but also to make a defensible

decision. It is this decision making regarding whether or not one of the criteria has been met that is the focus of the study. The study does not attempt to determine a threshold or measure of seriousness of conduct for referral of allegations into the Local Safeguarding Children Board procedures. It also does not make a judgement about the conduct of the workers or young people, or the decision making of the managers. The study does make available to a wider audience the descriptions of nine cases which were referred to the local authority designated officers in two Local Safeguarding Children Board areas. It also makes available the experiential descriptions of the knowledge, criteria and processes that participants described applying to their consideration of the allegations. The themes from this primary data provide a pragmatic body of knowledge from practice for other managers to draw upon. A second stage of the study explored the same cases constructed as vignettes for a broader multi agency sample of participants. In comparing the judgement and decision making described from the two methods of data gathering the study identifies some of the assumptions, understandings and differences between areas and between agencies. From this can be seen the influence of local practice and personal relationships in the response to allegations.

The report of the study begins in chapter two by locating it within a historical context which recognises that abuse of children by people employed to provide for their care or instruction has a long history. The background to the allegation processes however has a shorter history commencing from the policy developments that followed the institutional abuse inquiries of the late 1980 and early 1990s. While the details of the early institutional inquiries are now somewhat historical their inclusion serves to aid understanding of how abuse of children by people employed to act in their best interest has been constructed over time. The chapter describes the processes and mechanisms developed in response to the evolving understanding of abuse of people in professional roles including the introduction of the statutory procedures and the review of their implementation (DCSF, 2009). The third chapter provides an overview of decision making theory. Normative and descriptive models are explained, and the role of intuition and expertise. The cognitive biases and errors that are features of the heuristic strategies employed to manage complexity are described. The chapter

concludes by considering the challenges of decision making in child protection, and specifically when allegations are made against professionals.

The methodology chapter, four, locates the study within a constructivist perspective and recognises the 'borrowing' (Winter, 1989) of elements from qualitative studies which is a feature of the framework for the study. The two locality and two stage design is explained with descriptions of the service features of the two participating areas. The process of seeking informed consent from participants and strategies for ensuring confidentiality of the information are explained including recognition of the difficulties for some potential participants of being associated with the study. The ethical issues involved in exploring decision making in situations which had been recently or in one case was still subject to investigation are discussed.

The findings of the two phases of the study are explained in the fifth and sixth chapters. In the fifth chapter the nine cases are described and themes identified from the accounts of participants responding to allegations, the processes followed and the influencing factors in their judgement and decision making. The nine allegations that formed the primary source material occurred between March 2008 and February 2009. Interviews were conducted with the participants as soon as possible after the allegations arose. Chapter six describes the responses of a larger group of participants to vignettes constructed from eight of the 'real' cases. It describes the similarities and differences of the participants' responses to the vignettes when compared to the description from the managers who dealt with the original incidents. This second phase of interviews was conducted between February and June 2009.

The final chapter draws together the key themes that emerged from the findings. It includes some reflections on the design and conduct of the study highlighting potential improvements that could have been beneficial and consideration of the importance of timing in the production and dissemination of research. The report concludes with a consideration of the implications of the findings for practice.

CHAPTER 2: Abuse of Children by Professionals – a brief history

2.1 Introduction

The recognition of children's rights, and receptiveness to children's concerns about the behaviours and actions of people in educative and caring roles, outside of the family, has a relatively short history. Abuse of children by people in positions of authority and trust, in contrast, has an extensive history. It was not until the Infant Life Protection Act of 1872 that Government intervention was introduced to prevent the destruction of infant life by paid carers in 'baby farming' arrangements and day care. Within Poor Law and penal establishments of the nineteenth century, hard labour, discipline and corporal punishment were features of children's experience of adults in care-taking roles. This reflected the standards of society at the time and the prevailing belief, rooted in religion, that children were potentially evil, and that firm, even severe discipline, was needed to keep them to a "path of righteousness" (Corby, Doig and Roberts, 2001, p.24). It is not only in the use of physical punishment that the historical relativism of abuse by professionals can be identified. Howitt (1992) describes extreme forms of physical and sexual abuse by medical physicians in the 'remedies' and 'treatment' of childhood masturbation in the nineteenth century (Howitt, 1992 p.9). The abusive practices were legitimised by the 'scientific' status of medicine and medical practitioners at a time of rapid advances in science and technology.

Abuse of children by people employed to provide for their supervision, education and care encompasses a wide range of professional roles and agencies, each with their individual histories. What follows is a selective and simplified brief history constructed from a limited viewpoint and to serve a purpose. It focuses on the United Kingdom and predominantly England and Wales, written from the perspective of a social worker, exploring this specific area of safeguarding children practice.

The chapter commences by considering the influence of child abuse inquiries on the development of legislation and policies to provide a backcloth to understanding the institutional abuse inquiries of the late 1980s and 1990s. The

term 'public inquiry' is used in this context to refer to inquiries that produced a publicly available report. The chapter considers the heightened public concerns about paedophiles and reduced public confidence in professional knowledge and how these contributed to an atmosphere of professional uncertainty about responding to children's needs. The chapter moves on to discuss the escalation in the number of allegations in the wake of the Children Act, 1989, and the conflicted perception of professionals in the context of increasing revelations of abuse of trust. The final section provides an account of the introduction of formal arrangements for the management of allegations against people who work with children, and their detailed development within the education sector. It concludes with the increased profile of these arrangements across professionals, paid carers and volunteers within the context of the 'preventative' child welfare agenda of the Labour administration from 1997 to 2010.

2.2 From Public Inquiries to Statutory Procedures

2.2.1 The First Child Abuse Inquiry

The process by which public inquiries came to be regarded as prominent and powerful drivers for legislative change and a means to exert influence over the professionals involved has been well documented (Parton, 1983, Hill 1990, Parton, 1997). In relation to abuse by people in professional and paid caring roles this trend can be traced back to the first child abuse inquiry in 1945. It concerned the death of thirteen year old Denis O'Neill who was tortured, neglected and killed by his foster father, and his brother Terrance who was abused and neglected. The inquiry revealed poor selection of carers, a failure to supervise the children's care, failing to act on warning signs, poor record keeping and administrative muddles, and a lack of co-ordination between numerous bodies that shared responsibility for children in the care of the state. It highlighted shortfalls in practice which had existed for a long time in providing substitute care for children, and concluded that the legislation which existed was unsatisfactory (Home Office, 1945).

The findings of the inquiry, along with the conclusions of the review of the welfare of children in the care of public authorities and voluntary bodies in England and Wales (Curtis Committee, 1946) became instrumental in the

provisions of the 1948 Children Act. The Act formalised the government's role for child welfare and the state strategy became one of working to keep children within their families. The Criminal Justice Act of the same year brought to an end the birching of children for offending. Until this point not only was corporal punishment of children allowed by people whose responsibility was to act in their best interest, but some people in their professional role administered severe physical punishment sanctioned by government and ordered by the court. The Act did not address the use of physical punishment within residential care for children despite the cruelty of excessive punishments found by the Curtis Committee, particularly in approved schools.

In the period between 1945 and 1973 there were "numerous internal inquiries" focused on the maltreatment of children in residential homes and schools (Parker, 1995, p12), which prompted little attention (Parton, 1985). An inquiry into Court Lees (Home Office, 1967) condemned the excessive use of corporal punishment at the approved school. The concerns were not that the children were hit by a cane, but that they were not wearing appropriate clothing and the cane was not of the correct weight and the beatings recorded (Corby et al, 2001). Corporal punishment of children was permitted in many settings including private and maintained schools, nurseries and other settings caring for young children, as well as residential schools and care homes. It was not until 1986 that Parliament began to restrict the use of corporal punishment on children, first in state maintained schools from 1987, in children's homes in 2001, foster homes in 2002 and by 2007 in early years provision. Corporal punishment is still not prohibited in part time education settings, by sports coaches, private foster carers, youth workers, or nannies (Singleton, 2010). This inconsistency serves as a reminder of the historical relativism of the behaviours regarded as abusive, illegal or unsuitable which fall within the procedures for the management of allegations (HM Gov, 2006, 2010).

2.2.2 The Influence of Child Abuse Inquiries

The first child abuse guidance issued to professionals (British Paediatric Association, 1966; DHSS, 1970) was in response to studies which revealed physical harm to young children. The discovery of the 'battered baby syndrome'

(Kempe et al, 1962) was soon accompanied by a rapid professionalisation and expansion of child welfare activity. In 1973, in the context of the increased state resources for child welfare the death of seven year old Maria Colwell, at the hands of her step-father, while under the supervision of the expanded social work department was constructed within the media as a 'national scandal' (Parton, 1985) paving the way for increased state intervention.

The foundation of the arrangements that were to continue over the next thirty years emerged within guidance issued about the management of 'non accidental injuries' (DHSS, 1974) following the Maria Colwell inquiry. Published research, much of it originating in the United States, followed expanding the understanding about the forms of harm to which children could be subject and their effects (Kempe and Kempe, 1978; Garbarino, 1978; Finkelhor, 1979). By the end of the 1970s the focus had shifted from 'non accidental injuries' to a broader concept of 'child abuse' (DHSS, 1980). The awareness of abuse and increased understanding of the kinds of harm experienced by children within families has been argued to have paved the way for abuse of children in public care to be raised and believed (Corby et al, 2001)

By the end of the 1980s there had been 45 child abuse inquiries (Corby et al, 2001; Parton, 2006) receiving varying degrees of publicity, most concerning children living within their families. Inquiries critical of the lack of state intervention for some children (Tyra Henry, 1984; Jasmine Beckford; 1985; Kimberley Carlile, 1987) were followed by ones which questioned the processes adopted to protect children from abuse and advocated less precipitate intervention relating to sexual abuse (Cleveland, 1987).

The first *Working Together* (DHSS, 1988) best practice guidance which emerged in the wake of these inquires did not include specific reference to investigating allegations of abuse by professionals or paid carers. This was despite the deaths in public care of a number of children during the 1980s including Christopher Pinder in 1980, Shirley Woodcock, 1982 and Gavin Mabey in 1987 all in substitute family placements (Reder, Duncan and Gray, 1993). There had also been inquiries as a result of the sexual abuse of children

by senior residential staff in two residential homes Leeways (Lewisham, 1985) and Kincora Boys' Hostel in Belfast (DHSS, 1985).

In the period following the Cleveland Inquiry (1987) there continued to be inquiries concerning the deaths of children in the care of their families (Bridge, 1991; Bridge, 1995) but less professional certainty about intervention into families to protect children. The ambivalence between a family's rights to privacy, children's rights, and the state's role in monitoring and intervention were present within the Children Act of 1989, reflecting the inquiries that had preceded it. The Act included new powers available to the court to intervene to protect children alongside a 'no order' principle. Children were to be consulted about their wishes and feelings, and local authorities had a general duty to safeguard and promote the welfare of children in their area. Local Authorities were given a new welfare duty in respect of children accommodated for more than three months by the health or local education authority. Registration, inspection and review of different types of residential and day care services were strengthened. A volume of detailed guidance and regulations relating to residential care (DoH, 1991) was provided in response to concerns about institutional practices which had started to emerge in the late 1980s.

The *Working Together* guidance was revised to take account of these and other requirements within the Act. The revised *Working Together Under the Children Act 1989* (DoH, et al, 1991) introduced guidance in respect of abuse of children in residential and foster care with reference to the regulation of placements. Abuse of children living away from home in other settings was not addressed. In relation to investigations of abuse by social services departments' staff it recommended 'an independent element' (DoH, 1991, p35). For other extra-familial abuse by adults in contact with a child by virtue of their professional or voluntary role "the action to be taken should be the same as with any other suspected abuse". The concept of an independent element was further developed in subsequent guidance. Coinciding with the publication of the revised *Working Together* an investigation was initiated following the deaths of four children, attempted murder of three and grievous bodily harm of a further six within a hospital setting. The subsequent conviction of a children's nurse,

Beverly Allitt, highlighted the potential risks from professionals abusing their access to children in a range of institutional settings (Clothier, 1994).

2.2.3 Institutional Abuse in the late 1980s and 1990s

By the 1980s residential care had become almost solely a provision for older children from poor and disadvantaged families. Residential workers "poorly qualified and ill-equipped" (Corby et al, 2001, p.34) were required to provide care for adolescents often with challenging behaviours. In 1988 the Social Services Inspectorate drew attention to the use of physical restraint by poorly trained staff at the Melanie Klein House in Greenwich (SSI, 1988). This was followed by concerns about the use of solitary confinement at Ty Mawr, Abergavenny, as incidents of self-harm and suicide occurred. It was however the emotionally abusive treatment of children through the use of 'pindown' control regimes in some children homes in Staffordshire between 1983 and 1989 that raised more widespread concern about the quality of care and techniques used to control young people. The subsequent inquiry (Levy and Kahan, 1991) found that 132 children, including children of nine years, had been subject to isolation and humiliation. Deprived of day time clothing they were confined to a room with little to do and limited interaction for periods as long as eighty-four continuous days. Expressions of concern by young people subject to this regime were not received and understood as descriptions of abusive practices until raised by a fifteen year old girl with her solicitor. The social workers recorded positively the details of the institutional controls sanctioned by management (Levy and Kahan, 1991, p.167). Just as the beatings at Court Lees in 1967 had not been considered abusive of themselves, the use of 'pindown' had been regarded by inexperienced and unsupported staff as a legitimate control technique for difficult young people. In the wake of the inquiry standards of care in other residential homes came under scrutiny. Unsatisfactory practice was identified in other areas including Sheffield and Bradford. A review of care for children in England was commissioned by the Government which was led by Sir William Utting (1991). Similar reviews were undertaken in Wales (SSI Wales, 1991) and Scotland (Skinner, 1992).

Other inquiries soon followed. The investigation and conviction of Frank Beck in 1991 for the physical and sexual abuse of over a hundred children in his care led to inquiries by Leicestershire County Council (Kirkwood, 1993) and the Police Complaints Authority (1993). Twenty nine complaints had been made to the police, few of which were progressed beyond the initial contact. The police officers attitude to the children as untrustworthy because of prior criminal convictions produced an inadequate response to the concerns being raised. Parents, teachers, field social workers, social work students and temporary residential staff raised concerns which went unheeded by senior managers. Members of staff employed at the residential home were aware of, and some were involved in, the physical beatings of children. The lack of a complaints system, the emotional isolation and low status of children in care and absence of effective central management oversight were identified by the inquiry (Kirkwood, 1993).

Following the trial of Frank Beck an inquiry was initiated to examine "selection and recruitment methods and criteria for staff working in children's homes" (Warner, 1992, p.1). The inquiry report's recommendations included proposals that children who use the services should be encouraged and enabled to voice concerns about their treatment. This echoed the recommendations of Utting who had reported the previous year on *Children in the Public Care* (Utting, 1991) following the Pindown Inquiry. Research was commissioned in the wake of the inquiries to improve knowledge of practice in children's homes (DoH, 1998a).

Similar issues were identified by an inquiry undertaken by Shropshire County Council in response to the sexual abuse of children at Castle Hill independent special school (Brannan, Jones and Murch, 1992). Ralph Morris, head of the school was regarded as an authoritative figure exercising effective control. His powerful personality and perceived credibility resulted in disbelief by professionals and parents to children's reports of abuse. Several complaints had been made to the police which were not given due weight. Pupils placed at the school as a result of educational and behavioural problems were not considered to be trustworthy. Key recommendations from the inquiry concerned the importance of listening and attending to children's allegations and the

provision of support for young people making allegations throughout the processes of investigation and any trial (Brannan, Jones and Murch, 1992).

Abuse of children with disabilities by adults in caring, supervisory and educative roles also came to public attention in 1991. The Head Teacher at Scotforth House special school in Lancashire received an eight month suspended sentence after admitting to three charges of cruelty to children. Harsh and inhumane behaviour towards autistic children particularly around abusive feeding practices was described as "habit and part of the everyday ethos of the unit" by the inquiry that followed (Smith, 1992, p.309). The increased vulnerability of disabled children to all forms of abuse had already received recognition (Kennedy, 1989, 1990; Tharinger, Horton and Millea, 1990; Marchant and Page, 1992; Westcott, 1993). The use of residential and specialist facilities for disabled children had been identified as increasing the likelihood of abuse (Utting, 1991; Kelly, 1992). The difficulties of raising concerns and being listened to for all children in institutional settings were argued to be compounded by the children's disabilities and communication difficulties in verbalising abusive episodes and experiences (Middleton, 1995; Russell, 1997). Westcott and Cross (1996) reflected on the lack of specific guidance addressing professionals who perpetrate abuse and concluded that it was "urgently required", and should "include instructions on what action to take if a colleague is suspected of abusing" (Westcott and Cross, 1996, p.53). A call subsequently answered in the revision of the *Working Together* guidance (DoH, HO, DfEE, 1999).

The case of Philip Donnelly, director of nursing services at Booth Hall Hospital in Manchester, highlighted the failure of the professional regulators to take decisive action to prevent further abuse when it was identified. Philip Donnelly had been convicted of four counts of indecent assault on two thirteen year old boys at the hospital. Donnelly served nine months in custody of a two year sentence and on release was able to resume work as a nurse due to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) Professional Conduct Committee decision not to remove him from the professional register (Long, 1992). Long's argument that the profession tolerated acts of gross indecency and misconduct was reinforced with the three

year delay in removing from the UKCC Register of Nurses Paul Clarke, nurse and trainee health visitor, for taking indecent photographs of children (Shamash, 1997; Kendrick and Taylor, 2000).

Corby et al (2001) provide a detailed account of investigations and inquiries into the physical and sexual abuse of children in residential establishments in many areas of the United Kingdom between 1992 and 2000. These include abuse of disabled children in a community home in Northumberland; the physical abuse of children in care homes in Leeds and Kent; brutality at a Roman Catholic children's home in Aberdeen; the sexual abuse of children by two members of staff in a home in Edinburgh over a fourteen year period; the death of a child in the care of Harrow from an overdose of methadone; and the sexual abuse of a boy in the care of Lambeth by a staff member who subsequently died from a HIV related illness; and many more (Corby et al, 2001 p.86-90). In February 2000 as many as thirty two separate investigations were underway in England and Wales relating to abuse of children by people in professional and paid caring roles. Large scale historical abuse investigations by police forces in Merseyside and in Cheshire continued over several years resulting in significant numbers of former residents reporting abuse against care home workers. The findings of the investigations highlighted the vulnerability of young people within residential provision and the difficulties they had in presenting their concerns until after they had left the establishments. The police methods of actively contacting former residents prompted legal challenges and led to the establishment of a parliamentary select committee in 2002.

As abusive practices in residential establishments continued to attract attention Sir William Utting undertook a review of safeguards for all children living away from home, in hospital settings and penal institutions as well as care placements. The report findings (Utting, 1997) were presented, in August 1997, to a new Labour administration committed to tackling inequalities and social exclusion. It identified that basic good care practices were not consistently evident across the residential care sector and that urgent action was required to raise standards and the profile of residential care. The report reinforced the earlier recommendations of the Warner Report (1992) regarding recruitment and selection. It advocated that young people should be listened to and

involved in decisions which affected them. It proposed urgent attention to abuse of children with disabilities and the need for advice to professionals to communicate concerns if they suspected a colleague. Abuse of children in foster placements prompted a call for reinforcement of the regulations relating to placement and supervision, and a government code of practice for recruiting, selection, training and supporting foster carers.

The Government's response to the *Safeguards Review* (DoH, 1998b) led to wide ranging initiatives in relation to setting and monitoring standards of care. A series of outcome focused objectives were introduced across children's services in England not confined to children in care. A Ministerial Taskforce on Children's Safeguards was established in February 1998 to take forward the findings of the Review. The 'Quality Protects' programme in England, and the 'Children First' programme in Wales, emerged later in the year to support the management and delivery of children's social services informed by the recommendations of the Utting Review (1997). Proposals for M*odernising Social Services* (DoH, 1998c) quickly followed which included reform of the regulation and inspection systems, introduction of performance measures on the full range of children's care services, stronger systems for preventing unsuitable people working with children, a revision of the guidance on child protection, and reforms to improve protection of children living away from home. On similar themes the Welsh Office issued the *Building for the Future* White Paper in March 1999.

Running alongside these developments was a large scale Tribunal of Inquiry which reported in 2000 on abuse in care establishment in North Wales looking back over a period of twenty two years (Waterhouse, 2000). The Tribunal heard allegations of physical abuse from approximately three hundred and fifty prior residents, and allegations of sexual abuse from one hundred and fifty six. It concluded that there had been widespread physical abuse in the residential homes in Clwyd and physical ill treatment of children in foster homes in Clwyd and Gwynedd. In addition the inquiry concluded that there had been widespread sexual abuse of young people, mainly boys, in eleven children's residential homes, which included local authority, voluntary and private providers, in five foster homes and at an NHS adolescent psychiatric unit. The

method of the police enquiries in seeking out former residents of the homes to establish whether they had been victims was criticised by some researchers who argued that the allegations were exaggerated and motivated by compensation (Webster, 2005).

By the time the Tribunal reported many of its seventy two recommendations regarding recruitment, management and inspection had been identified in other inquiry reports (Utting 1991, Howe, 1992, Warner, 1992, Utting, 1997) and within the research commissioned by the Department of Health (DoH, 1998a). The introduction of a Children's Rights Director within the National Care Standards Commission in England and Children's Commissioner for Wales came from the recommendations of the Tribunal as did the appointment at local authority level of complaints officers for children, and formal procedures for 'whistle-blowing' for employees to be able to make complaints without fear of reprisal. The Ministerial Taskforce set up in the wake of the *Children's Safeguards Review* (Utting, 1997) was extended to include co-ordination of the Government's response to *Lost in Care* (Waterhouse, 2000). Revised guidance on *Working Together to Safeguard Children* was published in England and in Wales in 1999. For Wales a *Practice Guide to Investigate Allegations of Abuse Against a Professional or Carer* in relation to looked after children was also published in February 2000 (NAW, 2000). In Scotland revised inter-agency child protection guidance had been published in November 1998.

The revised *Working Together to Safeguard Children* (DoH, et al, 1999) guidance recognised that:

> "*Experience has shown that children can be subject to abuse by those who work with them in any and every setting.*"
> *(para 6.13, p. 65)*

The stated expectation was that all allegations of abuse of children, contemporary and historic, by a professional, foster carer or volunteer should be taken seriously and dealt with in accordance with local child protection procedures. It explicitly included day care settings, leisure services, church based organisations and voluntary sector providers of services for children. The need for an independent person to investigate the allegation from outside the service or authority was recommended when the allegation was against a

member of social services staff or foster carer. The investigation was identified to include three potential strands. These were child protection inquiries, a police investigation of a possible offence, and disciplinary procedures. Within this framework can be seen the foundation of the subsequent procedures for the management of allegations against professionals and paid carers in 2006 (HM Gov, 2006a). The revised guidance also recognised that perpetrators of abuse can act alone or in organised groups and therefore included a specific section on 'Investigating Organised or Multiple Abuse' (DoH, et al, 1999, p.67). This section was further developed as a separate document referred to as 'Complex Child Abuse Investigations' (DoH & HO, 2002), drawing on the experience of the large scale institutional abuse investigations.

This resort to increasingly detailed and prescriptive procedures mirrored the response to the outcome of high profile inquiries of familial abuse. Similarly, the messages from institutional inquiries became increasingly familiar with repeated findings resulting in researchers commenting that organisations responsible for children had not progressed far since the Warner report in 1992 (Corby et al, 2001; Erooga 2009). The inquiry report in 2009 of abuse at the Keralaw Residential School and Secure Unit in Glasgow endorsed this view. The inquiry considered information that one hundred and fifty nine prior residents reported emotional, physical or sexual abuse up to 2003. The same issues regarding leadership and management, training and supervision, improving the avenues for listening to children, more rigorous follow-up to inspection and more effective investigation and disciplinary processes had all previously appeared in institutional inquiries. What was significant was the argument that the abuse continued to occur during a decade of major policy and legislative changes relating to children and young people. These included strengthened regulations, the introduction of children's rights officers and increased advocacy for young people. The conclusion of the inquiry was however that these "modernisation initiatives" did not impact on day to day practice (Frizzell, 2009).

2.2.4 From Intra Familial to Extra Familial Abuse – a changing context

From the mid 1990s published research commissioned in the wake of the Cleveland Inquiry advocated a 'lighter touch' (Dartington, 1995) by professionals alongside support to children in need within their families. Intra

familial abuse and neglect cases were recast through a 're-focusing' of services to families. This coincided with a period of increased public concern about extra familial abuse and "the shadowy figure of the paedophile" (Jackson and Scott, 1998, p.88). Parton (2006) drawing on the work of Philip Jenkins (1992) provides an account of the construction of the paedophile in the UK in the period prior to 1990. It was however from the early to mid 1990s that media reporting intensified (Critcher, 2003).

A snap shot survey conducted during 2004 by Action on Rights for Children, an internet based children's rights organisation, provides an indicator of the range of job roles and number of professionals charged with sexual abuse of children. The survey identified forty five prosecutions of professionals for sexual offences during a three month period from September to December 2004. The offences ranged from possession and production of pornographic images to serious sexual assaults on children. The survey did not include cases where reporting restrictions were in place. The professional groups included police officers, teachers, social workers, general practitioners, a surgeon, priest, care home manager and a child psychiatrist. The majority were reported as having received custodial sentences.

The recognition of paedophiles infiltrating residential settings where children were especially vulnerable (Brannan, Jones and Murch, 1992; Kirkwood, 1993) led Utting to describe the presence of "sexually and physically abusive terrorists" within children's homes (Utting, 1997, p.5). The conviction of Jason Dabbs in 1993 for sexual offences against pre-school age children brought to attention the vulnerability of young children to professional perpetrators within nursery settings. This was reinforced again recently by the investigation of abuse by Vanessa George at Little Ted's Day Care Unit in Plymouth (Plymouth Safeguarding Children Board, 2010). An earlier study in America (Finkelhor, Williams and Burn, 1988) had revealed that sexual abuse in child care settings was more extensive than previously thought and that the abusers were as likely to be women as men. The investigation in Newcastle in 1992 revealed how Dabbs a student nursery worker had used "bribery, threats, tricks and treats" (Campbell, 1993) to create an environment within two nurseries where he manipulated and exploited sixty four children. The inquiry raised questions

about the screening of people for training and arrangements for supervision of trainees on placements (Hunt, 1994). In the same year the conviction of Paul Hickson, former British Olympic swimming coach for sexual offences against students over a twenty year period drew attention to abuse within sport (Brackenridge, 2001). Hickson was convicted of fifteen charges including two rapes and a number of indecent assaults. Thirteen victims gave information about sexual assaults after lessons or while carrying out fitness tests.

The arrest of Fred and Rosemary West in 1995 and events in Belgium with the arrest of paedophile Marc Dutroux for a series of child murders contributed to the threat from paedophiles being associated with that of child murders. Legislation to monitor and control sex offenders followed (Sex Offenders Act, 1997; The Crime (Sentences) Act, 1997). The subsequent murders of Sarah Payne in 2000, and Holly Wells and Jessica Chapman in 2002, by men previously suspected of, and for one of them previously convicted of, sexual crimes against young people, intensified the public obsession with paedophiles. Child protection became as much a public protection issue from risks outside the family as one of child welfare (Parton, 2006). This was reinforced in early 2006 by the press and public outcry, including calls for the then Education Ministers' resignation when it was revealed that a teacher cautioned for accessing abusive images of children and subject to Sex Offender Registration had been allowed to teach in school. An immediate review of all individuals on the Sex Offenders Register who were working in schools was initiated and steps put in train to distance the decision making regarding barring of individuals from government ministers in advance of the introduction of the Independent Safeguarding Authority. Changes to the barring arrangements were quickly introduced preventing anyone cautioned or convicted for a sexual offence against a child working in schools and education settings from February 2007.

Studies with professional perpetrators (Colton and Vanstone, 1996; Sullivan and Beech, 2002) provided insight into how individuals use their employment to access organisations with a view to targeting and sexually abusing children. Colton and Vanstone's (1996) 'self-disclosure' study of seven men who had used their role working with children to abuse highlighted how the culture within

some organisations was considered to have "opened the door to abuse" (Colton and Vanstone, 1996, p.131). From direct collusion to the difficulty that colleagues had confronting what may be an uncomfortable truth, organisational cultures had enabled some of the men who participated in the study to continue abusing children after initial recognition. An account is provided from one of the participants of being observed by the manager, a Head Teacher at a residential school, while inappropriately touching a child. The Head Teacher is reported to have responded to the observed abuse by asking another member of staff to tell the person the following day not to do it in future "in the television room" (Colton and Vanstone, 1996, p. 170).

Abusive behaviour, minimised and disregarded, was also a feature of reports of abuse of children by the clergy and in faith settings where pervasive secrecy enabled abusers to move from one area or parish to another. Some churches too readily accepted the denial of the alleged perpetrator (Francis and Turner, 1995) and in general church organisations were slow to recognise the extent of sexual abuse (Nolan, 2001; Sullivan and Beech, 2002). The trial and conviction of Peter Halliday in 2007 revealed that his sexual abuse of boys in Hampshire was known to the Church in which he worked in 1990 but was not reported to the police. He was allowed to resign his post as choirmaster without safeguards being put in place to prevent him working with children in other settings. Between 1995 and 1999 twenty one Catholic priests in England and Wales were convicted of offences against children.

An examination of arrangements for child protection and the prevention of abuse within the church identified shortcomings in safeguarding practice (Nolan, 2001). These included failures to recognise the extent and prevalence of abuse, the failure to communicate suspicions or even known incidents of abuse or misconduct, and the failure to respond effectively to protect children when such communication was made. In addition failures within selection and recruitment processes resulted in candidates for the priesthood not being rigorously scrutinised and failure to recognise the potential risks from lay people carrying out work within the church as volunteers or other lay staff. Ignorance of the nature of paedophilia was considered to have been compounded by a desire to protect the church from adverse reports and an instinct to forgive

(Nolan, 2001). Trials in relation to Brother James Carragher convicted in 2003 and then again in 2004 revealed the systematic abuse of boys at St William's Community Home in East Yorkshire between the 1960s and 1992. One hundred and forty boys alleged severe physical and sexual abuse by staff in organisations running the Community Home under the direction of the Roman Catholic Diocese of Middlesbrough. Doyle (2009) describes abuse by the catholic clergy as being "twice betrayed" (Doyle, 2009, p.242) as physical, sexual, emotional and psychological abuse is compounded by spiritual damage.

The scale and longevity of abuse of children by religious and lay adults within church based institutions was highlighted by the Commission to Inquire into Child Abuse in Ireland chaired by Justice Sean Ryan. The inquiry identified in excess of eight hundred abusers in two hundred and sixteen Irish institutions over an eighty six year period indicating that it was not accidental or opportunistic but an endemic and accepted feature of the system. Members of the religious orders protected and tolerated the actions of colleagues even when they knew they were breaking the law. Witnesses to the inquiry reported the power of the abusers, the culture of secrecy, isolation and fear of physical punishment all of which inhibited disclosing abuse (Ryan, 2009). The findings echoed those of earlier inquiries and studies which identified fear of victimisation or reprisals limiting complaints and children not listened to (Waterhouse, 2000) or not believed (Brannan et al 1992; Kirkwood, 1993) and a practice of moving people to other duties or allowing them to resign when abuse was reported.

2.2.5 Children's Rights and the Backlash

A greater awareness of abuse of children generally and specifically those living away from home provided a more receptive climate for allegations to be made and heard from the mid 1990s. This was accompanied by greater attention to the voice of the child as a result of the implementation of the Children Act, 1989, and the United Kingdom's ratification of the United Nations Convention on the Rights of the Child in 1991. Stuart Hart (2007) refers to Article 19 of the Convention as providing a "universal imperative for protecting children from abuse and neglect" not only from parents and carers but from any person caring

for the child. In addition Article 12 required that children capable of forming their own views should have a right to express them and their views be given due weight according to age and maturity.

The Government's *Learning The Lessons* (DoH, 2000b) in response to *Lost in Care (Waterhouse, 2000)* emphasised the need to improve complaints procedures. The arrangements put in place under Section 26 of the Children Act, 1989 and the Representations Procedure (Children) Regulations 1991 required a local authority to appoint an officer to co-ordinate representations. The introduction of the right of advocacy for looked after children wishing to make a complaint and a more user friendly and accelerated complaints process were some of the measures to strengthen the previous arrangements (DoH, 2000b). The common thread within institutional abuse inquiries that children were not enabled to raise complaints, and when they did were not listened to (Brannan et al, 1992; Kirkwood, 1993; Marshall, Jamieson and Finlayson, 1999) led to a premium on listening to children. Funding under the Quality Protects programme was designated for this work and the development of the *Total Respect* (DoH, 2000c) training pack for front line staff aimed to ensure that children and young people were taken seriously when they made a complaint or allegation of abuse or poor practice.

Receptiveness to children's views being taken as a valid account and considered equally alongside people in professional roles was not welcomed or shared by all. Research about the impact of allegations on staff groups was also emerging. Lindsay (1999) reported the findings of a survey which represented ninety four per cent of residential services for children in Scotland. It identified that while the frequency of allegations of sexual abuse against staff was relatively small the impact was of greater concern in terms of seriousness. Two themes were identified from workers' comments; first the need to ensure that abusive staff were detected and dismissed and secondly that the potential for allegations of sexual abuse creates anxiety and uncertainty for staff and the service providers.

A study by Horwath (2000) conducted in three residential units similarly found staff concerned about potential allegations. The study found a high level of

consensus of behaviours considered not appropriate which the majority identified they would discuss with a supervisor. Thirty eight percent of participants also reported that they would raise any concerns about colleagues with the individual. Horwath identified a high level of trust with colleagues and shared values which resulted in workers finding it difficult to conceive of a colleague as a potential abuser. A minority commented that the young person may have fabricated the report of abuse. Horwath (2000) concluded that the findings indicated that in some situations the needs of the worker take precedence over the welfare of the child. As a minimum they practice "child care with gloves on" (Horwath, 2000, p. 188) due to fears about how their behaviours will be interpreted for example if they try to prevent a young person leaving late at night.

As the 'empowering' agenda of children's rights gathered momentum the concerns from professional groups took a number of forms. The Bryn Estyn Staff Support Group was set up to counter the allegations made against former staff during the Waterhouse Inquiry. The group lodged an application to the European Court of Human Rights challenging the fairness of the three-year Tribunal. Action Against False Allegations of Abuse (AAFAA) organised a demonstration outside a Childline conference in May 1999 where the Shieldfield Nursery abuse inquiry was a major topic. Another group, the Campaign on Behalf of the Victims of Operation Care emerged in the North West, centred on the retrospective allegations and police process of contacting previous residents. It claimed that ninety former care workers and teachers had been falsely accused at a former approved school in Liverpool, with a number of men wrongly convicted. The group was subsequently re-named Falsely Accused Carers and Teachers (FACT) in 2000, and continued to campaign including making representation to Government, All Party Select Committees and within the House of Lords (Hansard, 18.07.2006 column 1263). The British False Memory Society and False Allegations Scotland were other campaigning organisations against the outcomes of abuse inquiries and professionals convicted of child abuse.

Criticism of the North Wales Tribunal of Inquiry (Waterhouse, 2000) suggested that the potential of compensation was a factor in those giving evidence

(Webster, 2005). Webster also expressed doubt about what he termed the Californian thesis which asserts that children who allege they have been sexually abused should be believed (Summitt, 1983). While accepting that sexual abuse of young people in residential care does happen Webster argued that the increased weight given to young people's allegations of abuse and the climate of moral panic had led to innocent people being convicted and imprisoned for crimes they had not committed. This was at odds with surveys of young people in residential care which indicated that the scale of abuse was greater than what was reported (Moss, Sharpe and Fay, 1990). There were also findings that the long term outcomes for victims was poor with twelve adults abused in the North Wales institutions having committed suicide (Cruz, 1998).

In January 2002 a Home Affairs Select Committee was established to inquire into the conduct of the investigations into past cases of abuse in children's homes. It resulted from the lobbying of supporters of alleged victims of miscarriages of justice. The Committee's remit was to consider the police method of contacting past residents, referred to as 'trawling' for evidence, and the role of the Crown Prosecution Service in determining which cases should be prosecuted and whether there should be a time limit on prosecution of cases of child abuse. A key factor in relation to these issues was that many young people in care did not disclose their abuse until they had left care and were adults when they were no longer at risk of potential repercussions. A recommendation to set a period of ten years after abuse beyond which prosecution should only proceed with the court's permission was rejected by the Government. Its response stated that it "did not share a belief in the existence of large numbers of miscarriages of justice" (Home Office, 2003) The Government was highly critical of the approach of the Home Affairs Select Committee which it argued had given 'disproportionate' emphasis to those who believed that there had been miscarriages of justice.

The claims about miscarriages of justice were not confined to the institutional inquiries. The story of the Shieldfield Nursery in Newcastle where abuse was reported to have been carried out by two nursery workers not long after the conviction of Jason Dabbs for abuse at two other Newcastle nurseries, divided opinion. The nursery workers, Chris Lillie and Dawn Reed, were acquitted at the

Crown Court in 1994 having denied allegations of sexual and physical abuse of a large number of children. The inquiry report that followed (Barker, Jones, Saradjian and Wardell, 1998) criticised the police's scepticism that there could be large scale abuse in a second nursery in the area and therefore the lack of a timely and robust investigation. Complaints against Lillie were interpreted as prejudice against men in child care and not given weight, and those against Reed disregarded because she was a women and competent worker. The inquiry report argued that prejudice about the family circumstances of the children resulted in the families being considered as the source of the children's distress in the early stages rather than the nursery. It also identified concerns that the court system did not assess the evidence of young victims well. Despite the belief of abuse of a large number of children by Lillie and Reed from those conducting the inquiry, the lack of a conviction and subsequent libel hearing in relation to the inquiry report contributed to the construction of the narrative about fabricated and malicious allegations made by children and their parents against professionals.

Within the Cumberlege Commission Report (2006), which reflected considerable progress since the Nolan Report (2001) in relation to safeguarding practice within the Catholic Church there was reference to tension with the "paramountcy principle" in relation to children's welfare if it was at the expense of an accused priest (Cumberlege, 2006, para. 2.16). The report referred to a "strong and vocal lobby of priests" who hold the view that the processes for dealing with allegations is weighted against them "and is a breach of Canon Law and natural justice" (Cumberlege, 2006, para. 2.17). During 2008 there were fifty allegations, relating to sixty four victims, made against clergy, staff and volunteers within the Catholic Church in England and Wales, thirty of whom were clergy or members of religious orders (National Catholic Safeguarding Commission, 2009).

Central to the debate about whether the pendulum had swung too far in the direction of children's rights at the expense of professionals was the changing relationship between public sector services and the public they serve. Cooper, Hetherington and Katz (2003) attributed the loss of public trust and confidence in professional knowledge to a combination of factors. These included the

Conservative administration's attack on professionals and trade unions from 1979 onwards and revelations of abuse of power inside trusted institutions. Parton (2006) highlighted the power of the media to undermine trust and reputations in both individuals and institutions. The introduction of private sector techniques to public sector services had been accompanied by increased accountability and transparency with consumers' and services users' voices strengthened. Meanwhile the increased availability of information on the world-wide-web had served to inform choices producing challenges regarding what was accepted of professional advice.

2.2.6 In Defence of Professionals

One of the professional groups no longer immune to criticism and challenge of their techniques for managing children's behaviour were teachers. With an escalating number of allegations being reported, teachers' associations lobbied the Department for Education and Employment. Guidance on responding to allegations was issued to schools (DfEE, 1995) which contained many aspects of the subsequent multi agency procedures (HM Gov, 2006a). It proposed external scrutiny through the head teacher or chair of governors contact with social services, and an individual within the local authority named within local procedures. The guidance identified the circumstances of referral to the police, referral for a child protection investigation, the process for an internal investigation, disciplinary processes and record keeping. It also advocated that suspension of the staff member should not be automatic in response to an allegation from a child.

Continuing anxiety within the schools sector regarding the potential for an allegation to be made mirrored that reported by Lindsay (1999) and Horwath (2000) in relation to residential care. In response, further guidance was developed which re-stated that teachers and others with lawful control or charge of pupils could use reasonable force in specific circumstances (DfEE Circular 10/98). Guidance had already been provided for residential children's homes (HM Gov, 1991; DoH, 1993) in response to the revelations of inappropriate use of physical interventions in the institutional abuse inquiries. The guidance did not define what was meant by 'reasonable force' and

acknowledged that there was no legal definition. The guiding principles were the level of force warranted by the incident which was proportionate to the circumstances. It was 1999 before guidance was issued in response to "anxiety about the rights of children in health care settings in relation to physical intervention and restriction of liberty" (RCN, 1999, p.2). Subsequent studies followed regarding the use of restraint in residential care (Morgan, 2004a; Morgan, 2004b) and an independent review of restraint in secure settings following the deaths of Gareth Myatt and Adam Rickwood (Smallridge and Williamson, 2008).

Uncertainty regarding the use of restraint was not confined to the schools and care sectors. Davis and Reeves (2004), in relation to radiological examinations, highlighted the fine line between "effective immobilisation" to gain high quality diagnostic radiographs and "forcible restraint". Their inclusion of a scenario cited by Sudbery, Hancock, Eaton and Hogg (1997) of a radiographer against whom an allegation was made for causing a bruise while restraining a child for a radiographic examination serves to highlight the professional fears regarding touching children. Davis and Reeves (2004) stressed the importance of two staff members being present during examinations particularly in situations when a potential non-accidental injury was the subject of investigation. As arguments were put forward that the number of false allegations were rising (NASUWT, 2003; Myers, Clayton, James and O'Brien, 2005) professional practice became increasingly defensive.

A study by Barter (1998) of investigations undertaken by the National Society for the Prevention of Cruelty against Children reported on thirty six separate investigations of seventy six allegations. The investigations concerned fifty alleged abusers, forty of whom were residential staff and ten were other residents. Just over half of the allegations were upheld, a third deemed inconclusive and nine found to be false. Barter reflected that issues of intent and severity which would be considered within familial abuse did not apply within residential care settings. Also issues of culpability within investigations of residential abuse extend to the managers of the facility as well as the immediate abuser. The research identified the lack of support provided to both children and the alleged abuser in a large number of the cases.

The National Foster Care Association suggested that roughly one in six foster carers would experience a complaint or allegation (Wheal, 1995). By 2006 this figure was being revised in response to a survey of over a thousand foster carers which reported that thirty five percent had experienced an allegation (Swain, 2006). Wilson, Sinclair and Gibbs (2000) reported on a longitudinal study into foster carers' experiences of a number of stressful events, one of which was an allegation being made by a looked after child. Sixteen per cent reported that an allegation of abuse had been made by a child in their care, mainly of physical abuse. From the study Wilson et al (2000) identified that the increased awareness of abuse and the greater attention to what parents and children are saying would "seem to increase the likelihood of allegations being made" (Wilson et al 2000, p.195). The questionnaire responses suggested that it was not the allegation itself or the fact that it had to be investigated that was most stressful for foster carers. The worst aspects for the carers who replied were the lack of information and exclusion from the process and poor feedback regarding the conclusion. These findings have been reinforced by subsequent studies (Minty and Bray, 2001; Phillips, 2004). A Foster Network study involving sixty four carers who had been the subject of an allegation reported that one in five stated they had not even been told what type of allegation had been made (Phillips, 2004). Hicks and Nixon (1989) had previously identified that social work practice in dealing with allegations of abuse against foster carers can exacerbate the impact on the carers. Similar themes regarding the need for fair treatment and support rather than automatic suspension had featured in inquiries of institutional abuse (Warner, 1992; Waterhouse, 2000). The reports recognised the need for support for both those alleging abuse and those complained against.

In July 2000 the conviction of a Head Teacher, Marjorie Evans, from a school in Caldicot, Gwent, for slapping a ten year old boy who had learning difficulties became the focus of a campaign by teachers' associations regarding the processes for responding to allegations against staff in schools. The legal and disciplinary processes had extended over a period of eighteen months, at the end of which the school governing body agreed for Marjorie Evans' return to the school as Head Teacher. Criticisms regarding the protracted process led to

David Blunkett, then Education Secretary, announcing in an address to the National Union of Teachers in April 2001 that a network of advisers would be established by the Department of Education and Employment. The network's function was to improve the process and speed with which allegations against school based staff were carried out. The network produced a series of guidance papers for schools one of which provided an interpretation of what may be regarded as 'unsuitable' conduct while another concerned definitions and thresholds in relation to school staff (IRSC, 2005). This advised that the initial ascribing of a category should be made based on evidence rather than "assumption or preconception" (IRSC, 2005, p.13). The categories related to whether the incident was 'corroborated, possible, unlikely or demonstrably false'. The guidance was not re-issued for the broader multi agency audience following the introduction of the *Working Together* (HM Gov, 2006a) procedures and the status of the documents remained unclear.

In 2002 the National Employers Organisation for School Teachers and six teachers' unions produced practice guidance for schools in dealing with allegations in advance of the central government department's response in 2004. The consultation document subsequently launched by the Secretary of State in 2004 at a conference for new head teachers stated its purpose as "aimed at defending teachers from false allegations, ensuring that teachers are not subject to damaging delays where their integrity is in question" (DfES, 2004). While its stated purpose had appeared to lean towards the professional organisations' agenda at the expense of children's rights the content challenged professional associations' negative portrayal of rising numbers of malicious allegations. The document included data about allegations collected from one hundred and twenty two Local Authorities between September 2003 and August 2004. The majority of allegations, sixty six percent, concerned physical abuse or inappropriate handling, and fifteen percent concerned sexual abuse. The document stated that "allegations that are invented are very rare" and that "almost invariably there is a real incident or event" at the basis of an allegation (DfES, 2004, para. 2.9). It recognised the concerns of workers about the potential for malicious allegations but argued that 'different perceptions', 'misunderstandings', 'misrepresentations' or 'exaggerations' can influence the presentation of the allegation. Sikes and Piper (2010, p.3) challenge this view

citing the figure of four percent of all allegations referred to the professional association, the NASUWT, of alleged physical and sexual abuse, which resulted in a conviction. The low conviction rate for allegations against people working with children including school staff is consistent with the conviction pattern for familial abuse and neglect. In 2003, the same year as the allegations against professionals data, convictions were secured on less than two and a half percent of all cases where children were deemed to be at risk of significant harm and less than a quarter of a percent (1.3%) of all those referred as a result of abuse and neglect (Creighton, 2004). The majority of allegations are resolved by training, counselling, support or disciplinary procedures in relation to the staff member (DfES, 2004 data).

2.2.7 The Changing Landscape from 2000

The developments that took place from 2000 in relation to allegations of abuse against people working with children occurred within the context of the modernisation agenda of New Labour. The approach to family policy resulted in strategies which were more interventional with the intention of using prevention as a means to be more truly protective (Parton, 2006). The conclusions of an inquiry into the death of privately fostered Victoria Climbié (Laming, 2003) provided added impetus to Labour's plans for increased integration of service delivery. The Government published a response to Lord Laming's Report (DfES et al, 2003) combined with a response to the first Joint Chief Inspectors Report which had been published the previous year (DoH, 2002). A series of radical changes followed to the organisation of children's services across England not all of which are directly relevant to a study which focussed on allegations against professionals, volunteers and carers. Measures which were relevant included the introduction of statutory Local Safeguarding Children Boards charged with co-ordinating and monitoring the effectiveness of safeguarding activities of partner agencies. From October 2006 Boards were required to have in place procedures for the "investigation of allegations concerning people who work with children (H.M. Gov, 2006a, p.79). The revised best practice guidance *Working Together to Safeguard Children* (H.M. Gov, 2006) became a statutory instrument. While it contained significant new sections of practice, such as reviews of all child deaths, allegations management was the one area of practice for which the lead central government department appointed a network

of advisers. This reflected one of the priorities within the government department which had just taken over responsibility for children's services beyond its former remit of education as responsibility for children's social care transferred from the Department of Health.

An appendix to the main text of *Working Together* provided a detailed description of the framework to be introduced. The guidance was largely a replication of that issued to the education sector in November 2005 (DfES, 2005a) made generic for all partner agencies of the statutory Local Safeguarding Children Boards. Staff in schools, local education authorities and teacher's unions had been afforded a three month consultation on the proposed framework for dealing with allegations against school staff. This same opportunity was not afforded to other organisations providing services to children when the framework was extended for wider use. The consultation draft of *Working Together* did not include the appendix detailing how allegations against people working with children were to be addressed through a formalised process with designated roles and responsibilities. When the procedural expectations were introduced this lack of prior consultation and expectations within the guidance raised some challenges.

2.3 Developments Following the Introduction of Statutory Procedures

Corby et al (2001), in considering the impact of institutional abuse inquiry reports, expressed a hope that they would not prompt defensive practice as formal complaints procedures and processes to protect 'whistle-blowers' were developed. They identified the negative aspects of inquiries into the abuse of children in the community with the increasingly prescriptive procedures previously highlighted by Parton (1997). While referring specifically to residential care they concluded that "it is important the same mistakes are not made" (Corby et al, 2001, p.94). The period since the institutional abuse inquiries has seen the professional guidance including that for allegations against carers, professionals and volunteers multiply in length and detail, and became statutory guidance (H.M. Gov., 2006a) following the Children Act, 2004. The fears expressed by Corby et al (2001) became realised with the introduction of an expectation that all allegations meeting the criteria set out in guidance would be reported to a local

authority designated officer who would have independent oversight of the processes of dealing with allegations. This applied even in cases that fell below a threshold of significant harm and to those that would be dealt with as a disciplinary matter not requiring police or social work assessment (H.M. Gov 2006a, p.153 & 239). The low tolerance of risk and consequent low professional confidence caused by the "proceduralist tendency" (Barlow and Scott, 2010) in relation to familial abuse, which was known to put pressure on decision making and produce increasingly defensive practice, was imported into the processes for responding to reported abuse by professionals.

The campaigning of teachers' associations and unions and other pressure groups continued, pressing a case for anonymity for teachers subject to an allegation. During the passage of the Education and Inspection Act, 2006, the discussion on a tabled amendment to provide anonymity revealed a judgemental attitude towards young people as "rights savvy", "spiteful" and "out to get that teacher" (Hansard, columns 1431-1435, 23.05.2006). Anecdotal tales were told of teachers who described their classrooms as a "war zone", and whose lives had been "devastated" referring to information supplied by the NASUWT that large numbers of allegations were exaggerated, false or malicious. The point was made that the proposed amendment only concerned teachers and did not address workers, volunteers and paid carers in other services for children.

While the amendment to the Education and Inspection Act, 2006 was withdrawn following debate in the House of Lords (Hansard, columns 1179 – 1186, 24.10.2006), an undertaking was given to review the allegations procedures contained in *Working Together* (H.M. Gov 2006a) and *Safeguarding Children and Safer Recruitment in Education* (DfES, 2006a) guidance. A national consultation took place during autumn 2007 on the effectiveness of the procedures and in particular considered issues of confidentiality and false and malicious allegations. Data was submitted by one hundred and twenty eight local authorities during 2007 which revealed that most allegations originated, and were being reported, from the school's sector with low levels of reporting from the health sector or police. The review concluded that while the processes were well implemented in the school's sector more was needed to embed them in the wider children's workforce. Less than three percent of the allegations were deemed to have been

malicious and just over thirteen percent judged to be unfounded. Introduction of the guidance within the police forces had been slow with uncertainty regarding the interpretation of the police role as "a person who works with children"(HM Gov, 2006a, p.152). The Association of Chief Police Officers commissioned the development of guidance for police forces regarding when allegations against police officers should be referred to the local authority designated officer under the multi-agency allegations procedures, as well as to the Professional Standards Department under the regulations which govern conduct and standards of professional behaviour, complaints and misconduct (Home Office, 2004, 2008). This guidance was distributed to police forces in August 2007 and included case scenarios to aid decision making of force managers when faced with an allegation regarding a child.

The *Review of the Implementation of Guidance on Handling Allegations of Abuse Against Those Who Work With Children or Young People* took two years to be published (DCSF, 2009). It was launched along with a consultation on practice guidance which provided a step by step guide to managing an allegation. The additional guidance was never subsequently issued following the change of political administration. In relation to 'exercising professional judgement' the draft practice guidance identified a series of relevant issues including "consulting with others", "keeping an open mind", "considering other options", "taking account of all relevant facts" and "giving each factor appropriate weight" (DCSF, 2009, page 9). It did not offer advice about the threshold or measure of seriousness of allegations to which the processes were to apply.

The Children's Schools and Families Parliamentary Select Committee's Fifth Report on Allegations Against School Staff noted that 'the first steps in dealing with allegations are crucial' (House of Commons, 2009). It suggested that there was too much pressure on head teachers to report allegations to the local authority even where there was no foundation to the allegation, and that head teachers were too quick to suspend staff. It argued for more discretion for head teachers and suggested amendment to the guidance to enable head teachers in 'identified circumstances' to be able to handle allegations internally. The Committee's recommendations did not prompt any change to the policy. The updated *Working Together* guidance (HM Gov, 2010b), as its predecessor had,

included that the decision was that of the senior manager in an organisation to determine if an incident met the criteria of an allegation to be referred to the local authority designated officer. The revised guidance did not amend this position or reinforce it, or contribute further to an understanding of the application of the guidance. The level of incident to which the procedures apply relies on professional judgement. The study in providing access to real cases and the practice wisdom of experienced practitioners with responsibility for this area of complex and emotive safeguarding practice contributes new knowledge at a time when the arrangements are again under scrutiny (DfE, 2010a, DfE, 2011).

Understanding the history and evolution of the processes of responding to allegations of abuse against people who work with children provides both the justification for this study and informs the analysis and discussion of the findings. We turn now to literature on judgement and decision making which is the focus of the research question.

CHAPTER 3: Understanding Judgement and Decision Making

3.1 Introduction

People make decisions every day about a myriad of things, some of which require lengthy consideration while others require very little. Some decisions will be rational, while others may seem less so. Some will be based on explicit assumptions and others will derive from tacit assumptions or a mixture of the two. In the context of their work professionals in children's services are held accountable for the decisions they make by their employing organisation, the regulatory and inspectoral bodies, and the users of the services they provide. Transparency and accountability for decisions is intrinsic to the performance and audit culture of public services, where poor practice based on ill informed decision making is "ever less acceptable" (Thompson and Dowding, 2002, p.9). Understanding some key theories and approaches relevant to the decision making of managers when faced with an allegation against a member of their staff is the subject of this chapter.

The study includes the activities and processes used by managers in responding to contradictory or ambiguous accounts of alleged behaviour. As such it incorporates "the assessment of alternatives" as required in judgements, and the "choosing between alternatives" of decision making (Dowie (1993, p.8). Eysenck and Keane (2000) recognised the similarities of the two but in relating it to research identify that:

> "In essence, judgement research is concerned with the processes used
> in drawing conclusions from the knowledge and evidence available to
> us. In contrast decision making is concerned with choosing amongst
> options, and can involve choices of personal significance."
> (Eysenck and Keane, 2000, p.475)

The research for this study has explored the knowledge that managers identify they use in gathering information. It captures their accounts of how they weighed the information available to them to make judgements about the right course of action to take. It also provides an account of how they described the process of choice about whether to refer the allegation under the formal arrangements described in the statutory practice guidance *Working Together to Safeguard Children* (H.M. Gov, 2006b, 2010b). In so doing it incorporates the processes of

judgement and decision-making as defined by Dowie (1993) and Eysenck and Keane (2000), and recognises the extent to which they are interlinked. As such the two processes will be referred to specifically when necessary but also throughout the chapter and within the study largely by the singular term decision making when referring to the process as a whole.

The chapter begins by considering normative theories of decision making which draw on logic, probability theory and decision theory. These provide models of how one should determine the best possible option or course of action based on what is intended to be achieved. Examples of decision analysis frameworks which support rational decision making derived from traditional decision theory are considered in relation to the study. The section moves on to discuss descriptive theories of decision making drawing on empirical studies from cognitive psychology and human sciences which describe how people actually make decisions. The role of intuition in decision making is then considered along with the concept of a 'cognitive continuum' (Hammond 1978) varying between rational and intuitive approaches. The section ends by considering some individual differences in decision making including personality, emotion and the role of expertise. The chapter moves on in the second section to summarise some of the cognitive biases and errors that can arise due to heuristic strategies adopted to reduce complexity. The final section discusses decision making in relation to child protection, with specific reference to allegations of abuse by professionals.

Studies that explore decision making can be focused on the decision maker, the decision making process or the decision itself. In relation to this study the focus of interest is on the processes involved in reaching a decision, including the factors taken into account, and the knowledge drawn upon. The study does not seek to comment on the quality of the decisions made by participants. Neither does it consider the decision makers as individual personalities beyond information about the training they have received on the management of allegations.

Decisions may be made by groups rather than individuals. Understanding decision making in this context involves considering group interactions and group dynamics. During the later stages in the overall management of an allegation the

group dynamics of a strategy meeting may be relevant to the progress and outcome of a case, but this is not the focus of the study. Therefore group processes in decision making are not included in this review of decision literature.

3.2 Theories of Judgement and Decision Making

There exists a wealth of information about judgement and decision making as a generic process applicable to most situations and activities. Research drawn from mathematics, economics, statistical analysis, computer programming and the behavioural sciences of cognitive and social psychology and sociology have contributed to decision theories.

3.2.1 Normative Rational Approach to Decision Making

Decision theory focuses on only those aspects which are goal directed and where there are alternatives to choose between, and the option is selected in a non random way (Hansson, 2005). Early research focused on optimal decision making and provided normative approaches which describe how decisions should be made in order to be rational and logical. Normative approaches assume people are rational agents, with consistent attitudes and preferences seeking to maximise self interest. The definition of 'normative' in decision theory is limited to rationality as other norms such as ethical norms are considered external to decision theory. Determining the best course of action which maximises expected utility requires knowledge of all possible courses of action, potential outcomes and their likelihood, and the values attached to the possible outcomes (Klein, 1998). The costs, risk and benefits are weighed by use of a statistical approach assigning probabilities to the various factors and numerical consequences to the outcomes. Examples of these include 'expected utility theory', which involves probability weighting utility values; and the use of 'Bayesian decision theory' used in relation to subjective probabilities rather than frequencies and potential frequencies in the physical world (Hansson, 2005).

Plous (1993) provides a summary of the axioms specified by Von Neumann and Morgenstern (1947) which underpin rational decision making. Plous (1993, p.81) includes 'the ordering of alternatives, dominance, cancellation, transitivity,

continuity and invariance' as the six key principles. These in essence require the decision maker not to be influenced by the way in which alternatives are presented or their order, but to focus on only the outcomes that differ, and select the best if the odds are good enough. If decision makers fail to follow the principles the expected utility will not be maximised. Following from the expected utility theory of Von Neumann and Morgenstern (1947) variations were proposed. Amongst them Savage (1954) extended it to include situations where only subjective probabilities exist, which involved beliefs and desires being assigned probabilities, to provide a 'subjective expected utility theory'.

Techniques which support normative rational decision making include decision matrices and decision trees. The techniques require first the deconstruction of a problem into its constituent parts which is easier for problems of the physical world than the social world. Decision matrices provide a technique to represent a decision problem in which the alternatives are tabulated against the possible states of nature which consist of the various unknown extraneous factors. In order to use a matrix to analyze a decision it is necessary to have information about how the outcomes are valued and to assign utilities to them (Hansson, 2005). For decision problems where there is less precise information it is more difficult to construct decision matrices.

Decision trees offer another technique for laying out all the alternatives and their consequences to aid the process of arriving at a logical and rational solution. Construction of a decision tree requires a collection of alternatives for action, and the comparative assessment of the potential outcomes of these actions and likelihood of these occurring. Decision trees, just like decision matrices, can involve determining the utility value of each outcome and the assigning of probabilities to various outcomes resulting in a mathematical criterion to identify the 'best' decision. While the goal is to make the process as objective as possible the process of producing a tree involves the construction of alternatives from practice wisdom and individual imagination. The assigning of utility values and probability estimates for the various outcomes are subjective; there is no single logic that people follow. What is considered rational or logical in terms of the values is guided by cultural conventions, practice wisdom and acquired rules which therefore become matters for debate.

Eileen Munro (2002, p. 117) in relation to child protection decision making suggests that decision trees are an effective way of "organising reasoning and analysing" a problem, but highlights the potential for thinkers to be overwhelmed by the potential alternatives. A normative approach that involves probabilities, utilities and quantitative values would for many practitioners seem unnatural in discussions about the protection of children. Determining what counts as a desirable outcome and from whose perspective, the child, the parent, the worker or the organisation, involves a value judgement. There are no objective criteria by which to weight the different accounts and ascribe numerical values of probability and utility. Statistical analysis of the decision matrices or decision tree, while an aspect of traditional decision theory, is however not a requirement. They can be used without numerical probability values to make the decision making process explicit and transparent. This provides a useful tool enabling the decision to be questioned or defended at a later stage. In laying out the aspects of a problem in a systematic way as occurs in developing a decision tree the preponderance of effects for one course of action may be so overwhelming that the decision can be made with nothing further required. The process can however be time consuming, researching information about each alternative and so would be most relevant to major decision points when time is available and the cost of error high.

3.2.2 Descriptive Approaches to Decision Making

While normative decision theories concern how decisions should be made to be logical and optimal, descriptive models concern how people actually make decisions. They have emerged predominantly from psychology and behavioural sciences rather than the fields of mathematics, statistics and economics which provide the background for normative rational models. Descriptive models recognise that people do not behave in optimal ways and that decisions need to be made in situations with less than full information. Cognitive psychology research encompassing perception, attention, problem solving, judgement processes, memory, and information processing generally has provided studies which conclude that people have limited information processing capabilities and that they are adaptive (Eysenck and Keane, 2000). To manage the vast amount of stimuli in the surrounding environment perception of information is selective,

not comprehensive. Working memory is limited in capacity (Baddeley, 1990) and people use simple rules, referred to as heuristics, in order to reduce the mental effort. Long term memory has a large capacity and relatively permanent storage ability but is slower in processing than working memory. Accessing information is aided by cues making information available to working memory (Thompson, 1999).

Several descriptive models have developed from empirical studies which have explored why people think and act as they do in making decisions. Simon (1955) proposed that rather than optimising their situation in making decisions people 'satisfice'. This involves selecting an option that satisfies the most important needs even if the outcome is not optimal, or the best possible of all outcomes. As such it reduces the resources needed in finding out about all the alternatives and simplifies the decision task.

Tversky and Kahneman (1979; 1981) proposed a 'prospect theory' which described how people are influenced by how a problem is framed and whether the outcome is viewed as a gain or a loss. This approach replaced the notion of 'utility' from expected utility theory with 'value' which they defined in terms of gains and losses. The value of the two is experienced differently with losses felt more strongly than gains. People take greater risks to avoid loss than they would to achieve a gain. The two factors result in behaviours which are both risk seeking and risk averse depending on how information is presented in relation to a decision problem. This means that it is possible to manipulate how information relevant to a decision is perceived, as found by Levin (1987) in a study of the fat content in food choices. In making judgements the options are evaluated according to a subjective point of reference based on beliefs and values from which the gains and losses are determined by the individual.

The notion of framing drawn from prospect theory (Tversky and Kahneman, 1979; 1981) is relevant to the study in that it suggests that people form a mental representation of a problem situation based on both the problem and the context, which will be influenced by how it is presented to them. Prospect theory refers to the presentation in terms of gains and losses. In relation to allegations against staff this could include loss associated with a staff member's service, or reputation for the team or organisation if an allegation became public. Despite

the risk of framing being deliberately manipulated to influence an individual's decision making, experiments have found that people when presented with a problem did not attempt to reframe the information to gain a different understanding (Tversky and Kahneman, 1979; 1981). Also different versions of the same problem have been found to prompt different preferences when presented separately although recognised as equivalent when considered together. Again this is relevant to the study in that managers will have more than one version of a problem situation, with two individuals presenting a different framing of the event according to their perception. Prospect theory suggests that it is possible for an individual to be intentionally or unintentionally manipulated by the framing of a problem situation and associated information.

Much of the research on problem solving and descriptive approaches to decision making has concerned well defined goal driven situations carried out under experimental conditions. This has raised questions about the transferability of findings to less controlled environments which are more knowledge and context rich real world situations. To understand judgement and decision making in real world situations research on expertise has pointed to the role of intuition and experience.

3.2.3 The Role of Intuition in Decision Making

The rational analytical model of decision theory is not adequate for many situations in which decisions are made because people do not typically behave in objective rational ways in reaching decisions. For many aspects of life the making of decisions is largely intuitive choices or value judgments regarding preference. This applies particularly in situations when a quick decision is required and there is no time to think through the alternatives, or there is a lack of information, or where the situation is chaotic. Intuitive decision making is a sensing activity, more artistic than scientific in nature. Benner and Tanner (1987) define it as "understanding without a rationale". It does not rely consciously on rational or linear thought processes but synthesises information into an integrated picture, making connections and relationships within the presenting information. The essential factor in intuitive decision making which differentiates it from guesswork is experience. This allows for a situational

assessment. It involves the recognition of a situation as typical or to recognise similarities or patterns encountered previously and to understand what those patterns typically mean. Rather than needing to weigh the pros and cons an individual may know how to act. It can therefore be expected that the greater the level of experience the greater the understanding. Habitual or unhelpful patterns based on prior experience can also exist which will be discussed in the next section considering errors and biases in decision making.

Schon (1983) proposed that just as in everyday life an individual having learned how to do something can execute activities, and make adjustments and decisions without conscious intellectual activity, competent professionals within their work situations do the same. They recognise and respond to collections of symptoms, irregularities, or patterns. Even when research based theories are utilised the professional still depends on the tacit recognition and skilful performance of their role. The phrase "knowing-in-action" (Schon, 1983, p.50) is used to capture how the spontaneous behaviour of skilled practitioners reveals a kind of knowing that does not stem from conscious resort to rules, plans or procedures. As a result professionals make decisions by knowing more than they can describe.

Brenner (1984) drawing on research from nursing and Munro (2002) in relation to social work suggest that for expert practitioners the connections between a presenting situation and understanding the appropriate action are internalised through experience. The combining of information and making inferences become almost unconscious cognitive processes owing as much to intuition as rational processes.

3.2.4 The Notion of a Cognitive Continuum

Hammond, (1978) proposed that rational and intuitive types of decision making exist on a continuum and that many decisions are neither entirely one nor the other but contain varying amounts of both. This notion of a cognitive continuum considers decision making as ranging from purely intuitive to the pure analysis of scientific experiments, including system aided decision making (Hamm, 1988). The most appropriate approach is determined according to the degree of

structure of the task, the time available, and the number of information cues. Decisions required in situations of a vague or poorly structured task, for which there are extensive information cues or sources and little time lend themselves to an intuitive approach. While an analytical rational decision process is best suited to well structured problems for which there is limited additional information or cues and time available to explore a broader range of options and responses.

Studying professional people making decisions led Klein (1998) to propose a 'recognition primed decision making model' which combines elements of rational with intuitive decision making. Klein argued that people use predominantly an intuitive approach but that in any situation there are cues or hints that enable people to recognise patterns. The decisions are not based on feelings alone but on a swift intuitive appraisal based on cues within the situation and a systematic process of considering alternatives of what has worked in the past, and what combination best fits the situation faced. Unlike the normative rational approach of decision theory the 'recognition primed decision making model' can respond to immediately presenting situations requiring decisions with the information gathering about alternatives drawn from past experience and pattern recognition. The more experience an individual has the more patterns they will have learned and be able to recognise. Based on the pattern, the person chooses a particular course of action. They mentally rehearse it and if they think it will work, they adopt it, or if not will select another which they will also mentally rehearse. In the model offered by Klein there is no actual comparison of choices but rather a cycling through choices until an appropriate one is found. Klein (1998, p.3) identified "intuition, mental simulation, metaphor and storytelling" as components; the storytelling being to make experiences available to others as well as themselves for the future.

Recognition primed decision making is argued to provide "a form of naturalistic decision making" (van de Luitgaarden, 2009, p. 253). The problem situation is not dissected into constituent elements but experienced as a whole in its natural context. The comparisons are real-life situations and experiences, not abstract alternatives. The approach does not require a fixed set of distinguishing factors but rather allows for selection of relevant cues to identify a good enough

solution. The direct connection to practice of primed decision making offers an alternative to practice guidelines and decision aids which draw on meta-reviews of research data and has the benefit of developing individual worker's decision making skills.

Schon (1983) similarly suggested that through experience, trial and error, and reflective thought practitioners' mental patterns and responses are revised and adjusted. The patterns assist in identification of cues and knowing how to respond. Through 'reflection-on-action' practitioners critique their practice including the tacit understandings that have developed around repetitive pieces of practice (Schon,1983). In this way they are able to alter or discard previously used patterns to enable one that matches the complexity of the situation to be developed. This involves a shift from attending to patterns from practice to meta-cognitive awareness of cognitive patterns by practitioners.

3.2.5 Individual Differences in Decision Making

Consideration of individual differences of participants beyond the agency of employment and prior training and experience was not a feature of the study. Individual difference in relation to the impact of emotion did emerge from the experiential accounts of participants, some of whom described their initial feelings and reaction to receiving an allegation against a staff member, and feelings at stages through the information gathering stage and decision. Relationships with the person against whom the allegation had been made, and with other colleagues featured in the descriptions, and coloured the value judgements about behaviours. These provide some insight into the influence of emotion on the decision making.

The role of emotion is one area of individual difference that has attracted research with affective reactions being identified as often the first reaction to stimuli. Positive affect is argued to expand creative thinking, improve assessment ability, including being able to link different sources and types of information, increase elaboration of information, and result in greater flexibility in negotiation situations (Isen, 2000). By alerting an individual to important aspects of a situation, emotion provides direction for cognitive processes and

behaviour (Schwartz and Clore, 1988; Frederickson, 2001). It may however also reduce information processing in situations of uncertainty (Lemerise and Arsenio, 2000) and lead to risk averse decisions (Hammond, 1996). Emotion can influence the information that an individual pays attention to in that they are more likely to recall information from memory consistent with their current feelings (Schwartz, 2000). Some emotional reactions, such as anger, have been found to have specific influence on decision making. Lerner and Tiedens (2006) found that anger led to selective processing of information, optimism and risk taking. Regret is another emotion that empirical studies have documented as influential in a variety of ways. These include anticipated regret resulting in decision aversion (Beattie, Baron, Hershey and Spranca, 1994), and looking for justifications (Simonson, 1992); while a bad outcome that was the product of a poor decision creates more regret than an outcome resulting from inaction (Kahneman and Tversky, 1982).

Within personality research there is no over-arching model or set of principles regarding the way personality affects decision making (Beresford and Sloper, 2008). Some key areas suggested as being affected by personality factors includes how a problem is perceived, the extent to which the individual wants to take control of making a decision, the extent of their information seeking, their engagement of others, their preferred style, and the extent to which they feel a need to justify their decision to others (Beresford and Sloper, 2008, p.33). Self esteem is another area where individual differences have been identified as influencing decision making (Josephs, Larrick, Steel and Nisbett, 1992 cited in Eysencke and Keane, 2000). Research found that individuals with low self esteem were fifty percent less likely to take a risk in a gamble and seemed to focus on self protection, concerned that a negative outcome would further reduce their self esteem.

3.2.6 The Role of Expertise in Judgement and Decision Making

Along with the recognition of individual differences in judgement and decision making has been the case made for the role of expertise (Dreyfus and Dreyfus, 1986; Chi, Glaser and Farr, 1988; Schon, 1983; and Benner, 1984). Beginning in the late 1970s the differences in the knowledge strategies of novices and

experts became the subject of numerous studies. Studies by Chase and Simon (1973) in relation to chess players, McKeithen, Reitman, Rueter and Hirtle (1981) and Adelson (1981) in relation to computer programming, Chi, Feltovich and Glaser (1981) in relation to physics, and Phelps & Shanteau (1978) in relation to livestock judges provided evidence of some consistent patterns. From these studies one of the major differences identified was that experts could rely on memorised solutions to problems in their domain. Novices did not have the same store of prior experiences to call upon as potential solutions to the problems they confronted. The response of experts was not simply replicating prior solutions stored in memory because some situations they encountered were novel. Experts were found to have a store of patterns representing commonly occurring configurations and situations and a store of solutions to apply to them. Shanteau (1992) argued that experts could home in on the critical pieces of knowledge needed and simplify complex problems. Experts were able to match the patterns to reach solutions even in novel situations. The studies also found that novices and experts differ in the way in which they represent problems with experts representing them in terms of underlying principles rather than surface features. Chi et al (1981) concluded that experts were able to classify problems in terms of solution principles to solve the particular problem. Experts were also found to work forward from the problem in developing their strategy while novices worked backward from the goal (Bhasker and Simon, 1977).

The study of expertise has also been a feature of professional practice in human services although researchers have identified the challenges of a definition of expertise (Fook, Ryan, and Hawkins, 1997). McCracken and Marsh (2008, p.302) suggest expertise encompasses clinical, technical and organisational aspects and consists of a "set of tools for thinking" which develops over a period of extended practice. This leads to the experienced practitioner responding very differently than a novice. Benner (1984) reflects this also in suggesting that the development from novice to expert involves a shift from linear consciously analytic models of decision making to unconscious and intuitive models based on prior experience.

In relation to social work Fook et al (1997) from a study of thirty experienced practitioners identified characteristics of expertise as including the ability to quickly prioritise relevant factors, ability to deal with complexity, and awareness of constraints and resources. The expert practitioners made minimal conscious use of formal theory and when used it was confined to specific concepts or assumptions. Experts think holistically and pick up clues which trigger responses earlier than less skilled performers (Dreyfus and Dreyfus, 1986; Benner, 1984). They are also able to use their store of experience to frame a situation rapidly recognising patterns and events (Chase and Simon, 1973; Munro, 2002).

Dreyfus and Dreyfus (1986) from a study of chess players and airline pilots identified five levels of proficiency and skill performance related to cognitive processes that correspond to stages in professional development. The stages of skill acquisition focus on strengths rather than deficits and do not reflect talent. Novice practitioners are described as predominantly utilising knowledge external to them, located in procedures taught in training and rules they have been given. Judgement and decision making at this level will be consciously analytical. At the expert practitioner level the prime source of knowledge is that of experience and practice wisdom. The intervening stages within the model of skill acquisition of advanced beginner, competent and then proficient practitioner are a progression from external knowledge to internalised knowledge drawn from experience. Expert knowledge is identified to be dynamic and the product of the accommodation of understandings of unique situations generating context-dependent understanding. The expert has a repertoire of cognitive patterns from past experience which interact with environmental cues to construct an appropriate response or action. Within this are many similarities to the model of 'recognition primed decision making' proposed by Klein (1998) which requires knowledge processes based on experience to identify cues. Margolis (1987) similarly proposed that experts draw upon a repertoire of patterns and when a situation occurs for which there is no pattern one is refined or reconfigured to more closely conform to the requirements of the situation. In this way the collection of interpretive patterns changes and grows to meet variations.

In regard to this study consideration of expertise is relevant in that the participants were in some senses at the expert end of the professional development scale. Their expertise was, however, in their field of professional practice and not in relation to dealing with allegations against staff although most had some prior experience of complaints or allegations to draw upon. For most managers allegations against staff were very infrequent occurrences reducing the potential to acquire extensive experience and patterns of responses to call upon. The influence of experience and the knowledge was a feature of managers' descriptions of decision making and is discussed within the findings of the study.

3.3 The Potential for Errors in Decision Making

Actual decision making diverges from the rational model people may choose to present (Carroll & Johnson, 1990). Patterns of deviations referred to as 'cognitive biases', have been revealed by empirical studies (van de Luitgaarden, 2009) which identify the ways in which human decision making systematically goes wrong. This has led researchers to conclude that within human reasoning there is a propensity for "errors, slips, lapses and mistakes" (Thompson and Dowding, 2002). These are largely the outcome of the heuristic strategies adopted to reduce the complexity of decision making. In the absence of infinite time and resources to devote to gathering and analysing options decision making is aided by simplifying assumptions and limiting information, or reducing the thoroughness of analysis. Research indicates that decision makers may not understand the heuristic strategies they use. So that while useful to deal with the immense complexities of the world and overcome the limitations of cognitive capacity these strategies may result in unconscious biases or errors.

As discussed in relation to prospect theory the way a problem is framed impacts on the way in which the acts, outcomes and other factors around the choices are understood and the decision that is made. Tversky and Kahneman (1981) found medical decisions were affected by whether outcomes were framed as the probability of living or probability of dying. In relation to financial decisions they found that in positions of gain people tend to be risk averse whereas in a position of loss people are more likely to take risks to avoid or recover losses. The effects

of framing have also been found to affect recall of events (Loftus and Palmer, 1974) impacting on the information with which people have to work in making a decision.

The use of information is also subject to biases potentially leading to errors in decision making. The timing of information received is one amongst several factors with two potential different effects depending on the characteristics of the individual decision maker. The 'recency effect' describes the process by which recent information is given more weight than information from the past. Or the opposite, referred to as the 'primacy effect', describes how the original information is given more weight than information subsequently received. Repetition bias describes the willingness to believe information given most often or from the greatest number of different sources which may not be correct. A 'psychological commitment' to a first hypothesis can make it difficult to revise (Dowie and Elstein, 1988). This 'anchoring effect', by which decisions are unduly influenced by initial information, shapes how subsequent information is viewed. An initial view may not be revised, amended or updated according to new information because the mental anchor acts as resistance to reaching a different conclusion. While experience provides important clues and cues in problem situations an unwillingness to change thought patterns used in the past in the face of new information or a new situation, or rejection of the unfamiliar can result in experience placing limitations on the options considered.

Selective perception whereby individuals screen out what they do not regard as salient contributes to a number of errors. The selective search for evidence, also referred to as confirmation biases (Kahneman, Slovic and Tversky, 1982; Plous, 1993; Gambrill, 2005) is the tendency to collect facts that support certain conclusions or an already established point of view. This tendency can lead to a disregarding of facts that challenge or support another conclusion (Nisbett and Ross, 1980). In relation to social work Holland (2004, p.144) warns against the tendency "to seek only the information that we wish to find". Wishful thinking, referred to in social work as 'the rule of optimism' (Dingwall, Eekelaar and Murray, 1983) has been identified in inquiries of child deaths (Reder, Duncan and Gray, 1993). It involves the tendency to see things in a positive light which can distort perception resulting in only positive cues and information being identified.

A premature termination of search for evidence can occur by which individuals may accept the first alternative that they think may work. This is similar to 'satisficing' (Simon, 1955, 1983) which as already explained describes the tendency to select the first option that meets a given need or the one that meets most needs rather than the optimal solution.

Ignorance of the relevant base rate of a particular incident or behaviour can result in misunderstanding of its likely occurrence. For example the number of allegations against people employed to work with children is very low but the media reporting and campaigning of professional associations may distort expectations about the frequency. Also relevant to the study is the potential for 'attribution bias' (Plous, 1993; Moore, 1996) which describes the differences between the way we perceive others' actions and our own. Studies of actor-observer differences reveal that an actor is likely to emphasise situational and environmental factors as factors in their behaviour, while observers are more likely to focus on dispositional properties of the actor. This extends to how we attribute cause to people we perceive as similar to ourselves. The more closely one identifies with a person the more that external factors are attributed for their behaviour and actions. If the other person is seen as being very different there is a tendency to "over attribute their conduct to internal drivers" (Moore, 1996, p.21). The potential for over identification with one party to an allegation against a staff member has been identified by Horwath (2000) whose study within the residential child care sector concluded that it was difficult to conceive of colleagues as potential abusers.

Self-fulfilling prophecies identified by Plous (1993) as one of the "common traps" while having some similarities to confirmation biases involve the misconception of a situation but which by evoking a new behaviour makes the original misconception true. Plous describes a famous study by Rosenthal and Jacobson (1968) in which teachers were told that, based on test results, some students would make greater progress during the year. The students did make the predicted progress despite the predictions being random. The study found that the teachers had given more praise and attention to the pupils expected to excel and as a result they made more progress. Self-fulfilling prophecies can equally operate in a negative way.

Stewart and Thompson (2004) identify one of the biases influencing practitioners' predication of risk as that of illusionary correlations. This is a tendency to see two events as being related when they are not, or related to a lesser extent. Moore (1996, p.23) suggests that one of the most common errors is to assume that "correlation implies causality" particularly when the correlation is consistent with one's own beliefs. Even when two things are closely related it does not mean that one causes the other. Case examples provided by Moore (1996, p.24) regarding risk of future violence by offenders describe some stereotype assumptions that can feature in risk assessments for which the 'correlations' between appearance, demeanour and risk have no theoretical basis or empirical evidence.

At times there is group or peer pressure for an individual to conform to the opinions held by the group. Alternatively it may be the perceived expectation of the organisation or pressure associated with role fulfilment leading to the individual conforming to the decision making expectations that others have of a particular role. Role expectation is relevant to the study in that the introduction of the statutory guidance required the identification of managers within partner agencies who would fulfil the role of senior manager for the purpose of notifying allegations. For many this will result from the position they occupy in the organisation rather than a choice. Adair (1985) identifies that the way to become good at decision making is to make lots of decisions. While senior managers will make decisions about a vast array of issues relevant to their service area allegations against staff are rare, making this an area of practice in which they are unlikely to gain a lot of experience.

Plous (1993, p.217) argues that the most "prevalent" and "potentially catastrophic" problem in judgement and decision making is that of overconfidence. He suggests in situations of extreme confidence to proceed with caution and consider why there may be a different correct answer. Munro (2008) similarly in relation to child protection identifies the most important strategy for minimising errors is simply to admit that you might be wrong.

3.4 Decision Making to Safeguard Children From Harm

The concepts of certainty and uncertainty and how these relate to child protection practice feature in both literature (Munro, 1996, 2002; Parton and O'Byrne, 2000; Taylor and White, 2001, 2006) and inquiry reports (Reder, Duncan and Gray, 1993; Munro, 1996; Reder and Duncan, 1999; Laming, 2003). Inquiry reports reviewed by Munro (1996), Reder et al (1993) and Brandon, Belderson, Warren, Howe, Gardner, Dodsworth and Black (2008) reveal how resistant workers were to changing their minds or revising judgements in response to new facts once a view had been formed. It was not the mistakes resulting from imperfect knowledge that were the subject of criticism within the inquiry reports but the errors that arose from biases in judgement processes and intuitive reasoning. Social workers and other professionals were slow to revise their judgements despite the limitations of the evidence on which some risk assessments were made. The resistance to altering their belief applied whether the view was optimistic or suspicious of a family. Reder et al, (1993) identified recurring themes which included workers making selective interpretations and not considering alternatives, misinterpreting evidence due to treating information discretely rather than seeing the whole, and being reluctant to abandon beliefs. Workers may selectively remember information that endorses their beliefs (Kahneman and Tversky, 1982), seeking only evidence which confirms, not disproves, an already formed view (Watson, 1960; Munro, 1996, 1999: Gambrill, 2005), and persisting in a belief or theory despite evidence which should invalidate or reverse it (Nisbett and Ross, 1980; Fish, Munro and Bairstow, 2009). Munro (1996, 2008) argues that in child protection workers need a willingness to re-visit judgements, accepting that they may be fallible, and the decisions may be wrong. The complexity of safeguarding practice requires that professionals are reflective about their decisions and decision making. Self awareness and critical reflection on decisions and the judgement steps that have led to them assist in minimising the biases and errors that are elements of human cognitive processes.

Judgement and decision making in safeguarding practice is a complex task with risk being a central concept. The notion of risk and the development of tools and frameworks to aid risk assessment creates an impression of objectivity and calculability. For some areas of safeguarding practice, for example in relation to

risk assessments of sex offenders and the barring of individuals from employment, actuarial decision tools have been developed from research evidence. These aim to provide objectivity and rigour and reduce the potential for individual cognitive errors and biases. More generally within professional practice decision making is expected to be analytical and evidence based, and as such comply with the normative rational model of decision making. Analytical decision making follows a logical process in responding to a clearly identified and defined situation. It involves identifying alternatives, gathering and evaluating information about them. It could include drawing up a list of pros and cons, consulting with others to draw on their knowledge and experience, examining research evidence and meta-analyses relevant to the specific case before selecting an option and acting upon it. The search for and critical appraisal of empirical findings that constitutes 'evidence based practice', is argued to be the 'operationalisation' of a rational choice approach to decision making (van de Luitgaarden, 2009).

Decision making in relation to safeguarding children is a contested area of public sector provision because the protection of children is the justification for the state's compulsory intervention into family life. Children's safety, health and education are issues about which the State has encroached into family life in many ways, and taken decisions away from individual parents. Teachers, health visitors, doctors, and social workers may operate intrusively due to their 'professional expert' status particularly with 'problem families' or families with difficulties (Parton, 1985, 2006; Hill, 1990). When the allegations of abuse concern the very professionals that are employed to work in children's best interest there is an increased need for the action and decision making to be robust and transparent. It is these two elements that underpin the expectations within the Working Together (HM Gov, 2006a, 2010b) guidance regarding the management of allegations against staff.

The need to explain and justify decisions to others supports analytical and rational decision processes. To be unable to provide a rational account of a judgement process and decision may raise questions about its quality and the justification for the course of action that followed. In activity to safeguard children the error of greatest concern to practitioners is of missing or misinterpreting a situation of risk to a child. There is equally the danger of a false positive decision

which can result in an unnecessary intervention. When applied to the management of allegations this may result in unnecessary suspension of a staff member, the calling of a strategy meeting, the initiation of an investigation and a recorded incident which may appear on future criminal record bureau employment checks. The suspension may become known within the community and assumptions passed on in ill-informed conversation long before the allegation is investigated. It is these outcomes of the potential for false positive identification of cases which meet the threshold for referral into the allegations management processes that concern workers, managers and professional associations. Campaigning on this issue has been responded to by the Government in the *Coalition Agreement* (HM Gov, 2010a) leading to a promise of anonymity for teacher's facing allegations within the *Education Bill 2010-2011* (DfE, 2011).

The procedures which guide the judgement and decision making process for responding to an allegation require the senior manager to tread a fine line. They need to establish that the allegation is not blatantly false and determine whether it meets the criteria for referral into the multi agency procedures or falls below that threshold and can be dealt with internally. Checking the integrity of the statements of the individuals involved or who witnessed the incident is limited by both time and the procedural expectation of contact with the local authority designated officer within one working day. Not only will different types of allegations and situations require different levels of enquiries to determine whether the referral criteria are met but so may managers with varying levels of confidence and experience. In some cases of alleged sexual abuse or suspected downloading or production of child pornography managers may make very limited enquiries for fear of jeopardising the evidence gathering of a police investigation. In other circumstances managers may choose to extend their enquiries to inform their decision making process. The outcome can have significant consequences for themselves, the child, the staff member, and potentially the service. Referral into the multi agency procedures takes the allegation outside of the organisation and introduces external scrutiny of the actions subsequently taken by the organisation.

Like other areas of safeguarding practice allegations against staff is an area of uncertainty where there are competing versions and interpretations of events.

Managers may have information with varying degrees of reliability from participants and partial witnesses. They need to keep an open mind recognising the difference between taking an allegation seriously and believing it. Managers are forced by procedural requirements to decide at an early stage what kind of situation they are dealing with and then persist in the categorisation of it. Decision making in situations of limited knowledge and time pressures support an intuitive approach. While managers may intuitively grasp all the various potential permutations of the events it is equally possible for a manager to proceed in a manner which seeks to confirm initial impressions or preconceived ideas and to ignore contradictory evidence. Previous research has highlighted that within the context of working relationships it can be difficult to conceive of colleagues as potential abusers (Horwath, 2000). While inquiry reports identify how holding on to this belief when faced with evidence or indicators to the contrary can enable abuse to go unchallenged (Brannan, Jones and Murch, 1992; Kirkwood, 1993).

CHAPTER 4: Research Methodology and Design

4.1 Introduction

Mills (1959, p.134) describes 'methods' as 'ways to ask and answer questions', and 'theory' as 'paying close attention to the words one uses'. Issues of durability of responses and generality are highlighted, but their primary purpose is identified by Mills to be 'clarity of conception' and 'economy of procedure'. As a novice researcher I followed Mills' advice to be mindful of the assumptions and implications of each stage in constructing the framework for the project. In this chapter the assumptions that exist within the methodological framework are made explicit. As each step of the research design is described, the implications of the choices made for the outcomes are discussed.

The chapter begins by locating the subject matter of the study within a constructionist framework. To do this the aims of the study are discussed within the context of research on child protection generally. It is argued that exploring the process of decision-making by managers when faced with an allegation against a member of their staff requires an approach that can accommodate a relativist and interpretive perspective.

The second section of the chapter describes the selection of methods for the study. The application of a two-stage design using in-depth semi structured interviews and vignettes will be justified within the aims of the study. The sampling strategy is explained including the changes that became necessary as the data gathering progressed to engage participants from the wider multi-agency network involved in providing services for children. The procedures adopted for data analysis in relation to the two phases of the study are described. The chapter concludes with a discussion of the ethical issues relevant to the study and how they were addressed.

4.2 Selecting a Framework

Much has been written about the socially constructed nature of child abuse (Dingwall et al, 1983, 1995; Taylor, 1989; Gibbons, Conroy and Bell, 1995; Dartington Research Unit, 1995; Parton, Thorpe and Wattam, 1997; Munro, 2002;

Parton, 2003). As a result it is difficult to say something new and interesting about the choice of constructionism as the epistemology underpinning the study. The temptation is to rush ahead to describe the methodology and methods for gathering and analysing the data, for it is in these that the conduct and findings of the study lie. The status of the findings and the contribution to knowledge however draw us back to epistemology and require that the selection of constructionism be explained.

4.2.1 Constructionism, Relativism and Interpretivism

Constructionism put simply is the view that meanings are constructed by people, not discovered or created by them, but constructed as people engage with and interpret the world (Crotty, 1998). This does not occur purely on an individual level. Meanings are transmitted at a social level and individuals approach and experience phenomena informed by an inherited culture. While constructivism refers to an individual's meaning making within a social context, constructionism refers to the collective development of the meanings of phenomena. Berger and Luckmann (1967) argue that when people interact they do so with the understanding that their respective perceptions of reality are related. As they then act in accordance with this understanding, their common knowledge of reality is reinforced. It is in this sense that Berger and Luckmann (1967) argue that all knowledge of everyday reality is socially constructed, derived from and maintained by social interactions.

Constructionism as an appropriate epistemology for understanding and explaining what is known about child abuse provides a framework which recognises that what is defined, talked about, and responded to, is constructed. Child abuse does not exist as something which has meaning objectively evident, independent of the consciousness that individuals bring to it. It is also not wholly subjective because its meaning is not limited by, or dependent on, an individual's subjective experience, restricted to the conscious self and sensory information. The behaviours themselves exist but the determination of whether, and in what circumstances, culture or point in time they are referred to as abusive is socially constructed. As expressed by Crotty (1998) it is both the behaviour as object, and people as subject, that contribute to the construction of meaning.

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The relevance of constructionism and of relativism to the project is that they recognise the influence of historical events, social forces and ideology (Hacking, 1999) to what can be known about the subject matter. What is described as child abuse does not have meaning outside the culture that construes it as such. The expansion in what is considered unacceptable child rearing practice, or standards to which it is applied, highlight the changes that have occurred in the way the concept is constructed. Dingwall's (1989, p.28) often quoted phrase about child abuse having undergone 'considerable diagnostic inflation' was in reference to the 'battered child syndrome' more than twenty five years after the work of Kempe and colleagues (1962). In the subsequent twenty years that 'inflation' has continued. Forced marriage, honour based violence, female genital mutilation, on-line sexual exploitation, gang membership and cyber bullying are just a few of the behaviours that latterly have come under the spotlight of child protection agencies. The categories of behaviours and responses serve to highlight the role of powerful institutions and dominant values within society, as well as other developments, which shape the definitions and perceptions of what is abusive. It equally assists in understanding why abuse of children by some professional groups in positions of trust has been a long time in its public recognition.

While the overall construction of the meaning of child abuse occurs at a societal level, the response of professionals varies at a local level. Perceptions of harm and the decisions of practitioners and managers construct the thresholds which determine the access to services locally within a broad framework of national guidance (Jones and Gupta, 1998; Pugh, 2007; Horwath, 2007). Judgements about harm to children by their parents and carers, and decisions about inaction or intervention, and the appropriate level of response, have proved difficult to reach inter professional consensus about (Birchall and Hallet, 1995; Dartington Research Unit, 1995; Jones and Gupta, 1998; Brandon, Thoburn, Lewis and Wray, 1999; Brandon, Belderson, Warren, Gardner, Howe and Dodsworth 2008). This continues despite the integration of services, the development of common core skills (DfES, 2005d, CWDC, 2010), increasingly detailed procedures (HM Gov, 2010), and shared assessments tools (DoH et al, 2000; DfES, 2006). These mechanisms and tools have aided information sharing and contributed to a common language to discuss the needs of children. The

judgements of professionals about the appropriateness of parenting styles and standards, and parental strengths and deficits however depend on interpretative use of knowledge and practice wisdom, which varies between individuals and agencies.

In relation to alleged abuse by people employed to educate, care for or support children there are additional complexities. The socially constructed expectations of the roles they fulfil facilitate relationships of trust with children, their parents, and colleagues. These do not occur in a vacuum but are located within society's expectations about the conduct of professionals working with children, and the institutions established to define and regulate that conduct. This draws attention to the role of assumptions, beliefs and values, as well as the cultural context, the law, and a body of professional knowledge and government guidance, within the construction of the professional roles.

Organisational variations in the codes of conduct relevant to different roles increase the potential for inter agency tensions as actions within professional practice come under scrutiny. Judgements about what constitutes poor or inappropriate professional conduct towards children change over time and between situations. The use of physical punishment for example ceased to be allowed within government funded schools in 1987 (HM Gov 1986), but was not banned in private schools until 1999 in England and Wales (HM Gov, 1998a), 2000 in Scotland, and not until 2003 in Northern Ireland. There remain advocates for the return of corporal punishment within education settings, and parents who would approve of its use in child care situations where it is prohibited. Physical intervention and restraint is used by professionals fulfilling a variety of roles. While there are policies and guidance to aid professional practice, its use in a particular situation is a matter of interpretation by those directly involved. The judgement of appropriateness is dependent on an understanding of intent and potential risk of harm. These are subjective interpretations in situations of heightened emotion which are fraught with complexity.

A reported allegation will have arisen as a consequence of the coming together of a unique set of events relating to at least two people in a given place, at a given time. The social actors involved in the incident, child and professional,

and potentially a peer or colleague witness to the event, will provide an account of their understanding and interpretation. There can be no one single truth of the incident just the reconstructions from two or more individual's cognitive operations. The individual required to respond will rarely have witnessed the event and will potentially receive inconsistent or contradictory accounts from which to negotiate an understanding. The tools and materials with which the managers have to work are the reconstructed accounts of the social actors involved, a process framework, and their own subjective knowledge and history. Through dialogue, the interpretation of the actions and interactions of the actors to the incident are open to re-interpretation and negotiation.

The first phase of the study captured the subjective accounts provided by participants of their experience of receiving and responding to an allegation against a member of staff. In these circumstances the knowledge claim for the study is not that of a generalisable truth of how managers make decisions when allegations are made against their staff. It is rather that it reveals the local and specific occurrence of nine incidents reported to the participants. The data were the collaboratively constructed accounts of their interpretations and attributed meanings as described and understood within the interview dialogue. The engagement of a different cohort of managers may have constructed meaning about the reported behaviours in a different way. The two stage method of data gathering drew on this assumption to further develop the study. The second phase data consisted of eliciting responses to the original incidents when presented as vignettes to a different group of managers distanced from the emotional context and service outcomes in which the incidents took place. From the descriptions of their understandings of the incidents, processes followed and knowledge used was constructed an account of how practice was performed locally and specifically to achieve an end result.

The approach to the study is qualitative, based on the philosophical standpoint adopted to understand child abuse and the nature of the research problem. Eliciting an account of the decision making of managers focuses upon processes and the phenomena and the meanings derived. It is insight made possible by the actors themselves describing and defining their experience. Recognising the presence of multiple and diverse perspectives of the individual

incidents and the culturally and historically situated interpretations of child abuse highlights the relevance of the relativist standpoint adopted by the study and of interpretivism as the theoretical perspective of choice.

4.2.2 Aspects Drawn from Phenomenology

Self awareness of the impact of my subjectivity on the conduct and findings of the study necessitated a conscious strategy and conceptual framework to enable me to think critically about my involvement in the process. As the instrument of data gathering, the sole interpreter identifying themes, and the report writer, my role was intrinsic to the whole process and findings. Prior knowledge and membership of a shared professional network with some of the participants involved the danger of making assumptions and filling in gaps. The notion of 'bracketing' my prior knowledge and presuppositions to ask the most basic of questions prompted a 'theoretical borrowing' (Winter, 1989) from phenomenology.

Phenomenology as a philosophical discipline is associated with the writings of Husserl, Heidegger, Gadamer, Sarte, Arendt, Levinas, Derrida and Merleau-Ponty amongst others (Moran, 2000). While much of the phenomenological literature is not concerned with research methods the writings are used to 'fortify' qualitative research. For this study key concepts were drawn from the 'social phenomenology' of Schutz (1962) with its focus on action, interaction and interpretation of the social world. The concepts of intersubjectivity, relevances, bracketing and the notion of the 'disinterested observer' provided by Schutz were used to refine the study. The project is not phenomenological research but in keeping with phenomenological analysis the study does seek to make available experiential first person accounts of the meaning of the phenomena of managing an allegation against a member of staff from the lived experience of the manager.

Conscious experience is the starting point of phenomenology and refers to experiences that an individual has lived through or performed. The central structure of an experience is that it is directed toward something, that it has intentionality. The first stage of the data gathering captured the experiential, first person accounts of the experience of living through, thinking about, making

decisions and performing actions by participants who had received an allegation against a member of staff. The data consisted of the descriptive accounts provided by participants of their experience and the understanding they brought to the process, not the phenomenon itself.

Schutz (1962) identifies that within the social sciences the 'objects' of research that the researcher is wishing to interpret are themselves involved in the process of interpreting the social world. Experience of the world is intersubjective in that people are engaged in an on-going process of making sense of the world in interaction with others. The activity of research is therefore one in which researchers are seeking to make sense of this sense-making. This view embedded in Schutz's writing provided increased awareness of my position as an individual trying to make sense of the sense making of the managers. The role of 'researcher' did not give me privileged access to knowledge or understanding. The methods of interpretation available to me were the same as those used by the participants and others in their daily lives; the same as had been used by the participants in making sense of the accounts of the incidents. Individuals have a "stock of actual knowledge at hand" (Schutz, 1962, p.7) from which they can make sense of things they experience. They do this according to a system of 'relevances' which enable them to select from the environment and from interactions with others those elements that make sense for the purpose at hand.

Schutz (1962) identified the gap between the system of 'relevances' used by an ordinary person acting in the world, and a social scientist who utilises a set of 'relevances' selected as appropriate for the objectives of research. In doing so Schutz explains that a social scientist may focus on aspects of behaviour that are taken-for-granted by the ordinary person, but which for them are topics of cognitive interest. The social scientist is said to assume the position of the "disinterested observer" (Schutz, 1962: p.36). This refers to a lack of involvement in the situation being studied and the life of the individuals involved. It also reflects a lack of interest in their activities beyond the cognitive interest in the behaviour being researched. The notion of a "disinterested observer" provided awareness within the interview context that my interest in the participants was confined to one aspect of their experience not all that they

chose to present. The process of selection and reduction of the descriptions for the project report involved the ethical dilemma that aspects of the interview conversations were omitted.

A phenomenological approach to research requires that researchers seek to discover the world as it is experienced by those involved in it and the meaning they attach to their experiences. Only in putting aside usual or prevailing understandings is it thought that researchers can "see the world afresh" (Crotty, 1998: p.86). In trying to arrive at this kind of understanding Schutz (1962 p.104) refers to Husserl "borrowing terms from mathematical technique" in calling the procedure "putting the world in brackets" or "performing the phenomenological reduction". It expresses the process by which a researcher suspends belief in what they think they know about the phenomena. By bracketing preconceptions and focussing on the conscious experience as described by the participants it is argued that the researcher becomes open to understanding the phenomenon as a lived experience (Speziale & Carpenter, 2007).

The challenge of putting aside all that I thought I knew to hear and understand the participants' experience of their situation and decision-making required a conscious strategy. Within the literature there were few guidelines on how to achieve 'bracketing'. The concept seemed to suggest that there would be a need, if it were possible, to divorce the practitioner from the researcher. In the absence of a defined strategy for achieving this it was the adoption of the techniques of reflectivity and reflexivity from professional practice that provided the basis of my 'bracketing'. Drawing on the definitions provided by Fook (2002, p.43) reflectivity refers to a "*process* of reflecting upon practice" while reflexivity refers to "a *stance* of being able to locate oneself in the picture". This involves being able to appreciate the influence of one's own self on the knowledge and actions that result, including in the research context. Of significance is awareness of speech and language, as well as knowledge that prompts will impact on thinking and what is recalled, contributing to the story told. Active listening and seeking to provide neutral verbal and controlled non verbal prompts were techniques employed during interviews. Listening to the recordings provided a mechanism to monitor and self critique the interview dialogue. It also acted as a prompt for reflection on the interview experience

and resulted in reduced verbal prompts during the later interviews. The use of reflective notes supported continuous appraisal of my influence during the subsequent categorisation and interpretation of the data. Use of the participants' own words within the report maintained the centrality of their experience to what was presented. Although starting from the phenomenological notion of 'bracketing', the strategies employed to remain alert to the influence of my presuppositions were those of a reflective practitioner. Schon (1983 p. 68) wrote about the 'reflective practitioner', who becomes "a researcher in the practice context" by reflecting-in-action. The process he described was one of thinking about what one is doing while in the process, and evolving or adapting the way of doing it. The self awareness required to reflect-in-action to hold biases in check fitted well with the need to be conscious of the way that my background, personality, presentation and perspective influenced the interview situation and the potential for my experience to influence what I prioritised within the analysis and report writing.

4.3   Field Work

Two Local Safeguarding Children Boards were approached to participate in the study. This was a requirement of the study design which included a two stage approach to data gathering. The first stage involved managers describing concrete allegations they had dealt with against a member of their staff. The second stage utilised vignettes to explore decision making with managers when they had no direct involvement or organisational responsibilities and no direct knowledge of the actors in the situation. The details of the real cases in stage one were used to construct the vignettes for use in the second stage. The vignettes were presented to managers in the alternate area to which they had originally arisen. This minimised the potential for a manager when presented with a vignette to already be aware of the case thereby enabling these allegations to be explored 'cold'.

The criterion for selection of the two areas was that they had in place established procedures and processes for the management of allegations and were willing to host the study. Beyond that the selection was made based on practical considerations of accessibility and ethical considerations that there would be no

conflict of interest with my work role as adviser for this aspect of safeguarding practice. The Local Authority areas have been given pseudonyms of Southborough and Northvale to protect the anonymity of the participants in the study and confidentiality of the cases.

4.3.1 Describing the Two Areas

<u>Southborough</u>

At the time of the study Southborough was a large metropolitan district area with a population of approximately 530,000 (ONS, 2009). There were over 109,000 children and young people between the ages of 0 and 17 (ONS, 2009). Over 9% of the population was of black and ethnic minority origin, the largest group being of Pakistani heritage. The area had a large manufacturing sector and also a significant service industry sector. It was a focal point for leisure, retail and culture. There were high concentrations of localised deprivation.

Within Southborough education was delivered to children under the age of sixteen by one hundred and forty primary schools, twenty seven secondary schools, three of which were Academies, six Special Schools and three school inclusion centres. Thirty six children's centres deliver integrated provision for children and families. The Early Years Profile records eight hundred and sixty nine providers offering over thirteen thousand child care places (Ofsted, August 2008).

A NHS Trust Children's Hospital provided for children from within Southborough and was a specialist tertiary centre providing for children beyond the local authority boundary. There was also a NHS Trust General Hospital and Maternity Hospital which served the district. Services for children and young people who were at risk of or involved in offending was provided by a multi disciplinary Youth Offending Team.

<u>Northvale</u>

At the time of the study Northvale consisted of an urban city area and a number of small rural villages. The total population within the local authority boundary was estimated at over 190,000 with just under 36,000 aged between 0 and 17

(ONS, 2009). The black and minority ethnic groups constituted approximately 6% of the population, the largest groups of which were people of Turkish, Kurdish, Eastern European and traveller/Gypsy origin. The urban area was relatively affluent although there were pockets of deprivation. Northvale's economy was based on the service industry, including public sector, health, education, finance, information technology and tourism being significant employers.

Children's care services were provided through approximately ninety full-time foster carers, incorporating mainstream and professional schemes (Ofsted, 2008). There was one residential home and one respite residential children's home providing short breaks for children with learning difficulties or disabilities. There were eight family centres providing integrated children's services and seven field social work teams.

Pre-16 education comprised of fifty four primary schools, ten secondary schools, five independent schools, two special schools, two pupil referral units and one 14 -16 Skills Centre. In addition Early Years provision comprised of 239 registered childminders, 41 day nurseries and 44 play groups.

There was a NHS Hospital Trust providing a full range of services, and Child and Adolescent Mental Health Services provision which included in-patient tier 4 and outreach provision. Services to children and young people who were at risk of offending or had offended were provided through a Youth Offending Team.

4.3.2 Negotiating Access

An initial approach to the local authority designated officers for Southborough and Northvale indicated an interest in the proposed study. Following the initial contact the process of negotiating access to participants within the Local Safeguarding Children Board agencies was different for the two areas. Northvale was the first area in which interviews were facilitated. The Research Ethics Comittee and Research Governance arrangements for this area are administered within a single Research and Develoment Unit which served to streamline the approval process. A report was presented to the Local

Safeguarding Children Board on the 17th of October 2007 (Appendix A) and engagement in the study endorsed by partner agencies.

In Northvale the Manager of the Local Safeguarding Children Board also fulfils the role of the local authority designated officer (LADO). This provided a single point of contact and access to participants. The local authority designated officer on receiving an allegation from a manager forwarded the Participant Information Sheet (Appendix B) and Research Consent Form (Appendix C) electronically. The details of managers who expressed a willingness to participate in the study were then forwarded for inclusion in the sample. The first participant was recruited in March 2008.

The Research Governance arrangements for health and social care institutions within Southborough necessitated three separate submissions which delayed the commencement of recruiting participants. The role of the LADO is in name identified as an individual but the function is carried out by a team of child protection advisers within the Safeguarding Unit. A meeting with the Senior Manager, Service Manager, Business Manager and Local Authority Designated Officer took place on the 29th of April, 2008. This was followed by a briefing about the research provided to the child protection advisers on the 21st of May, 2008 to estabish the practicalities of engaging participants. The Senior Manager provided verbal information to the Operational Executive of the Local Safeguarding Children Board and secured endorsement for the study conditional on sight of the ethical approval. A letter was produced by the local authority designated officer to accompany the Participant Information Sheet and Consent Form to be sent to potential participants. An administrator within the team maintained a record of the managers to whom research information had been provided and collected consent responses. Details of managers who consented to participate were forwarded for inclusion in the sample. The first participant from Southborough was recruited in June 2008.

4.3.3 Purposive sample

Denzin and Lincoln (2000) identify that many qualitative researchers utilise purposive sampling methods. The benefit over random sampling is that it

enables the researcher to identify individuals or groups within specific settings where the processes that are being studied are likely to occur. This study focussed on infrequently occurring situations. The nature of the data being sought for the first phase of data gathering required a purposive sample to select only managers who had experienced this situation within the study period. It excluded allegations that came to attention indirectly. The second criterion for participation was that the individual consented to participate in the study and in this way the sample was made up of self selected participants who were willing and confident to discuss an aspect of their professional practice.

At the outset it was anticipated that inclusion would be selective with participants drawn from the broad spectrum of children's service agencies and providers. This was to incorporate a variety of service providers, types of alleged abuse and decision options with selection based on what more each case could add to the developing understanding. The slow pace of engaging participants necessitated a pragmatic decision to reduce the sample size for the first phase of data gathering from twenty to nine. The recruiting process had possibly been made more difficult because participants were being asked to commit to two rounds of interviews. In addition was the sensitive nature of the topic which was highlighted when a potential participant expressed that identification with the study would be detrimental to his organisation. The inclusion in the second data gathering phase of a broader range of participants who had not all had recent direct experience of managing an allegation ameliorated some of the negative aspects of being associated with the study.

The nine participants for the first phase of the study were the first nine managers who had dealt with an allegation against a member of staff during the research period and who consented to be interviewed; five from Northvale and four from Southborough. The nine participants were recruited between March 2008 and February 2009. The organisations engaged in this phase of the data gathering were school services, fostering service, a community nursery, private sector nursery, voluntary organisation, and contracted transport service.

A decision was made to move on to the second stage of data gathering in February 2009 and recruit additional participants from organisations not

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represented in the first phase. The inclusion of a broader range of organisations was not in pursuit of 'generalisability' as this was rejected at the level of epistemology. The inclusion of additional agencies in the second phase was to enable the study to be useful within the multi agency context of Local Safeguarding Children Boards. It facilitated the presentation of a range of experiences from which managers in agencies can consider how these relate to their situation. It also facilitated the objective of the study to explore the criteria and thresholds for allegations applied across different statutory and voluntary organisations.

The additional participants were identified by the local authority designated officers. Direct contact was made and the research information provided. All the participants approached to join the study for the second phase agreed to do so increasing the number included in the sample by nine. No proportionate comparison was involved therefore there was no necessity for an equal number of participants from each area. The number of participants in the second stage of the data gathering was eighteen; ten from Southborough and eight from Northvale. Two of the interviews in Southborough involved two participants when colleagues from the team self selected to join the interviews. The full sample for the study included managers from Health organisations, PCT and NHS Hospital Trust, Police Service, the voluntary sector, private sector, Early Years providers, primary and secondary schools, children centres, church based services, fostering, and local authority children's services.

		Schools	LA Children's Services *	Health	Police	Early Years**	Vol Sector	Private Sector	Church Orgs
Northvale	Male	1			1			1	
	Female	2	1	1		1			
Southborough	Male			1	2				
	Female		2			2	2		1

* LA Children's Social Care includes fostering

** Early Years includes LA, private and community enterprise provision

4.3.4 Options for Data Gathering

In selecting the methods of data collection options consistent with a qualitative design were considered. Observation was ruled out for both phases of data gathering due to the limitations of what could be observed and the nature of the data being sought.

Focus groups were rejected for the first phase based on the confidential nature of information about allegations of abuse, some of which were the subject of ongoing investigation and disciplinary process. For the second phase focus groups would have been possible but difficult to manage to ensure an equal hearing of the different agency responses. For the second phase the use of questionnaires containing vignettes was also considered as it offered an established data gathering strategy in child protection studies (Johnson, 1993; Robson, 1995; Birchall and Hallett, 1995; Horwath, 2007). The economy of time and potential to capture a larger number of respondents and a wider range of professional occupations would have been their benefit. Questionnaires however prompt standardised answers without the potential to ask follow up questions to better understanding the thinking processes of individuals. They are also not well suited to seeking understanding of attitudes, perceptions and values (Gould, 1996).

Telephone interviews were rejected in favour of direct semi structured interviews taking account of the emotional aspects inherent in the subject matter and the need for reflexive opportunities for the participants, even if only briefly. The silence of reflective time is more problematic in distance communication unless the participants to the conversation have an established relationship which was not the case in this study.

4.3.5 Two Stage Interview Process

A two stage research design was developed to maximise the data available from the allegations referred into the study. Eliciting information about how people make decisions is problematic. Accessing attitudes, values and beliefs is particularly difficult and the presentation of socially desirable responses a possibility (Mishler, 1986). The two stage process was designed to go some

way to addressing the limitations of experiential accounts of responding to alleged behaviours.

The stage one interviews elicited accounts of the process and activity that participants' described undertaking when initially responding to an allegation of abuse made against a member of their staff. The behaviours were therefore considered to have met the criteria for an allegation or the participant was seeking advice as to whether it was met. The interviews explored the factors taken into account, the underpinning knowledge, decision strategies and any organisational influences identified in the decision making.

An interview protocol (Appendix D) containing six areas was provided and discussed with participants at the beginning of the interviews. While not prescriptive in that the areas were not discussed in order, it did at the outset detail the key areas of the study. These six areas can be summaries as focussing on:

(i) The content and context of the allegation

(ii) An account of the process that they followed in determining what action to take, including people they consulted, guidance they took into account and prior knowledge or training that they drew upon.

(iii) The issues that they identified as important in relation to their role in managing allegations and their organisations expectations.

Reinforcement provided at the beginning of the interview that my role was that of a student confirmed that my interest was academic and curious. My approach beyond that was facilitative not challenging or interrogatory; seeking a descriptive account of what had happened, the key players, and the sequence by which information was brought to their attention and how they responded. Open-ended questions were framed as 'what' and 'how' rather than 'why', and there was no attempt to evaluate the decisions made or actions taken or input corrective comments. For the most part once given a cue to tell their story the participants described it with minimal prompts. Occasional use of brief summaries facilitated confirmation that I had understood the sequence of events, the players in the situations and the decision points. They also provided a useful tool to prompt additional explanation to increase the level of detail.

It was intended that the interviews would be on an individual basis however during one of the interviews the manager invited another person who had been involved in the allegation process to contribute. Within the second phase of data gathering this occurred on two occasions with participants including a colleague in the interview. These second phase interviews with two participants provided an additional dynamic as the participants interacted and exchanged different views and understandings not always agreeing and at other times consulting together. It served to highlight the non standard responses obtained by interviews which were an accepted and expected feature of the qualitative project design. The different contributions of each interviewee to the conversation were identified within the transcripts by use of different fonts and are given equal weight within the report.

The second stage of data gathering utilised vignettes. Vignettes have been used in research in conjunction with other forms of data collection to obtain more information from participants than would be gathered from a single strategy. This second stage was included to elicit accounts of judgements about professional behaviours when de-contextualised to better understand the organisational influences, and personal and emotional responses on the decision making of managers.

4.3.6 Use of Vignettes

Vignettes used as a data gathering strategy in research provide concrete examples of situations, people and their behaviours on which participants can offer comment or opinion (Hazel, 1995). They have the potential to elicit perceptions, beliefs and attitudes from responses to stories (Hughes (1998) that approximate to the complexities of reality while distancing the issue from personal experience (Finch (1987). As such they are akin to case studies used within child protection training which explore how different disciplines understand and respond to an issue and apply theoretical and research knowledge to a case (Horwath and Morrison, 1999). It was anticipated that members of the multi agency network from which the participants were drawn would be familiar with case scenarios used within training situations. It was this

familiarity to practitioners that made vignettes appropriate to a study which holds a practitioner perspective at its core.

Research literature on vignette techniques identifies their application in a broad range of social science studies over many decades from anthropological studies (Herskovits, 1950, cited in Hughes and Huby, 2002) and psychology research (Anderson and Anderson, 1951) in the 1950s. They have been utilised in quantitative studies (Finch, 1987), in qualitative studies (Hill, 1997; Hughes, 1998), and as part of multi method approaches (Wade, 1999; Barter and Renold, 1999; MacAuley, 1996). They have been applied with individuals and also with focus groups (Wilkinson, 1998; Sim, Milner, Love and Lishman, 1998). The stimulus material has been presented in a number of formats which have included video recordings (Cohen and Staryer, 1996; Leierer, Strohner, Leclere, Cornwall and Whitten, 1996; McKinstry, 2000), and on computers (Stolte, 1994; Vitoritch and Tyrell, 1995). The most frequently used format is written words but again these have been diverse, from one or two lines (Birchall and Hallett, 1995) to detailed case descriptions unfolding over time (Clark and Samphier, 1984).

In relation to the subject matter of this study there are many examples of the use of vignettes to explore decision-making. In nursing research Denk, Benson, Fletcher, and Reigel (1997) explored end-of-life medical decision-making using vignettes, while Ross et al (1999) researched practitioners' clinical decision-making about the detection and management of depression. Vignette techniques have equally been used in exploring decision-making in child protection. These have explored the severity rating of abuse scenarios (Birchall and Hallet, 1995), judgement of potentially abusive behaviours by social work students (Christopherson, 1998), decision making at the point of referral (Spratt, 2000) and knowledge processes and reflexivity of practitioners (Sheppard, Newstead, Caccavo, and Ryan, 2000).

The vignettes uses in the second stage of data gathering were constructed from the information of the real allegations gathered in the first phase of data gathering. Eight of the nine cases were used. The case not included was one where the participant had been prepared to share only minimal information due to its very recent nature and had talked instead about prior experience. A

strategy meeting had taken place the previous day and there remained outstanding issues. For the other eight cases the description of the allegation provided by the participants in their own words was used to construct the vignettes, to minimise as far as possible the effect of myself as researcher.

The settings of the allegations within the vignettes were ambiguous with only minimal contextual information. This was to enable participants to apply the reported behaviours to their own organisational context and apply their own subjective constructions and meanings. The vignettes were presented to participants in discreet segments to aid the process of describing the influences on decision making at each stage. A concurrent account (Ericsson and Simon, 1980) was obtained from the participants as they read the vignettes and 'thought out loud' about the factors they would take into account, the knowledge they would use, and any other action they would take as they moved towards a judgement and decision.

In order to minimise order effects the vignettes were presented in a random order to participants with seven of the eight being presented first at least once. A minimum of three and maximum of four were discussed at each interview and the vignettes were each considered by a minimum of five and a maximum of ten participants.

The indeterminate relationship between beliefs, expressed intentions and actions was considered within the design of the study. There are divergent findings from earlier studies (Rahman,1996; Carlson's, 1996) as to whether the responses to vignettes represent how people would act in real situations. The potential gap between expressed intentions to vignettes and action in real situations was recognised in selecting the method. In view of the nature of the study this gap did not undermine the data. The combination of the participant's 'real' decision making and 'decontextualised' decision making enabled the different knowledge and influences to be drawn out and reflected in the studies descriptive account.

4.3.7 Transcribing the Interviews

As the transcription of interviews was undertaken I came to understand that what was produced was the result of a series of choices rather than a

transparent account of an interview (Kvale, 1996; Jaffe, 2007). The translation (Slembrouck, 2007; ten Have, 2007) or transformation (Duranti, 2007) of sound recordings to text for each of the interviews involved selection of the features of the talk and interaction that were transcribed, and those that were not. Bucholtz (2000) proposed a continuum from two extremes of naturalized and denaturalized in the range of transcription practices. Naturalized or 'literacized' (Bucholtz, 2000) transcription is that which has many features of written language, with punctuation and paragraphs that do not occur in speech. Denaturalized transcription preserves the idiosyncratic features of oral language such as stutters, pauses, repetition, "ums" and "ers". The two transcription practices have been suggested as suited to specific methodologies with denaturalized transcripts being suited to methodologies such as grounded theory and critical discourse analysis (Oliver et al, 2005).

Although not adopting such methodologies the first two transcriptions were denaturalised including non word sounds, half spoken words, repetitions, unexpected external sounds, and spaces of varying length to represent silences. They began from the introduction and continued to the farewell. Subsequent transcriptions did not include the preliminary talk as these added nothing to the research questions and instead began from the first interview question. Non words were also replaced by spaces after the first two interviews. The transcripts continued to include repetitions, spaces to represent the silences of thinking time, half expressed words and ideas and external sounds that distracted attention; movements, the emotional expression of laughing, and participant's emphasis of specific words or phrases. Half completed ungrammatical sentences were also included when participants changed the emphasis or direction of where they were going in their story. Dots replaced the non words to reflect the thinking time that these 'err' and 'um' sounds provided within speech while making the copy easier for participants to read. Punctuation was added when a break in speech was apparent but continuous speech was not paragraphed. While some authenticity was lost by the editing introduced, the meanings were not lost within this process.

The transcripts of the interviews were more detailed than the analysis for the study required. A key consideration of the almost verbatim transcribed accounts

of the words spoken was the participants own recognition of their contributions. The transcripts were sent to the participants as a record of the interview. Many of the participants involved in the first round of interviews spoke about the transcriptions they had received when we met on the second occasion. One of the participants described how she could 'hear herself' in reading the transcript while another referred to being able to 'hear her accent' within the transcript. These reflections provided confirmation of the choices made of the level of transcription within the methodology and goals of the study. The participant's recognition of their own accounts represented in a way that they could 'hear themselves' indicted the trustworthiness of the text as the basis for analysis for a study that seeks to speak to practitioners.

4.3.8 Analysis of the Data

The initial process of analysis began and proceeded in tandem with the transcription when an initial sense and feel of the interviews as whole constructs was obtained. The analysis was not carried out at the level of single words or phases but at a broader level to reveal the meanings contained within sections of dialogue. This was aided by remaining in contact with the audio recordings of the interview conversations throughout the period of analysis. The completed transcripts although recognised as being a step removed from the raw data provided an accessible medium to move backwards and forwards through the data as ideas emerged and for reflection away from the computer.

The objectives of the study developed with practitioners provided the starting point for the analysis. These fell into five component parts:

- Insight into the types of allegations being referred into the formal arrangements for managing allegations
- The influencing knowledge and factors which underpin the judgements made by managers in responding to allegations.
- Insight into how allegations were viewed and understood within their own and partner agencies.
- The criteria, thresholds, processes and knowledge applied by different statutory and voluntary organisations when concerns were raised.
- The wider social and organisational responsibilities and tensions for managers when faced with an allegation against a member of staff.

The first objective was met by inclusion of accurate descriptions of real cases provided by participants but at a level that did not jeopardise the anonymity of the cases or individuals concerned. The data from the nine descriptions of responding to the real cases was aligned to the second and final objectives, and the stage two data involving vignettes was used in relation to the last three components.

A qualitative data analysis software programme QSR NVivo 8 supported the process of analysis. It provided an 'organised storage "file" system' (Creswell, 1998, p.155), which assisted in locating and organising material. It allowed for easy movement of dialogue segments to consider in different categories. The coding as it developed was stored within the programme along with imported copies of the original transcribed interviews. The initial process of 'enriching the record' (Richards, 2009, p. 75) by considering each interview in turn and recording initial ideas and reflections did not involve the use of the NVivo 8 software programme. This process was commenced during transcription and in the first reading of the completed documents. Handwritten notes of thoughts, reflections and threads connecting interview records were added to printouts of the transcribed interviews.

Richards (2009, p.77) provides suggestions which she describes as "taking off from the data" of noting interesting passages within the text and reflecting on why it is interesting; making comparisons with other situations and considering why it was of personal interest. This provided a strategy to begin to think about the data, to identify questions, to make connections, and note similarities and differences across cases. Having read and noted issues and ideas within cases there was a need to move to look across cases to identify themes and issues beyond the individual accounts. Facilitating this required a coding framework in which all information from the cases on particular topics could be collated, read and reflected on. Richards (2009, p.96) distinguishes between three types of coding which she terms as "descriptive, topic and analytical coding". These three types were used as the basis for the coding of the data into categories.

Descriptive coding was commenced first and was at case level producing the summary of each case, participant organisations, types of abuse, and a

summary of case attributes. The topic coding that followed involved aggregating data segments across all stage one interview records based on the interview schedule. These consisted of the context of the allegation, the content, the participant's perspective on what action to take; participants' view of knowledge used; people consulted; what they did; and previous experience and training (see Appendix E). To these were added some 'provisional codes' (Strauss and Corbin, 1990, p.45) from research literature and studies of decision making which although context specific to their studies of origin provided useful ideas to considered against the study data. Bogdan and Biklen's (1992) suggestion of 'process codes', 'activity codes', and 'strategy codes' fitted well with the managers' descriptions of their thinking and actions in responding to an allegation and helped to refine the categories that originated from the interview schedule. From the stages of decision making suggested by Carnevali, Mitchell, Woods, and Tanner (1984) 'exposure to pre-encounter data' was adapted to produce a code of pre-allegation data which captured the historical information that participants during stage one described as being incorporated into their decision making. From Hart (2000) was drawn the category of 'noting the impact of feeling' (see Appendix F). As the data was coded according to the categories the process of grouping information provided new insights resulting in additional categories being added. The influence of the parents, the role of the alleged abusive worker, and the participants' perspective on young people who make allegations, were key ones.

The data gathered in the second phase of interviews was initially divided according to the vignettes to provide a comparative account of the managers from different agencies responses to the same case information (see Appendix G and H). It was divided into the segments of information as the cases were presented resulting in twenty five categories across eight vignettes to which information was coded. The framework of categories for the first stage of analysis was then applied to the coded segments from the vignettes as applicable. For example the category of exposure to pre-allegation information was relevant to five of the eight cases but not the remaining three, and the participants' views were contained at one segment of the vignette when pre-allegation data was presented. Some of the categories cut across all vignettes

and at all stages such as the participants' views on what informed their decision making.

Following on from the process of placing conceptually similar passages of dialogue together under accessible topic headings was the identifying of recurring patterns and processes described by managers. These provided the concepts and themes around which the findings were organised and presented. In setting out to provide a descriptive and exploratory study of decision making when allegations are made against adults working with children the analytic coding was confined to reflecting on the information coded under the topics. The descriptive codes met the objective of making available information about the types of allegations referred into the formal process. The themes that were developed from the topics provided the descriptive account of the influencing factors in the managers' decision making, and the similarities and differences within responses to vignettes provided the material for reflection and discussion about thresholds.

The study's explorative nature supported a 'descriptive' account with the data organised into themes with interpretation limited to offering some insight and understanding, and no attempt to provide a conceptual scheme (Strauss and Corbin, 1990). The inclusion of significant sections of narrative where the "informants speak for themselves" (Strauss and Corbin, 1990, p.21) recognised the expertise of the participants in describing their experiences and knowledge. The report of the findings makes available to other managers "a pragmatic body of knowledge from practice" (Polkinghorne, 1992: p.151) from which to consider their own decision making when responding to an allegation.

Within the conduct of the study issues of reliability, consistency and transparency have been considered. As a lone researcher I undertook all the data gathering, the data transcription, and the analysis ensuring that there was consistency and reliability of process (Aitken and Mardegan, 2000; Taylor and Dionne, 2000). The account of the key decisions taken from the conception of the study, through each stage of the field work, to the conduct of the analysis, provides an 'audit trail' (Lincoln and Guba, 1985) which contributes to the study's transparency.

4.4 Ethical Issues

Eisner (1991) captures the essence of ethical dilemmas in conducting research when highlighting that:

> *"We do not like to think of ourselves as using others as a means to our own professional ends, but if we embark upon a research study that we conceptualize, direct, and write, we virtually assure that we will use others for our purpose.*
> *(Eisner, 1991: 225–6)*

The recognition of this from the outset provided an uneasy reminder that while the intention was to contribute to the knowledge base for practitioners involved in managing allegations; this project was of my construction and for my advantage. Responding to the ethical issues became a process of designing a project that would safeguard the individuals involved whilst seeking to produce a study useful to other practitioners.

Ethical considerations were ever present in the design of the study, throughout the period when the fieldwork was being conducted, and finally in the analysis and writing up of the project report. The ethical requirements of conducting research provided for review of the proposal by the National Research Ethics Service, National Patient Safety Agency, NHS (NRES, April, 2007). In addition to which the professional and ethical codes for social work practice and research (GSCC, 2002; BASW, 2005), to which I subscribe provided guiding values rooted in respect for the person. The application of ethical behaviour throughout the conduct of the study was however less the result of the application of general principles and rules derived from the NRES requirements or the four research governance reviews that took place, or even adherence to a professional code of conduct. The application of ethical standards was intuitive, drawn from internalised moral values and personal integrity of professional practice applied to the research process. Transparency, honest communication and respect for the managerial responsibilities of the participants provided the foundations of my approach. Awareness of my self interest in the study and resultant biases and values assisted an honest presentation to the host areas for the study and in turn to the participants. My 'positionality' (Marshall and Rossman, 2006) as a regional adviser for safeguarding and a student undertaking research with a professional interest in the subject was made explicit. The areas in which the study was conducted were not ones in which I held a lead advisor role. While reinforcing the

separation of the roles it is recognised the regional adviser status of the work role had the potential to influence the responses of participants.

First in responding to the ethics within the research design, principles about confidentiality and informed consent posed distinctive demands in relation to the subject matter. Joan Sieber (1993) highlights the intertwining of ethics and politics in sensitive research. She identifies that the motives and perceptions of others who may have interest in the research may be at odds with that of the researcher and the facts. Abuse of children by people in positions of trust is a sensitive topic which attracts negative media reporting and considerable public interest. Unions, pressure groups and professional organisations have an interest in the decision making about allegations against staff. Maintaining confidentiality about reported alleged abuse was therefore prioritised.

The design of the first stage of data collection incorporated separation between myself and the potential participants to facilitate their ability to decline. Written information about the aims of the project, the two stage interview process, and a consent form was sent to potential participants by the local authority designated officers who acted as gatekeepers (Denscombe, 1998) to the research environment. The identities of the individuals who agreed to participate were made known only after their agreement had been secured or they had expressed agreement for direct contact to discuss the study. Two potential participants who pursued discussion subsequently decided against participation. For one this related to the perceived risk and unwanted consequences of being associated with a study about alleged abuse of children by professionals. In recruiting some additional participants for the second stage of data gathering direct contact was made with potential participants identified by the gatekeepers.

Differing perspectives and expectations of researchers and participants about the manner, timing and depth of information required and desired in obtaining consent have been the subject of debate (Birch, Miller, Mauthner, & Jessop, 2002; Graham, Grewal, & Lewis, 2006; Lee and Renzetti, 1993). In the context of this study the process of determining the information required to obtain informed consent was assisted by the participants themselves. All were established managers within children's services organisations. While recognising the potential

sense of vulnerability created by being asked to explain past decision making the participants were not service users, children or being recruited as members of a vulnerable or oppressed group. Power differentials between researcher and researched framed in terms of educational level, socioeconomic status, legal status, health status, ethnicity, age, sexual orientation, cognitive ability, language preference and/or membership of a stigmatized group were not relevant. The power differential that required sensitivity was instead rooted in the control of how their point of view would be presented and the maintenance of their reputation.

All the participants involved in the study were professionals involved in managing the delivery of children's services. They were themselves familiar with conducting interviews and were not passive within the interview encounter. They determined the time allowed and within one of the interviews the participant purposively and explicitly limited what was shared of information about an allegation. By arranging the interviews in their work settings it provided participants a legitimate and ready means of withdrawing from the interview at any point. Some, particularly in the second phase of data gathering, negotiated their engagement on an ongoing basis by determining how many vignettes they discussed in the time that they had available. This provided reassurance that they regarded their right to opt out as genuine and that they retained control over the interview encounter and information giving (Graham et al., 2006). All the managers who participated in the first phase agreed to and arranged second interviews. The interviews were digitally recorded with the permission and signed consent of participants. The recording was overt to ensure awareness of when their words were being recorded and to prevent the risk of involuntary disclosure. Information shared once the recorder was turned off was not included.

Within the process of the field work care was taken not to identify the young people and the people against whom the allegations had been made. Arbitrary names were selected for the individuals for ease of reference and to aid the readability of the vignettes. The focus of the study provided distance from the two individuals within the situations discussed who would be most vulnerable; the child and the worker against whom the allegation was made, neither of whom had given consent to their story being shared in this way.

The third area where attention to ethical issues was required was in the analysis and use of the material gathered as part of the qualitative inquiry. A commitment to confidentiality and the protection of participant identity was addressed in writing up the study. The full details of the cases have not been included as these reveal too much information about the professionals and children from which they could potentially be identified due to the individualised nature of the incidents. Within the data gathering, and the selection, reduction and organisation of the data into themes, strategies from reflective practice were employed to assist the process of 'bracketing' preconceptions.

In keeping with data protection principles (HMSO, 1998), only information consistent with the project plan was gathered. It was collected in a fair and lawful manner without deception and used only for the purpose of the study. The information was anonymised and its storage, retrieval and access during the period of the fieldwork and the analysis and report writing was restricted to maintain confidentiality. At the conclusion of the analysis the audio recordings of the interviews were destroyed. The anonymised typed transcripts which had been provided to the participants have been retained for reference.

CHAPTER 5: Discussion of the Allegations and Decision Making

5.1 Introduction

The study set out to meet two broad objectives. It sought to make available to managers in services for children descriptive accounts of real allegations made against staff which had been referred under the formal arrangements for the management of allegations (HM Gov, 2006a, 2010b). The second objective of the study was to explore the knowledge used to inform the decision making of managers when presented with a report of an incident of abusive or poor practice from a staff member. This included consideration of whether the seriousness of the incidents being referred varied across children's services agencies and organisations.

The first objective draws on the primary source material gathered in interviews with nine managers. The second involved the descriptive accounts from managers of their response to both real incidents, and accounts of judgement processes in response to vignettes, to explore the criteria being applied and processes in use in a broader range of agencies and organisations working with children.

This chapter discusses the findings from the descriptions by participants of responding to the nine cases in which allegations against staff members were received between March 2008 and February 2009. It locates the cases within the total number recorded during the year March 2008 to March 2009. The participants' descriptions of the criteria and knowledge applied, processes followed, and prior training and experience are discussed along with other influences specific to their agency and the local area.

5.2 Nine allegations of abuse made against people who work with children.

The nine allegations of abuse made against people who work with children are a small cohort of cases drawn from those referred between March 2008 and February 2009. The two areas Northvale and Southborough received 59 and 90

allegations respectively during the twelve months from the end of March 2008 to March 2009. In both areas the largest number of recorded allegations involved education based staff, with those against foster carers forming the only other substantial group. In the Southborough area more than two thirds concerned allegations of a physical nature while in Northvale there were almost equal numbers of physical and sexual abuse allegations. Those of a sexual nature were the largest category overall.

5.2.1 The Nine Cases

The descriptions below provide a basic outline of the situations in which the allegations arose. The names for the children and young people and workers are fictitious to aid the process of confidentiality. In cases where information that pre-dated the allegation was described by the managers as an influencing factor in the decision making this is also included. Case C was not used as a vignette in the second phase. The summary descriptions provided below are the only details that will be made available in any version of the study used for publication.

Case A

Anne was in the care of the Local Authority and placed with a single, white, female foster carer. Anne was 17 years old and white British. The information reported by Anne was that she was in the kitchen on her mobile phone and the foster carer had become really cross with her and reached around her and pulled her roughly away from the kitchen countertops.

The foster carer reported that Anne was on the phone, stood with her back to the gas hob which was alight. Anne had long hair and the foster carer physically moved her away from the hob.

Additional information was that Anne had previously made an allegation against another carer and was described as 'having a history of making allegations'. The manager and social work staff had during the previous two weeks discussed how they would respond to an allegation which they anticipated

because Anne was not getting the service she wanted in moving to independence.

Case B

Paul was a pupil at secondary school on a school trip. He was 15 years old and white British. Paul alleged that he was kicked by the teacher who was female and white British. The allegation arose when in a classroom situation Paul had his legs stretched out across the gap between desks. In moving up and down the row the teacher was forced to step over Paul's feet. The teacher asked Paul to move his feet and when he did not do so she kicked the side of his foot telling him to move.

Additional information was that there had been an incident the previous day when Paul had been in trouble which the teacher had dealt with. In the aftermath of the incident in the classroom Paul had sought support from peers to complain about the teacher's conduct.

Case C

A member of the community overheard the caretaker from the local primary school talking to two young people aged 8 years. The comments included inappropriate sexual references to paedophiles. The caretaker had also made threats to neighbours and been noticed to be under the influence of excessive alcohol in the community. The behaviours had not occurred in the school setting. The head teacher was made aware of the events in relation to the caretaker by a member of the local community.

Case D

Kevin was thirteen years old and of mixed heritage, in the care of the Local Authority and placed with foster carers. The allegation was that Kevin had been hit by the male foster carer who was age 60 years. The allegation was reported to the out-of-hours family placement support service by the female carer who did not think the allegation was true but was seeking the young person's removal from the placement. The incident began when the foster carer was on the telephone and Kevin wanted attention and tried to disrupt the call. It had followed an unsettled period of challenging behaviour by Kevin and family

stresses for the carers. Initially the incident was approached by the family placement service and manager as a placement breakdown until it was confirmed by the foster carer that he had hit Kevin across the head. The incident escalated further following the hit across the head and culminated in the carer using physical force to disarm the boy of a kitchen knife.

Kevin had a statement of special educational needs which identified emotional and behavioural difficulties. He attended school on a part-time basis.

Case E

John was 11 years old and white British. He had autism, Tourette's and Attention Deficit Hyperactive Disorder. John was left in a car by a support worker while the worker made a personal visit. John sought help from a passer-by when the worker, a white British male, did not return and was out of view. The support worker informed the child's mother about the incident when returning John home and informed his manager the following day.

Case F

Julie received taxi transport to and from special school. She was 14 years old and white British and had learning difficulties. The allegation against the taxi driver was that he transported Julie alone in the front of the car having dropped off the escort and other pupils. He had made physical contact by squeezing her leg at the knee and tickling her, and Julie was delivered home late on a couple of occasions when she was described as 'giddy'. The allegation was received indirectly when Julie's mother requested a change of taxi driver. The mother had also informed the school seeking their assistance in talking to Julie. The school spoke to Julie and forwarded the information to the transport service which had also been contacted by the taxi driver aware that an allegation was being made against him.

Case G

Emma was 4 years old and white British and attending nursery. Emma told her mother that one of the nursery staff, Sue aged 33 years and white British, had smacked her when she had been in the toilet at nursery making a mess with the soap. Another child, a boy of three was said by Emma to have been in the toilet

at the same time. The incident was reported by Emma's parents on the same day and enquiries begun by the manager on the next working day. The manager's enquiries indicated that there had been two incidents of Emma being corrected by staff on the day, only one of which involved Sue. The incident in the toilets was dealt with by a different member of staff. Emma was not spoken to regarding the reported incident except by her mother and the outcome of enquiries was inconclusive.

Case H

Sonia was 16 years old, of Asian heritage, on a work experience placement in a shop. One of the male supervisors in the shop had invited Sonia into his office, asked her to remove her shoes and touched her feet. Sonia informed a member of staff at the retail outlet the following day and the shop management made enquiries and took disciplinary action against the employee. The school staff member who visited Sonia on work experience was informed during her visit to the placement at the start of the second week. The incident was then referred to the deputy head teacher.

Case J

Joe was a white British boy age 3 years who attended nursery. Joe's mother and grandmother reported to the nursery manager that Joe had told them several weeks earlier that a male member of the nursery staff had slapped him. The nursery worker Haz was male aged 28 years of Pakistani heritage. The manager was aware that Haz had not been working at the nursery for several months and was deployed in another part of the service. The manager suspended Haz during the making of enquiries. The allegation followed a prior incident when the mother had lost her job for trying to deceive her employer for which she held Haz responsible.

5.2.2 Case Attributes

The nine cases include children from nursery age to older teenagers. Of the eight cases for which the children's age, ethnicity and gender information was provided six of the children were of white British heritage, one of mixed heritage and one of Asian heritage. The gender of the children was in equal proportions male and female. Two of the young people were in the care of the local

authority and placed with foster parents, one of whom had a statement of special educational needs. Two other young people also had statements of special educational needs. Within a sample size of nine cases the number of children in care and children with special educational needs is disproportionate to the numbers within the child population. While nothing can be concluded regarding the proportion from these vulnerable groups there is significant research which identifies the increased vulnerability to abuse of children with disabilities (Brookhouser, Sullivan, Scanlan and Garbarino, 1986; Kennedy, 1989, 1990, 1992; Tharinger, Horton and Millea, 1990; Utting, 1991; Marchant and Page, 1992; Westcott, 1993; Kelly, 1992) and of children in care (Utting, 1991; Utting,1997; DoH, 1998a).

The national collection of data about allegations which took place in 2007 (DCSF, 2009) did not identify the circumstances of children from which to distinguish if children with disabilities and children in care featured more prominently. The data set focussed on the agency of the staff member subject to the allegation, timescales for completion of actions and outcomes. The two host areas had continued to collect these data for the Local Safeguarding Children Boards. While it did not record disability or other specific vulnerabilities of the children it did distinguish allegations against foster carers as a specific agency grouping. Allegations against foster carers constituted 10% of the total of all allegations in the Northvale area and 15% of the total in Southborough. The sample in this study would suggest that further work could usefully be considered by the Local Safeguarding Children Boards to establish whether there is a higher instance of reporting of inadequate or inappropriate aspects of care for children with disabilities and if within this are learning points for services and organisations.

Two of the allegations concerned children of nursery age. Both of these were reported to the manager by the parents. In neither case was the child spoken to directly about the alleged behaviour except by their parents. In one of the cases the parent had expressly requested that the child be spoken with to obtain her account which the manager declined to do. The participant explained the reluctance to ask the child directly if she had been hit by a member of staff:

*"...she (Mum) wanted me to sit her down and ask her about when this
member of staff hit her.
I said well no I can't do that. Well why can't you do it. I said because I'm
putting things to her that may not have happened, or you know she may
not, she's probably forgotten all about it by now because it's two or
three days down the line now, in a child's life it's quite a while."*

The preferred technique was to 'read' the child's other communication system
of behaviour. Observations were made regarding how the child presented within
the nursery and interacted with the worker who was alleged to have hit her.
This issue of speaking to young children who raise concerns, complaints or
allegations is discussed further when the scenario is encountered as a vignette.

The organisations and service providers included within the nine cases were:

> Schools (Primary and Secondary)
>
> Foster Care
>
> Nurseries (private and community sector)
>
> Voluntary Sector
>
> Private Sector Contractor

The staff members against whom the allegations were made in eight cases
were white British and one was of Pakistani heritage. Six of the workers subject
to allegations were male and three female. The allegations against the three
female staff members all concerned physical action. The allegations against the
male members of staff included physical, sexual and neglectful behaviours. Two
of the participants who had held decision making responsibility in relation to the
nine cases were Irish and seven were white British; seven were female and two
male. One of the participants held a management role in relation to adult
services with reciprocal cover arrangements with the manager for children's
services. The allegation arose during a period that they were covering children's
services.

5.2.3 Exposure to Pre-Allegation Information

Most of the managers were in possession of information regarding the worker
and the young person prior to the alleged incident taking place. In four of the
nine cases managers described specific pre-allegation information which was
relevant to the way that they described interpreting the content of the incident.
In one case (case A) the participant described discussing with the social worker

for a young person in foster care two weeks earlier how they would respond if the young person made an allegation against the foster carer. The participant described that:

> "we felt she was gearing up to an allegation.....because historically she's got what she wanted.......So she's used the process of making allegations maliciously to get her own way".

> "....and so inevitably when she wasn't getting what she wanted the allegation came in."

In a second (case B) the young person had been in trouble the previous day for an unrelated incident which had been dealt with by the teacher. The participant when asked to describe the allegation commenced with the earlier incident:

> "And it was a telephone call, because it was the member of staff against whom the allegation was made who then telephoned me to bring it to my attention....because it was a foreign exchange and during that exchange there had been an issue where a student had misbehaved and that member of staff had dealt with it. But then later on this student then made an allegation against the member of staff that the member of staff had actually kicked him."

The participant's interpretation of the reason for the allegation by the young person was:

> "...he was then looking for a way to sort of take the heat off him in that situation and one of the ways he's done that is to make an allegation against the member of staff".

The prior incidents were a major component of the information for both cases when referred on to the local authority designated officer. In relation to Case A only the historical information providing a brief care history, description of the young person's presentation, and placement plans had been recorded rather than the alleged behaviour or description of the incident. In the second case the prior day's incident was attributed as a potential cause of the allegation by the manager at the point of referral. Both incidents involved a physical intervention by the worker which had taken place. The participants however referred to the incidents as 'malicious' in one case and a 'fabrication' in the other. They described the incidents as fitting in with what had been experienced in the period prior to the allegation. While the descriptions of activities undertaken did not reflect a selective search for information the narratives were suggestive of pre-conceptions shaping how the incident was understood.

Detailed knowledge was also present about significant family stresses for the carers and the challenges of the young person's behaviour in Case D. The initial response of the participant was to the immediate problem of a placement breakdown. The participant described how the understanding of the background informed the judgement that maintaining the placement was not going to be possible. Information from the alleged perpetrator's partner, also a foster carer, included an expression of disbelief at what the young person was alleging. In describing the judgement processes the participant identified knowledge of prior allegations and complaints and also the potential for a physical incident resulting in the lack of need for a "conscious thought process":

> "I mean...you know the potential for physical given that this young man kicks off at that level fairly regularly. I suppose I didn't even have a conscious thought process because this is just what happens in dealing with this young person."

The description from the participant went on to explain how at the earliest opportunity she asked the foster carer directly if he had hit the young person. With the assault acknowledged by the foster carer the need for formal processes of investigation were confirmed. It also reinforced the action required from the service of arranging a new foster placement with some urgency.

In relation to Case J the involvement of the worker in an earlier incident which led to the child's mother losing her job was known by the participant. It was also known that the worker had not been at the setting where the child attended for day care for several months. The participant did not use this information to disregard the allegation as likely to be malicious or to respond in a less robust way:

> "So we reflected on it because the lad concerned was not working in a base nor had he worked in the classroom since October. He does the supervised child contact for the xxx Council and hadn't been located in here. But we took a decision at that point to suspend him, on the spot, without prejudice..."

Employment records were collated including rotas regarding his deployment, prior conduct and recruitment, along with the child's records. It was however previous experience of dealing with an allegation, when outside agencies had required suspension of staff members, which was the determining factor in the type of response rather than pre-allegation information about the worker or child and family:

"...in terms of employment that we decided to actually suspend with immediate effect was influenced, I must admit, very heavily by the previous experience we had in terms an allegation against a man and that all of our men potentially would be suspended on the spot. So we needed to suspend with immediate effect even though we knew he was elsewhere and he wasn't the man concerned that they had identified and there was no others within that unit that could be identified as having done that either."

In Case C there was both an established work relationship and already identified employment issues in respect of the worker against whom the allegation was made:

"Two things were coming out at the same time. The same person disclosed about what they deemed to be an inappropriate conversation with children disclosed something else which was having an impact on my staff member."

The response to the allegation relating to children became "an element of a larger package" involving human resources services. The lack of detail shared regarding this allegation did not facilitate full understanding of the influence of pre-allegation information on the approach taken.

5.2.4 Receipt of a Reported Allegation

There was no single clear route by which allegations were brought to the attention of participants. For two the report was outside usual work hours at a weekend and during a holiday while they were at home. For three participants they received notification of the incidents direct from the worker against whom the allegations were made. For one of these the report from the worker was supplementary to other sources of information but was instrumental in drawing the matter to the participants' notice as an allegation of possible abuse. For the remaining two, whilst the worker was the initial source of information, other events resulted in awareness of the allegations disclosure being unavoidable:

"I also know why he told me as well. He'd got no choice because I realized this on further investigation that the child loved the drama and he was telling everybody even passer-by's in the street. The whole school knew, in fact the school phoned the parents and said 'is this true'. So he'd got no choice but to tell us."

For the youngest children the incidents were reported by parents direct to a manager within the service and reached the participants, at a more senior managerial level, within the hour. In two cases there was more than one source of referral, and for two the allegation was a second strand rather than the

primary reason for contact. In only one case was there a significant delay before the allegation reached the participant. In this instance the delay was a week. The young person, the parents, and the private organisation in which the young person was on work experience did not contact the school to notify directly in the intervening period. This delay did not however impact on the process of responding to the allegation by the private sector organisation, a point that will be returned to when considering the influence of the procedures on judgement and decision making.

One case was received by the participant from a third party source, not directly from the worker, child or family:

> "That one is about a member of staff who is currently not at work because they're off sick. And it was reported by a member of the community, and it wasn't while we were at work, it was while they were living their private life in the community.
>
> Somebody made sure I heard
>
> Somebody had overhead it and the person who had overhead it between my staff member and a child in public informed me."

The indirect path by which it became known did not result in a reduced response.

> "I didn't feel it was my place to judge the validity or the credibility of that information. I passed...well I sounded people out and we decide that a strategy group would be in order."

For the two cases in which the allegation was the second strand the initial information involved a request for a change of service provision. For one an initial contact was described as a 'concern' which was 'logged' by a team member:

> "...a phone call was received into the office that I wasn't initially aware of, which was not a complaint nor an allegation but a concern...."

The concern was not recognised as an allegation until information was received from the worker expressing concern that an allegation was being made prompted by direct contact from the child's step-father. At the same time information was received from the school. Whilst this described inappropriate conduct by the worker obtained from the mother and from speaking with the young person, the school's contact was not of an allegation requiring a safeguarding response but a request for an alternative driver.

In the second case, which began as a request for a change of service, this involved the care needs of a young person when the immediate need was for a new placement. The allegation, while referred to early in the contact, was disbelieved by the female carer. When an assault was subsequently confirmed by the male carer the allegation reinforced the need for a new placement which remained the most pressing intervention:

> "...this is a clear assault he has actually admitted   no question this young person has to be moved and he has to be moved now.....At that point it was still clear the placement was breaking down, and the young person needed to be moved.....We would find out what had happened in the fullness of time."

The routes of referral provided different starting points which did influence the sequence of information gathering but within the descriptions of judgement processes and activities there was nothing to suggest that the route or sequence of referral influenced the decisions made.

5.2.5 Responding to a Reported Allegation

While some initial responses reflected the influence of pre-allegation information, for participants where the allegation was unexpected and the first they had dealt with the participants described reservations and uncertainty:

> "I suppose you set off thinking I hope this is just a story, you know, I hoped it's going to really be proved that the little girl that it's probably her brother that's hit her or something and she's just made all this up, let's hope it proves like that. But we've got to look into it as though it's not."

> "And I was gathering my thoughts and I thought.. I'm sure we're going to have to suspend him, I wasn't absolutely sure, and I would look up the policies and procedures, and I wasn't happy, I just felt it was all wrong what he had done, and that it was serious..."

This did not however work against them following a systematic decision making process. Despite their uncertainty they actively sought to understand the overall significance of the behaviour, and pursued information about the relationship between events, and the context in which the events occurred.

For participants who had previously dealt with an allegation their reflections on their first or earlier experience included similar feelings of uncertainty and disbelief:

"I think the first time you think the child is lying. You think this is all set up...
I think the natural reaction is to minimize it, to explain it away, excuse it, you try to find the easy route out."

All participants described an immediacy and seriousness to the responsibility that receipt of an allegation against a worker involved. This applied equally to participants who were aware of the formal safeguarding procedures and those who were not.

The majority of participants (5) moved quickly from receipt of the allegation to referral to the LADO. One described a systematic approach to the gathering and weighing of information including consulting with a colleague prior to the making of this decision:

"...and so I then said right can you get witness statements from everyone who was there. I said don't give them any leading questions but just ask them, what they saw, what they heard...
Get them to write down the statements. And, in order to do this, sit them again in the classroom."

"I obviously reflected on it over the weekend ..... when I came in, I talked to one of my Deputies, who does child protection and talked it through with her, and said that I think it's probably a case I'm going to have to refer to the local authority designated officer, and she said yes, I think that is the best thing to do. So that was then when I picked up the phone and then telephoned him and at that stage we had all the statements..."

For one participant the gathering of information from other staff, employment records and other documents which verified the worker's location at the time of the incident was for the purpose of referral to the LADO:

"....what we did we sampled staff members and a student to ascertain who had been working within the base within that period of time ...."

"....we detailed all of the review of documents, the literature review that we'd done and provided all of that what you saw as documentary evidence."

"...once we'd made a verbal contact we faxed through the documentation to them, had dialogue with them."

The staff member had been suspended prior to the referral being made.

For two participants the information gathering took place alongside of the contact with the LADO. For one the contact was a request for guidance as to

the appropriate action to take rather than the outcome of a decision process which determined that the allegation met any specific criteria. The participant's description of responding to the concern that had been raised was robust despite feeling the need for guidance on what more was needed. The individual had no prior knowledge of procedures for the management of allegations:

"I ran through it quickly with him and he said what are you doing now. I said at the moment all I'm doing is getting initial sort of records from each member of staff that was around when this incident supposedly took place. I'm getting individual records from them to see if we've got any gaps in it, any links in it, anything like that that, you know, we can sort of try and piece things together as to where this child's coming from."

In describing the judgement processes which followed the alert to the allegation four participants adopted forensic terminology. Collecting information became 'evidence gathering' and 'witness statements' with attention to 'neutrality' and 'non contamination' of evidence:

"...let him talk to the students, not ask any leading questions but just get them all, to write out a statement of what happened. "

"And we've got evidence as far as possible that's neutral, that hasn't asked any leading questions and then once we've got that weight of evidence that's when we can make a decision."

"And we took it from there. We took statements from the girls that they wrote out themselves and then we took more in depth statements where we sat with them. "

"We were trying to avoid any contamination"

"We'd got a clear admission..."

The descriptions of analytical techniques included plotting the course of events to understand the sequence, and if, and how, an incident could have occurred:

"So it wasn't until we'd got everything wrote down and we sat and went through it all that we could clearly see that there was a morning incident and an afternoon incidence....."

Another participant described how the inconsistencies in the actors' stories were mapped out to provide a basis for further information gathering and challenge when a disciplinary hearing took place.

"In the meantime I'd produced a points to prove spreadsheet if you like, because the statements differed slightly and I wanted to know how he could explain why they differed."

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Alongside of the descriptions of analytical process were intuitive moral judgements about the alleged behaviour:

> *"I remember saying to him, 'you should not have done that'...I do remember saying that, that came from the gut, 'you should not have done that', and he said 'I know'."*

> *"...the young person had been assaulted by a foster carer and that is absolutely not okay"*

5.2.6 Initial Feelings

While the majority of participants described their response in terms of activities of what they did or directed, four participants also recalled their feelings on receipt of the allegation.

> *"It was stomach churning."*

> *"So for a whole weekend basically, I mean, you know, till Monday your mind, you're thinking like what on earth has happened. I have one day off and something like this happens. And then like I get in and obviously parents being very distraught that's quite upsetting, and staff being upset and also kind of angry as well so I'm trying to explain to them that they've got to try and be a bit kind of empathetic about it really. You know, how would you feel if that was your child, what would you do. It's difficult. So it was stressful very stressful and quite upsetting actually."*

> *"It was long-lasting, it affected me for the rest of the day."*

> *"...I felt physically sick....I always feel physically well in the cases I've had to deal with this because clearly we have a duty of care to the children, but I'm also acutely aware that when allegations like this happen and allegations are made that it turns people's lives upside down totally. So it always really fills me with absolute dread."*

Included within the descriptions were also emotional responses related to the staff member and empathy to their situation:

> *"But I also felt quite sorry for her in the fact that, it was like well how do you protect her as well as the child because she was having to go through all this, all these allegations and she's like, I haven't, you know, I haven't done anything of the sort."*

> *"Well I was trying to take any personal out of it, because he's a likable sort of person he is a nice support worker."*

> *"He strikes me as a standard genuine straight up normal type of a guy. And you transpose yourself into that and think God if that was me how would I want to be dealt with, would I want to have a fair hearing be treated with respect and dignity until proven."*

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"So whilst I went home, it did prey on my mind in thinking God I wonder what, you know someone's life has been turned upside down and potentially two people's lives have been turned upside down."

A participant who had dealt with a number of allegations including a serious one that led to the conviction of a member of staff reflected on the emotional learning from earlier experience:

"I had the thought of 'oh my god here we go again' and 'why me', but I just knew what needed to be done and did it."

"...no I have done all the soul-searching the questioning that this can't possibly be true let's try and explain it away no I've done all that."

"Forget the relationship with the teacher forget the relationship with the child it's the allegation."

"...I didn't get emotionally involved I didn't take sides with either side. You can't do that".

5.2.7 The Influence of the Actors in the Situation

Once the allegation was received the participants, in managing the situations, became the major drivers. In five cases the young person central to the allegation was not spoken to by anyone in the organisation prior to the incident being reported to the LADO. The two children of nursery age and one boy with learning difficulties were not spoken with directly, about the allegation throughout the whole process, by anyone in the organisation. For one of the nursery age children observations of behaviour and interaction with the staff member were part of the judgement process which informed the outcome beyond initial referral. The four young people over the age of fourteen years were involved in providing statements or accounts of the allegation in the period of initial consideration and investigation of the allegations. In one case a young person's peers were also included as a source of information.

Principles regarding the 'paramouncy' of the child were contained in the narratives of the two participants from the early years settings.

"...we've all agreed that for the safety and the safeguarding of every child that it's necessary to protect children from both men and women and that the child's right to safety and confidentiality has to come first."

For one this was expressed along with describing the difficulties of conceiving of the worker having done what was alleged:

"....I found it hard to believe that this member of staff would have done anything as such. But then again I know we take the child's side the safety of the child is paramount to us, we have to put the child's side forward we have to believe them."

The role of the worker once the allegation was made varied from being excluded from the process to being actively informed at each stage of the process:

"I didn't inform the member of staff because that's not procedure."

"We kept her informed all the way as far as what we knew what was going on and what was being said by the parents and by the child protection officer, and so she knew all the way just as much as we knew."

Most of the workers were aware of the content of the allegation and contributed information, including providing a written account of the incident in three cases. Three workers were the source of the initial information about the allegation and three acknowledged abusive, poor and ill-informed practice. For two participants the acknowledgement by the workers of poor practice was described as making the process easier suggesting some uncertainty or lack of confidence in their decision making:

"... he was pretty straight, said that he ..I acknowledge that I've made a mistake and left myself vulnerable by dropping off the escort first. He was adamant and sought to reassure me time and time again that nothing improper had happened but recognized what I was doing and recognized that it was following due process which made me feel a little easier in terms of I wasn't making.... I wasn't judging the allegation one way or the other but just acting on what I had to act on."

The influence of the worker was also experienced indirectly as a product of their personal qualities, prior work and working relationships, including with the child:

"...but he's got a fabulous understanding of how kids work and how they think. For instance the looked after children contract he sees things that a lot of people don't see. He's very good, but he cannot read very well, he cannot write very well, but he's superb with these kids, you know, he really gets through to them..."

"...this actually sounds to us as though she actually got quite attached to this foster carer, and she hates being attached to people so she was looking for a way out, and this was her way out."

"...there have been no other allegations of this nature against him. He is a competent taxi driver, all of those things that came in, you know"

"But there were four members of staff and I know every one of those members of staff would not have covered for that member of staff. "

Within the majority of interviews the influence of the worker on the judgement process was also present in the attention given to the need to safeguard staff and the risks of being subject to an allegation:

"... this particular issue is protecting our carers because, particularly the specialist carers as this is their job, they have given up their job to be specialist carers and so this is their employment....it would mean that we were failing in our duty to look after them as well as anything else so we need to get the balance right."

"...we have a duty of care to the foster carers and of course we do get an element of malicious allegations against foster carers. I mean not many but you know we do get; we look after very troubled children...."

"...they do more than they should do above the call of duty, because it's in their nature to do that. And sometimes they do need pulling back a bit, because they can be taken advantage of. So I feel the staff need looking after and they need to know the rules and that's what I want to do, make sure that they know the rules and explain why and what can happen if they carry on doing these things."

"...just very conscious of the impact that might have on the taxi driver and allegations that sometimes are made, when they're founded absolutely right, when they're unfounded or found to be somebody elaborating can have a real negative impact on reputation, relationships can be destroyed damaged."

The influence of the child's parents was a factor to varying degrees in six of the cases. For one of the young people in care contact was made with the parent to validate information, while for another the parent was the main complainant. One parent while 'disappointed' by the actions of the worker provided a 'testimonial' of prior good practice which was used within the disciplinary process:

"Mum informed me that she feels very sad about the situation because the support worker has brought the child out of himself especially when she was desperate at the time the support worker started working with the child .....she also sent in a testimonial for the support worker".

One of the parents made direct contact with the worker to raise concerns about their behaviour. The worker was therefore alert to the allegation before it was made known to the participant. It was the worker's response in contacting the participant which changed the status of the concern. This happened simultaneously as information arrived from another source raising the level of

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alert. Beyond the initial alert the parent wanted confirmation that action was being taken not only to protect their child but other children as well:

> "I returned a call to the stepfather, who wanted some reassurance that we had taken some action, that Jimmy would not be transporting his child nor any other. He sought reassurance that he wouldn't be transporting any other child."

In two cases the parents were unhappy about the level of response to the alleged behaviour. One was concern that it had been escalated:

> "I said now because the allegation has been made I said the chances are that I will have to pass it on to the local authority designated officer and she said well she would hope that we would be able to resolve things internally sort of within the school."

> "I then said, right this is the situation and in fact I have had to refer it on. She was a little bit annoyed because she said I wanted it resolved in here, because there were other issues as well, not just that incident, but other issues related to her son the way she felt he'd been treated. But then she said well look I want a compromise solution here I wanted it kept low key and sorted out in here. "

While in another case the parents pressed for a more robust response:

> "Mum went away seeming okay then she   I'm trying to think whether she rang or she came back in to say she wasn't happy, and she wanted something more doing. I said well, what would you like us to do more, you know, we've involved the child protection officer this that and the other. She couldn't tell us what she wanted doing she just wanted something doing."

In addition to the main actors in the situation who shaped the understanding of the incident was the individuals that supported the participants decision making by providing a point of reference or advice. The majority (7) of participants described the role played by trusted colleagues whose judgement was valued:

> "...it's about judgment calls, isn't it. And it's therefore your making a judgement yourself so you've got to be able to rely on your own judgement to a degree but then also to take advice from other people and to take advice from them where you feel that their judgment is one that you can trust. And usually it's then people on your senior team, and that's people you tend to have worked with for a while so that over that period of time you know that if you go to someone you'll get some good advice.

> "I don't think any of us would make decisions about members of staff without consulting with somebody else first really."

For some participants the broader issues for the organisation were also factors taken into account. This was most evident within the descriptions from the

voluntary and private sector organisations where the impact of reputation on the business and on the local authority as a client was also a feature:

> *"Instinctively you know that the risks to the Authority of not taking action are immense. And for whatever reason, if we didn't and the next day something happened you just knew then that the Authority will be left wide-open."*

> *"I think it's reputation for the Authority, to be seen to be acting correctly."*

> *"We've had quite a busy time in getting this contract set up and the last thing we need is for it not to happen…. So there are some competing priorities, I suppose."*

> *Above all, well not above all, but …along with protecting the child, and listening to the member of the staff, protecting the nursery, protecting my business. If something like this is true, and it all goes to court and it all gets out that could ruin us. So you've got that in the back of your mind as well and its sort of I've got to get to the bottom of it, I've got to know.*

> *"…we can't do anything really without contacting the legal line because we wouldn't be insured. So you can think what you like and you can think that they are going to tell you what your original thoughts are, and they very often do, but all this is recorded by the insurance company First Assist they're called, and as long as we're doing what they say then we're covered by insurance…"*

The participants described a broad range of influences surrounding the allegation from which no one pattern could be discerned. In each case there was a coming together of elements which included prior knowledge of the child and worker, the influence of parents and the organisational expectations as well as information relating to the incident in differing combinations. These applied for cases from statutory services aware of procedures and services without this prior knowledge. Expressions about reputation were more explicit in the non-statutory sector.

5.2.8 Timing

The process for responding to an allegation against a member of staff set out in Appendix 5 of *Working Together to Safeguard Children* (HM Gov, 2006a, 2010b) from which local procedures are developed includes a small window for the manager to interrogate what has happened. It includes the expectation that allegations will be referred on to the LADO within one working day.

While the process by which the notification of incidents reached the participants varied the response on receipt was in all cases prompt, including for cases arising outside of normal working hours. In six of the eight cases where it was possible to plot the timeline of events contact was made with the LADO within one working day of the incident. In the two cases where contact was delayed this did not represent a lack of active response to the allegation. The allegations each received a rapid and robust response in accordance with the organisations internal procedures including disciplinary action against the workers. In one of the cases this was completed within the week based on advice from the organisations insurers:

> "Our legal line said that because of the nature of this incident that we should hurry it along so that the support worker didn't suffer unduly wondering what was going to happen. So on completing the investigation and talking to the mum we phoned him and asked him to come. So it started on the Monday and the disciplinary hearing was arranged for the Friday...."

The three incidents which occurred in settings where managers were not aware of the formal allegations management safeguarding procedures received as prompt a response as cases where the procedural expectation of one working day was known.

Participants aware of the timescale of reporting allegations referred to the time available but not in most cases as a pressure or limiting factor impacting on their decision making. The participants' narratives did not include additional information sources or judgement processes that they would have pursued had more time been available to them.

One participant who did have additional time to 'reflect on it over the weekend' due to the timing of the incident during a school trip over a holiday period identified the benefit:

> "...in some ways that made it easier because of that distance involved and what was going on it then meant that you didn't have to make a quick or a hurried decision because you couldn't do anything."

> "If you had an incident where someone had done something, had misbehaved in a lesson, and you were thinking how you'd deal with it but then that person made an allegation against a member of staff as well then you could see that that would be that could be more complex in the sense that you wouldn't have as much thinking time..."

The participant however went on to describe a lack of choice regarding whether the incident required a referral outside of the organisation to the local authority designated officer. From this it is unclear what considerations were part of the additional reflective time.

5.2.9   The Decision Point

Contact with the local authority designated officer was within the construction of the study a key decision point in the case. It was recognised as the point at which an incident is transformed from being internal to the organisation or service to one with external scrutiny, recording and reporting requirements. It also introduced the potential for the allegation to appear on a Criminal Records Bureau disclosure. Participants however described a number of different situations in which contact with the local authority designated officer was made. These served to provide an alternative understanding of the position of manager's judgement and decision making about a formal response to alleged poor conduct.

One participant described a systematic and analytical decision making process involving information gathering, reflection and consultation with others prior to referral of the allegation to the LADO. Despite this description the participant went on to reflect a lack of choice about when behaviours are judged to meet the criteria for referral:

> *"I said plus the way the law is now worded I said that's what I have to do. I have to pick up the phone if an allegation is made against a member of staff and ring him and then when I talk through some of it he (LADO) then makes a decision as to whether he feels you know further investigation is needed, he needs to get involved..."*

This was consistent with three other participants from the Northvale area:

> *"And the way the procedures operate, and the way that people operate, you're just a ...you're a conduit as the Head. A piece of information comes to you; you're not there to judge, you're not there to apportion blame rightly or wrongly. You are there to conduct that information on to other people who can take it further and actually do what is necessary to be done with it."*

> *"...it's very black and white in a sense, as soon as an allegation comes in we always discuss them with....(the local authority designated officer). There is almost no sense, no time that we wouldn't discuss it with (LADO).*

> *"Well it's about an allegation against an adult, isn't it. So when there's an allegation against an adult then the procedures for xxxx is that you refer straight to the LADO."*

The participants presented normative statements related to policies and procedures of what managers ought to be doing which was described as being reinforced within the training provided to managers within the authority:

> *"I think the phrase that stuck in my mind from the training is compliance is not an option....That's the little phrase that I have kept at the back of my mind that I know that if there is something physical alleged to have happened between a child and an adult it must go; compliance is not an option. You just take it straight forward."*

In questioning the role and responsibility of managers to decide which allegations against their members of staff met the threshold for referral to the LADO four participants in Northvale described 'non decision making' rather than a choice between two options. One participant described questioning this during a training session:

> *"Surely, don't we filter that a little bit and sort of look at it, weigh up the evidence and see looks like there's obviously nothing to this and therefore you know we just make that decision so that we only send ones that we think alright you know there could well be something here and send those to you (LADO). But he said no, any allegation that's made has to go to him and he then, he might well make a very quick decision you know just from talking it over the phone that there's nothing to it ...But it has to be reported."*

The deferring of the decision about a worker's conduct to the LADO had the effect of distancing the responsibility from the organisation itself:

> *"...and then she said well there you are look that's what you always do you always close ranks you come together and you support the teacher. I said no hold on I said that's why I said to you I'm not going to do that because that's often the allegation, the accusation that is made that we close ranks. I said I've passed it on to the local authority designated officer, I said so he will be making the decision, he will be carrying out an investigation not me. So that we can't be accused of that I said."*

This presentation of a lack of choice based on an interpretation of the guidance was not reflected by participants within the Southborough area for whom a lack of training and knowledge of the guidance was more a factor. Two of the participants located in a private sector and a voluntary organisation were not familiar with the Local Safeguarding Children Board procedures or *Working Together* (HM Gov, 2006a) guidance prior to the incident captured within this

study. The participant from the private sector service learned of it and the processes to follow when put in contact with the local authority designated officer via a helpline. The participant from the voluntary organisation was advised by the service regulator that an incident required a safeguarding response. While robust action had been taken in response to the conduct of the worker the additional requirements were unexpected and not part of the local and national organisational procedures:

> "I asked why because it's not in our policy and procedures. I mean they pass our policies and procedures so why are they questioning them. They come and inspect us, they know all about us, so it was a surprise. They endorse our policies and procedures, so why were they telling me to do something that wasn't in them…They just said it was good practice, but how would we know that it was good practice. I don't know how I'd know that."

One further participant described being 'tentatively aware' from a case within another local authority where they had acted as an advocate for a child who alleged being physically threatened by a teacher. The internal decision making of the school resulted in exclusion of the child rather than an approach which considered the adult's behaviour. This participant had previous experience of managing a serious allegation of sexual abuse involving the police, social care and education which extended over many months. From that experience was an expectation of process that any allegations would be dealt with by statutory agencies and a powerlessness due to the community based status of the organisation. Only the participant from the Southborough area based in statutory services was familiar with the procedures and clearly described that once the physical assault was confirmed the action required was that set out in procedures:

> "At which point I asked the female foster carer on the phone she needed to ask him whether he had hit the young man and he said he had. So he came on to the phone and told me what had happened. At that point it was a section 47 clear cut, no questions asked."

The procedures were those of a child protection investigation (Children Act, 1989, s.47) including a medical, strategy meeting, and investigation as well as reporting the incident to the local authority designated officer. The participant identified that allegations particularly physical ones against foster carers 'will be somewhere in the LADO procedures' if only to check if the involvement of the local authority designated officer was required. The participant however also described that:

"...we do have to check out whether there's actually anything in it at all before we go anywhere"

Whilst this 'checking out' was a feature of other descriptions it did not limit the response in the scenario of a parent alleging physical assault which was improbable. Rather than ruling out the need for a safeguarding response at an early stage the worker was suspended and the case referred to the local authority designated officer and police. Their involvement did not add to what was known about the incident or the worker but may result in the allegation appearing in information provided by the police for a Criminal Records Bureau employment check in the future.

5.2.10 The Influence of Knowledge and Experience

The five participants from Northvale and one from statutory services in Southborough located the knowledge which underpinned their practice as rooted in many years of experience. In addition the education based staff and one from fostering services described training and briefings being provided about allegations management which had been to raise awareness of the Local Safeguarding Children Board procedures. One held a specific role in the process as a chair of strategy meetings. Learning from this role and in relation to previous allegations had been case based without formal training. A background of child protection training and lengthy experience was reflected by this and other participants in the statutory organisations:

"....we've not done any specific training on that and so we all base our experience on our previous experience."

"...well all your child protection training comes into play..."

"It's perhaps difficult really to be clear about what it is that influences because you bring everything on board with you, you bring all that practice, all those years of practice behind you and sort of all those bits of training that you did over the years sort of all add up to the reason why any decisions are made."

Outside of the statutory services the participants had not had the benefit of training specifically focused on allegations and two had not undertaken any training on safeguarding of children. For one participant a previous role which involved keeping the office procedures folder up to date provided a valued source of knowledge:

"I haven't had training no but I do know about that. I used to do the admin here so I am aware of the policies and procedures because I use to read them, and I know where they are. I can't remember them all but you sort of pick up if something isn't right and I think I'll just check that out, I'm sure I've read that somewhere, but no I've not had training.

Other responses included descriptions of the judgement process being 'just very obvious' and a 'no brainer', and the outcome of 'a lifetime of experience' reflecting the difficulties of experienced practitioners identifying the aspects from practice which are drawn upon in responding when a specific incident is reported. A participant with no prior awareness of the allegations procedures captured this use of tacit knowledge:

"I think the fact that I've dealt with parents and children for such a long time maybe helped but nothing particular. I've never ever had an allegation against any of my staff before so that was totally new. ...I think it was just sort of, you look at it and you think right then what can I do. ....and its sort of I've got to get to the bottom of it, I've got to know. Right what do we do? I can only speak to the people who were here 'cos I wasn't here. I've got to build up a picture and find out what's gone on."

Within the nine cases were three that were progressed in a robust way despite the lack of any awareness of the Local Safeguarding Children Board procedures or the *Working Together* guidance (2006a, 2010b). The organisations did not have prior similar incidents from which to draw experience. Two cases were located in private sector provision and one within a voluntary agency. One of the cases was subsequently reported to school and a referral made to the LADO. The private organisation had already responded to the conduct of the member of staff through its disciplinary processes. The described responses in the three cases were largely consistent with the procedural requirements based on a process of the individuals deciding how best to approach the reported incident. The consistency of response without the detailed procedural knowledge raised questions about the relationship between prescriptive procedures and effective practice. The element that can be identified as omitted in the cases progressed without knowledge of the LSCB procedures was the long term retention of a record of the incident. One participant explained that the worker still had to be informed of this and anticipated their concern.

In three cases, as already discussed, the local interpretation of the national guidance served to produce responses driven by notions of compliance. One participant made this point explicitly describing themself as a 'conduit' of information rather than a decision maker in relation to staff employed in the organisation. Another described following orders from the LADO in relation to a decision about suspension of the workers employment activity:

> "He just told me that was what we had to do so that was fine I can carry out orders"

This thinking provided an alternative understanding of the decision making when allegations are made against staff. The risk-averse practice that procedural compliance promotes was expressed strongly by one participant who identified the safeguarding of themselves and the member of staff as an element of this:

> "It's the procedure. I'm protecting myself. I'm protecting my member of staff by putting it on up because if it is false then it'll be discovered to be false. You've got to have faith in the system."

> "I personally like the procedures. I like the fact that they are laid down that they are regimented   they work. They worked for me they protected me   they protected members of staff and they are fair to both sides."

This attention to safeguarding of workers will be returned to when comparing the judgement and decision making from these real cases with the responses when the same situations were considered as vignettes.

CHAPTER 6: Discussion of the Findings from Vignettes

6.1 Introduction

The data drawn from interviews utilising vignettes constructed from eight of the nine real allegations is discussed in this chapter. The factors considered important to the decision making process by the participants are explored in turn for each vignette. In addition the similarities and differences of the participants' responses to the vignettes when compared to the description from the manager who originally dealt with the allegation are discussed. The dominant themes which emerged from the analysis of participant's responses to the vignettes are reflected within the titles attributed to each of the eight cases.

6.1.1 Case A – A self fulfilling prophecy?

The vignette regarding a young person alleging that her foster carer pushed her was considered by nine participants from Southborough. This involved managers from within the police service, the local authority children's services, a voluntary, a community and a private sector service provider, and a manager within the Hospital Trust. The case information was provided in three sections. The first described the two actors involved in the incident and the background of the young person having previously made allegations, including the manager's anticipation of an allegation. The second section provided the account of the incident as retold by the young person; and the third section provided information as relayed by the foster carer of the period prior to the incident and the incident itself.

The information gathering activities described by participants were consistent with the original incident and focussed predominantly on obtaining direct accounts of the incident from the young person and the foster carer. Only two participants included within the information that they would gather the history of any prior concerns about the worker's conduct. For the majority (5) a key factor was whether the young person wanted to make a formal complaint. In the absence of this, a low key response was considered appropriate by most participants. These included advice on poor practice and mediation between the worker and young person to help each understand the position of the other. The

action of the carer in physically moving the young person was not thought to be wholly appropriate in the vignette scenario or when applied to workers in the participants' own organisations. This applied even when the information described action to move the young person out of danger. One participant described this in terms of a breach of protocols regarding conduct and would have pursued a warning under disciplinary processes. Expectations regarding speaking to the young person about the need to move to safety either before or instead of the physical handling were proposed. Advice on conduct to the worker to reduce the potential for an allegation was also at the forefront of approaches described by participants.

Three of the participants referred to contacting the local authority designated officers. For one participant this was to seek advice because the age of the young person in the vignette was outside their working knowledge. Two referred to it as a requirement, with one describing it as "being seen to be doing the right thing". The latter two were police officers who hold a specific role in relation to notification of allegations which includes sharing information with the local authority designated officer and agreeing a course of action when an allegation is made against a professional from another organisation. In applying the circumstances of the vignette to their own service the approach they described was of a formal investigation of assault with referral to Police Professional Standards as well as the local authority designated officer. This was considered necessary despite describing situations in which physical interventions are "lawful"

> "....if it turns out that she was say going to arrest her, it's a lawful act, and you can rag people about in the right circumstances and use reasonable force. If they're kicking and screaming then you can use sufficient force to restrain her."

The lawful use of a physical intervention was contrasted with inappropriate conduct that required investigation:

> "If it's say if it was a police officer who's gone up to somebody and like, and done that and dragged them to the floor without any interaction or they've done nothing wrong building up to that then obviously you've got something that wants investigating."

The majority of participants did not regard the allegation of sufficient seriousness to warrant referral to the local authority designated officer.

The information regarding the young person having previously made allegations against workers was not a factor that participants regarded as relevant within the decision making of responding to the allegation. Some referred to "crying wolf" similar to the manager who had dealt with the allegation initially. Others identified that the young person could be telling the truth regardless of prior allegations and that each must be taken seriously. Half the participants described the way in which the history of allegations was presented as being "discriminatory", prejudicial", "subjective and pejorative" and "pre-emptive". The feeling was expressed by one of the participants:

> *"I think if that's your starting point you've already made your decision before actually the young person has raised any issue."*

The use of the prior information to be proactive and act to minimize the potential of allegations, to respond to the young person with increased sensitivity, and to consider strategies to protect the staff member, featured in the majority of responses.

The judgement process of participants to the vignette varied from what was described in the real incident. This difference appeared to be the result of the disregard of prior allegations and the anticipation of an allegation which had been features in the original case. Also an expectation of referral of all allegations to the local authority designated officer which had influenced the original decision making was evident only for the police participants in relation to the vignette. While the strategies of gathering of a range of information and discussions with others was consistent with the original the interpretation and consideration of available options varied. The process as a result while appearing to have many similar features produced a different judgement about the conduct of the worker in the scenario and the most appropriate response.

6.1.2 Case B – A Question of Intent?

The vignette regarding an allegation by a young person of being kicked on the foot was considered by the ten participants from Southborough involved in the second phase. They included managers from within the police service, the local authority children's services, a voluntary agency, a community and a private sector service provider, a manager within the Hospital Trust and a child protection adviser within the Anglican Church. Two of the interviews, with police

officers and managers from a voluntary sector agency involved two participants. The vignette was presented in three sections. The first described the actors involved and an incident the day before the allegation arose when the young person was reprimanded for his behaviour. The second section provided a description of the incident and ended with the worker contacting the manager to report the allegation. The third section described the information gathering activity and a summary of the accounts from other people who had been present. This included that the young person had sought to raise a petition amongst peers about the adult's behaviour.

The majority of participants (7) described activities to gather information about the incident drawing in accounts from the young person and the worker against whom the allegation had been made. In three of the interviews, involving four participants, information gathering included accounts from other young people present as had occurred in the original incident. One participant identified the second worker present as a source of information. Another participant identified that they would want to know who was present but this was not developed to include interviewing other young people or the worker's colleague also present. The approach in the original incident had involved all the young people sitting in a room in "exam like conditions" providing a written "statement" of what they saw. A factor within this was that the allegation arose in a situation away from the usual work base during a trip abroad. It is not known if the same approach would have been adopted had the staff and young people been directly accessible to the manager.

One of the participants identified that they would have referred the allegation to children's social care for someone independent of the organisation to 'review'. This was based on the conflicting positions of the young person and worker and the series of events which were described as potentially impeding the young person from being able to express his views to someone within the organisation. Within this decision making was an identification of the incident the previous day when the staff member had dealt with the young person in relation to another incident. For others this connection was made following the information about the petition that the young person circulated amongst peers to complain about the teacher's conduct. While the previous day's incident had

been a prominent feature of the described response to the original allegation participants identified this as an entirely separate matter and not relevant in responding to the allegation.

Four of the participants included within the information gathering consideration of the worker's prior conduct. Only one referred to including consideration of the young person's history and went on to describe establishing whether their conduct with other staff was similar or at variance. Three further participants highlighted the need to explore the relationship between the worker and young person. One highlighted the power differential and the responsibility of adults in "modelling behaviour for young people". A strategy of mediation and conflict resolution was proposed by four participants, with one participant suggesting that this would be required for the longer term to reduce the potential for further incidents. The young person's agreement to this course of action was identified as central, with the young person being regarded as the person who determined if a formal approach was taken.

> "If he wants to take the allegations further I think then it's took out of the manager's hands then, it's got to go further."

> "And then Paul needs to be asked about how he feels about the process and what needs to happen and then we would go from there."

Once the behaviour of the young person organising a petition was included the focus on the young person's wishes was moderated but still described as important in agreeing an approach.

> "Depending on his level of cooperation and understanding, and possibly his parent's understanding, it might be helpful to have a meeting with them to talk about these other allegations to see how much Paul is accepting of what other people were saying."

The petition started by the young person was referred to by the majority of participants (6) although for many this was not developed further. While some regarded the petition as trying to get back at the staff member this did not substantially alter the response to the allegation.

The notion that the worker had acted in a way which placed herself at risk of an allegation was identified by half the participants. For an equal number the behaviour of the worker was thought to have been inappropriate or ill-considered. For one participant this took the conduct into disciplinary processes

and requiring a warning. This was based on the conduct being against protocols which guide workers' behaviour in the participant's organisation.

The actions and responses to the vignette varied in several ways from the thinking and response described in the original incident. The differences centred on a reduced attention to the connection between the previous day's incident and the allegation, and the participants judgements about the behaviour of the member of staff. There were some changes to decision making following the behaviour being described within the vignette as a 'tap' to make the young person move his feet rather than a 'kick'. One participant however reflected that

"...a lot of it is about how the receiver perceives things as well I think."

The intent on the part of the worker was described as being a determining feature of the response to the incident including whether a disciplinary response was required.

"But if when it was looked into it looked as though actually she'd really kicked out at him in anger well then I think that actually takes a different threshold that then becomes disciplinary."

"We would have to know how hard the tap was whether it was done in a jokey mood or whether it was done out of anger cause he didn't move his feet"

"But it probably.. if it wasn't meant with any malice or she didn't hurt him in any way.. but we would have to bring her in and say you know this is a verbal warning and it will be recorded. We don't do that to clients."

Referral of the allegation to the LADO was identified as appropriate by two participants. The contact was with a view to sharing the information that an allegation had been received but with an expectation that the cases would be dealt with as an internal disciplinary action by the organisation. In addition the two police participants described sharing the information with the LADO in their role of overseeing the management of investigations against all professional groups. While this process is a matter of routine they stated that they would not have expected that an allegation of the type described in the vignette, if made against a police officer within the district teams, would have been referred to the local authority designated officer. A low level response or mediation was

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identified by the majority of participants (7) as their approach to the described incident without referral outside the organisation.

Within the descriptions of responses to the vignette a small number of subjective judgements adopted as a starting point had little surrounding or supporting evidence. One position adopted was:

> "I'm sure that she's not gone up and kicked him but you know has pushed his foot out of the way."

A different position was adopted by another participant:

> "Obviously Lisa's not going to admit that she's kicked him anyway even if she did."

While the design of the study did not include making a value judgement about the action of the worker the responses to the vignette were dominated by this. In locating themselves in the place of the manager, participants' judgement about the action to be taken was intrinsically tied to their view about the appropriateness or otherwise of the behaviour described. In distinguishing between a "violent kick" and a "tap" to the side of a foot in a situation of a young person provoking a challenge one participant expressed:

> "...what she did was tap his foot which seems a reasonable sort of discourse to have with a teenager."

While the incident was regarded as of low level concern:

> "It would just be another day, I think"

6.1.3 Case D – Consistency of Approach

The vignette regarding a physical assault on a young person in foster care was considered by eight participants from the Northvale area. The group consisted of a manager within the police service, a children's centre manager, the child protection lead adviser for the PCT, private sector transport manager, two head teachers and a deputy head teacher, and a manager in children's social care services. Five of the eight had participated in the first phase of data gathering. The vignette was presented in four sections. The first information described the actors directly involved in the incident and a description of how the allegation had been reported by the adult's partner who had not been present. The second section provided background information about the young person and

challenges his behaviour had presented at school and within the home. It also included stresses for the adults which had been present over the previous twelve months. The third section was a short statement that when spoken to the adult had said he hit the young person. The final section of the vignette was the summary description of the incident provided by the manager.

Information about gender, age and ethnicity was included for each of the eight vignettes. The large majority of participants did not make reference to this information. Vignette D was one of two which attracted a comment by one participant in relation to ethnicity. The observation regarding ethnicity was that it was of no concern, "except if the carers are racist". This line of thought did not feature further in the description of the information gathering or decisions made regarding action to take. The age of the worker attracted two causal inferences: that the carer's age may result in tiredness leading to the individual struggling to meet the needs of a thirteen year old, or to intolerance. Age featured further when considering outcomes and an observation that "local authorities are criticised for retiring people off" but speculation based on experience that it would be very likely he would "go off sick".

The allegation within the scenario presented was a third party report rather than being received directly from the young person or worker. Five of the participants recognised this prior to it being highlighted in the interview dialogue. For three participants the second hand nature of the information was not considered to influence the response to the allegation. One explicitly rejected the assessment of the female carer that she believed the allegation to be untrue. All three described proceeding as if the account was first hand and refer to the LADO the report of physical abuse of a young person.

There was no dominant pattern to the gathering of information. Two participants questioned the role of the female partner when applying the scenario to their workplace situation saying that they would want to deal directly with the male worker and young person involved in the incident. In contrast one identified that they would begin by speaking with this carer and was alone in engaging with this individual. This difference related to the type of service provision of their organisation. Two participants identified that they would begin by seeking the

information held by the organisation about the young person and worker. This would be information in case files and personnel records. One referred to seeking this information at a later stage and the rest did not include seeking this information specifically. This information would be expected to be collected and presented to a strategy meeting which four identified as part of the process for planning an investigation. For two this was prior to all other actions while for others it followed confirmation of the child having been hit. Only one participant described their information gathering strategy consistent with the manager in the original. The original incident was however on a weekend when the options were limited and the presenting problem referred to the manager had been a placement breakdown. Contact with the LADO was not possible immediately in the original situation and was not part of the manager's strategy until the foster carer confirmed hitting the child.

An influencing factor identified by three participants in relation to gathering information direct from the actors in the situation was an uncertainty based on a lack of training at interviewing potential perpetrators of abuse. While it would not be expected that within the agencies they would conduct formal investigative interviews the concerns about speaking with the actors to the incident was captured by one participant in explaining:

> "..let's say the person was hit but then you can end up asking questions which it could then lead to say a police case or something like that. The problem then is the person isn't skilled at asking the right questions and the evidence is thrown out because they've been leading the person on and then that's always thrown out."

The advice of the local authority designated officer and their agreement or direction as to who should be spoken to and how this should be conducted was the solution for the participants raising these concerns.

Initial reactions to the scenario include relief that the allegation was not of a sexual nature, the identification of it being the most common of complaints referred to the fostering team, and an immediate application of the individuals' understanding of local procedures. An allegation of a physical assault was categorised as a child protection issue and the alleged perpetrator in being a professional was identified to take it into the allegation management processes. Three participants identified that they would gather information and only after the assault was confirmed would they refer into the LADO. In responding to the

information presented in the vignette three participants drew on practice experience to generate a number of hypotheses as a means of querying the information. These ranged from 'the child could have made it up', to 'in the worst case scenario it could be true'. This process was most evident when considering the stresses within the worker's home situation. Inferences about the possible cause of the incident were built into the hypotheses:

> *"The kid will be living in this household I don't know for how long.. with all the stresses that these carers are going through..., so the kid may well not be getting a lot of attention from the carers because of all the stuff that's going off so he may well just be thinking, oh my god I need some attention..."*

> *"Or it might be that there's an issue between Mike's partner and the lad or that Mike's partner is also thinking that well look we've got enough on our plate and actually although he's willing to take it on with all these other host of issues he's got actually we're better just getting rid of this lad."*

> *"I know certainly from experience with staff over the years sometimes when it's all hell and no notion in your personal life work is the only stable solid place you've got. And I guess one of my hypotheses would be that Mike might have felt that my one stable place where I'm doing good, I know I'm doing some good stuff and I get a bloody kick in the teeth from Kevin....."*

The majority of participants (7) in considering the many stresses within the foster carer's family situation described that they would not have a bearing on the response to the allegation. They were however at the forefront of participants' thoughts regarding support required and staff welfare issues. Concern for the workers' welfare and strategies of responding on behalf of the organisation were more prevalent than concern for the child. One participant identified the worker as a victim himself as he was threatened when the situation escalated.

In considering the stresses the participants reflected on their own organisations and the expectation that this was information that the organisation should have known and responded to before the allegation arose. Five participants expressed that the organisation had failed to safeguard the worker. The need for the organisation to have provided training on de-escalation, and the worker to have applied the strategies, were central to their accounts.

Of those participants who considered the question of suspension of the worker (6) the majority (5) would have done so once there was confirmation of the physical assault. One participant who expressed reluctance to suspend staff identified the "feelings of alienation" experienced and the increased difficulty of integrating them back into the workforce afterwards. For this individual's service there was a potential for a staff member to be re-assigned to a role not in contact with children. For another participant it was the lack of alternatives that made suspension necessary.

Half of the participants applied a breadth of knowledge from practice within their service area which went beyond the content of the vignette. This included maintenance of the service to the young person, the impact of a worker's suspension on service delivery to others, public expectations of the service, the organisation's responsibilities for staff welfare and failure to respond earlier to the workers' stresses, disciplinary issues and criminal investigations. The responsibility for the decision making was described as located with the manager by three participants until it was confirmed that a full investigation was required. Two described at an early stage seeking the advice of the LADO regarding action they should take. A further two described it as a "multi-agency" shared decision made within a strategy meeting prior to other decisions regarding interviewing actors in the situation. All participants after receiving full details of the incident identified that the allegation was of a serious nature and were consistent in their expectation that it would require a response beyond the individual service as was concluded by the manager in the original incident.

6.1.4 Case E – A Question of Capability?

The vignette regarding a young person left unsupervised in a car was considered by eight participants from Northvale drawn from the police service, children's centre, children's social care, a Primary and a Secondary School, the PCT, and a local authority contracted private sector transport provider. The vignette was presented to participants in three sections. The first described the actors to the incident and the information received by the manager from the worker who called to report the incident. It also included an assessment by the manager of the workers emotional state when making the report. The second

section explained that the worker had informed the young person's parent and the mother's emotional reaction. It also included the manager's description of the worker's strengths and difficulties. The final section of the vignette provide a description of the incident gained from the young person's mother which included the story she had been told by the worker and by her son.

The immediate observation to the circumstances in which the allegation had arisen was for half the participants focussed on the young person not having an escort. This drew on the various service providers expectations of young people not being transported alone by workers. One of the participants developed this further putting a case forward that:

> "It may seem crazy and that people are going overboard but in these days of allegations and things like that if someone is left by themselves with a child, a child can make an allegation and it can be very difficult to then argue, you know, you're then in that very difficult situation."

Another theme common to the majority of the responses (6) was a focus on the "unacceptable" conduct of the worker in the scenario described. The remaining two participants expressed similar views when describing their feelings in response to the conduct, but in less pejorative terms. These initial reactions describing moral judgements about the worker's conduct mirrored that of the participant who had received the report in the original case.

Views regarding the worker's conduct were carried forward into speculation and assumptions for which there was no supporting evidence provided in the vignette. These included that the worker had alerted the manager because he had been "caught", that he may well have done it before, and thought by telling the manager "that would be the end of it". Also was the notion that the worker lacked respect for the child. Of these value based statements, the first was also expressed by the participant who dealt with the real incident.

Activity to inform the decision making was dominated by three strands of information gathering. The majority of participants (6) identified the importance of prior information about conduct and whether there had been concerns about the worker's actions in working with children. Four stated that any prior concerns would raise the level of the response they judged necessary. The two further strands involved speaking in detail with the worker and speaking with the child's

mother. These processes were largely consistent with the activities described by the participant who dealt with the original allegation. The participants did not refer to checking the organisation's procedures and protocols or calling the insurance company which had featured in the original description provided in the first phase. One participant did talk about the organisation's policies and protocols but not in the context of seeking guidance. It was instead as an organisational response to make sure that staff were clear about what they must, and must not do, and tightening policies if conduct expectations were not clear.

Only one participant referred to speaking with the young person to obtain their account. This was in contrast to vignettes A, B and C which involved young people of age 17, 15 and 13 respectively in incidents of a physical intervention or action by the worker. It is unclear why the young person's account in this vignette was not considered necessary and whether this related to his younger age at 11 years or his disability and learning difficulties. The incident was also an act of omission rather than of alleged commission as had been the case in the other vignettes.

The view of the parent featured strongly for the majority of participants (6) although it was described as not being the deciding factor. Some participants (3) described how a parent would not have all the facts and there was a limit to what could be shared of information confidential to the worker. In circumstances of prior concerns about the worker's conduct this was regarded as of greater importance in informing the decision making than the parent's views.

Three participants included speaking with partner agencies. For one this was to provide reassurance to organisations working with the young person that action was being taken in response to the concern. For one the contact was predominantly to gather information about the child that the agency would not hold. One participant described the decision making as being a shared responsibility:

> "...I would be saying to the line manager we need to decide what we are doing about Philip. We need to decide on a multi agency basis. This falls for me into potential neglect or at least inappropriate to work with children and young people."

Contact with other agencies included seeking guidance regarding the safeguarding aspects of leaving a child in a situation of potential risk from the LADO and the investigative agencies:

"In terms of how we progress I would be taking the advice of the LADO and colleagues from social care, police if they were involved".

In taking a broader and forward looking perspective one identified that if the worker was employed by another organisation, liaison and sharing information with that employer would be required. This did not rely on information within the vignette but was rather the ability to consider imagined or possible other aspects to an allegation.

Participants quickly moved to locating the behaviour within a hierarchy of management responses. For one participant this was their immediate response and preceded consideration of other information they may require. At some point in the discussion of the vignette participants went through a process of considering the levels of response available to the organisation and described their decision making in terms of what they would do. Participants were clear about what factors would not influence their decision making. These included the worker acknowledging their poor practice, the worker's own difficulties related to dyslexia, the inconsistencies in the worker's accounts to the manager and parent, and the wishes of the parent for the worker to continue in their support role with the young person. The latter of these was an influencing factor in the decision making in response to the original incident.

Strategies adopted by participants in considering the detail of the cases in the vignettes included trying to put themselves in the place of the actors. This occurred in relation to the worker as participants tried to understand the thinking that had informed the actions. Similarly trying to understand the perspective of the mother and speculating that fear of losing the support service may have influenced her expression of wanting the worker to continue. Some speculated at 'worst case scenarios' of what the outcome could have been. One considered the risk of harm to the child, and the risk of re-occurrence, in determining the level of risk to the organisation of implementing a low level response.

The majority considered a low level response dealt with internally as the level of response required. The possible outcomes varied from advice from the

manager, verbal warning under disciplinary processes, to suspension from unsupervised work for a period while their understanding of their role and responsibilities was assessed and developed through training and management advice and supervision. The majority (5) felt the level of incident reflected in the vignette could be managed within the organisation without recourse to the allegation management procedures or other agencies. For these participants the issue was one of capability rather than safeguarding. The remaining three participants while they would have made contact with the LADO and partner agencies reflected that they expected the outcome would be for the organisation to deal with the matter as a disciplinary matter. The described outcomes from this process were consistent with those proposed by participants who advocated for dealing with it as an internal capability issue.

Two participants described using the experience to confirm or tighten procedures for the organisation and to remind other staff of expectations around conduct:

> "It's a learning experience, isn't it? Learning the lessons of what we don't do right."

Other organisational considerations included the need for the organisation to feel confident that the worker could work safely in the future. This echoed the feelings of the participant who had dealt with the original incident who expressed:

> "I did for a little moment maybe think I hope we are doing the right thing here by keeping him on, would he do it again. I hope he doesn't let us down."

6.1.5 Case F – A Misunderstanding?

The vignette was considered by the same ten participants from the Southborough area as had considered vignette B. The vignette regarding a young person being transported home was presented in four sections consistent with the pattern of information received by the manager in the original scenario. The first described the actors in the situation and information that the young person had been delivered home late and the parent wanted a change of worker. The second section was information direct from the worker after being contacted by the child's step father. The third was from another service provider that the mother had shared concerns with; and the last piece of

information was obtained from the young person when spoken to by another service provider at the request of the mother.

In appraising the first information to make an initial judgement there was no single consistent response and participants focussed on a range of issues. For one their attention was on the requested change of worker which they said would be provided. Two described wanting information from the worker to understand why the young person had been delivered home late, while three immediately identified wanting additional information from the child's mother regarding her concerns. One participant began by identifying the gaps in information and questions they would want to find answers to. The strategies for information gathering that followed fell largely into two approaches. Four began from a position of wanting to speak to the worker, while six described beginning by seeking clarity of her concerns from the child's mother. Half of the participants made reference to the mother's knowledge regarding her daughter which was expressed by one in relation to her instincts:

> "...her instincts aren't out. She knows her child, and she may know her child's responds to stress or whatever..."

Four participants included speaking with the young person as a source of information. Following the second section of the vignette two included contact with the stepfather. For one participant this contact included the mother also being present for any discussion. Four queried the reasons for the stepfather's direct contact to raise concerns with the worker. In applying the vignette to their own organisation two explained that they discouraged workers providing personal contact details to service users and would expect it to be via the organisation.

Within the initial report were two aspects, these were that the young person had been delivered home "slightly giddy" and delivered late by the worker. Two participants focussed their attention on the issue of lateness while for six the "giddiness" was their initial focus. Four associated the giddiness with potential alcohol use and one participant only on re-reading realised that alcohol was not mentioned in the vignette information. The potential of this behaviour being

entirely innocent and the result of the young person enjoying herself were included in the considerations of four participants.

Age and gender featured in some participants (3) considerations which included that they would not have assigned a male worker to a female of 14 years with learning disabilities:

> "I mean, the fact that I wouldn't be asking a 42 yrs old man to take out a 14 year old girl with learning difficulties is another issue."

> "I'm very wary about putting male staff with, shall I say, nubile teenage girls, without clear safeguarding risk assessments in place, because, you know, they are vulnerable. Girls can say anything or anything could happen."

> "We wouldn't have put a male with a female of that age anyway."

In responding to the vignette participants described several strategies, including "trying to formulate a guess", putting themselves in the place of the worker, considering the issue from the mother's perspective, and mentally working through potential explanations. One participant described their approach as "doing a mental risk assessment" as they weighed up the issues for the girl, the worker and other children within the group. Two participants described 'knowing their workers' and considering how the behaviour fitted with prior experience of the individual. It was not clear what weight would be given to the new information if it conflicted with previously held views.

The vagueness of the first two sections of the vignette prompted speculative approaches of trying to apply their experience and possible explanations to fit the scenario. Some participants (3) described actual situations they had dealt with to compare the details. The explanations they considered ranged from potential sexual assault, the worker joking with Julie, her elaborating on the events, or a misunderstanding. In the absence of a clear allegation participants' descriptions consisted of activity in seeking and clarifying information from the actors. One participant described at the first stage referral outside of the organisation to children's social care and the LADO, and possibly the police. For the majority this stage was reached in the third section of the vignette where the allegation of physical contact by the male worker towards the young person was made. A "formal approach", a "proper investigation", "external

scrutiny" and "referral to us (police)"; "referral to child protection team", and referral to local authority designated officer featured in most (7) descriptions. These were based on a view of the behaviour described in the vignette:

> *"Right well, I mean that's now becoming a clear potential allegation of sexual assault, or potential inappropriate sexual behaviour."*

> *"It's a potential sexual offence"*

> *"...Julie is making an allegation about well what could be indecent assault but you know we don't know yet."*

> *"That is totally inappropriate. If she'd been three maybe, do you know what I mean, but a 42 year old man and a 14 year old girl he shouldn't have been touching her body so that's wrong anyway."*

Two participants applied prior experience to described paedophiles as 'grooming' managers within organisations to gain trust and access. Another described the behaviour as potentially 'grooming' of the young person:

> *"And particularly with behaviour like this which is, which can be quite subtle and can be misinterpreted. You know tickling can just be tickling or it can be grooming activity towards further sexual contact."*

While describing the increased seriousness and that the threshold had been reached for formal investigation the participants still remained open to a range of possible explanations reflected by one participant:

> *"...because some people inadvertently do things that place them in a very vulnerable situation and sometimes that can be about abuse, but it can be about their learning."*

The perceived need for multi agency contributions of information they held as well as more formal investigative processes took the descriptions of the response required outside of the individual agencies. Interviews with the other young people and the worker's colleague were included by some (4) participants once the decision point of the need for a formal investigation was reached. Prior to this some participants described consulting with others including another manager, their regulator, and informal discussion with the safeguarding unit.

Participants were conscious of the point at which they cease to gather information and refer on. Some participants (3) referred to not cutting across the investigative process and were conscious of "contaminating evidence" and the dangers of people asking questions of young people without the necessary

skills. The direct contact of the stepfather with the worker was described by one participant as 'contaminating' the evidence. Informing the worker about the content of allegations was similarly regarded:

"...there's a fine line about alerting somebody to the fact that basically they've been rumbled in their activities and giving them time to cover up and get rid of any particular evidence that might be around depending on what the nature of the allegation is and fairness to them in terms of informing them that an allegation has been made."

Suspension or removal from contact with young people pending the outcome of the investigation also featured in several (6) descriptions of the progress of the allegation. The participants applied knowledge and understanding beyond the initial consideration of the allegation in responding to the vignette. In looking forward they considered the possibilities and their consequences for future employment of the individual. Regardless of the outcome of the investigation participants identified that they would address the practice issues of the worker being alone with the young person having dropped off his colleague and other young people. For some (2) this was a disciplinary matter while for others (4) it was poor or unsafe practice. The responses to the vignette were largely consistent with the original incident. The delay in the first piece of information reaching the manager in the original scenario resulted in the three pieces of information being considered together when information arrived from new sources. This prompted immediate contact with the local authority designated officer, suspension, and the initiation of an investigation.

6.1.6 Case G – The Difficulties of Uncertainty

The vignette was considered by the same eight participants from the Northvale area who had considered case D and case E. The allegation from a young child of being hit by a staff member at nursery was presented in three sections consistent with the information as it had become known to the manager in the original incident. The first section described the main actors in the situation and the initial referral of an allegation by the child's mother. The second section provided additional information about the child and observations of her demeanour with the worker against whom the allegation had been made. It included information about the presence of another child in the toilet area when the incident was said to have taken place. The final section provided a

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summary of the information gathered by the manager at the conclusion of enquiries. This included conflicting information from the child's initial allegation made to her mother and the worker's account. The inconclusive outcome produced a "very uncomfortable situation" for some participants and a focus on the support needs of the worker for others. The initial information as the allegation was described in the vignette was unclear to some participants and some explanation was required of the sequence of events. Having unpicked how the manager learned of the allegation and gathered information in the original incident the majority of participants (6) noted that because it was an allegation against a member of staff it would necessitate contact with the LADO. For three this was further attributed to it being a physical allegation:

> "The thing that differentiates this for me...is that there has been actual physical contact. It's the physicality of it and the risk and danger that comes with that."

> "...I would have to speak to the parents   listen to what they've said and then if they are accusing one of my staff of hitting their child then I would go down the referral route."

Two participants referred to the degree of force used. This was related to whether there were any injuries as evidence of an assault and also for one participant it was a wish to better understand what the child meant by 'hit':

> "Whether we are talking about a smack whether we're talking about she came in and tapped her because she wanted her to hurry up or what she meant by hit."

There was no suggestion that it would be acceptable depending on the level of force used. The clarification was to avoid responding to the parent's account of the child's allegation at face value and to try and unpick what was meant by the child.

Three participants described contacting the LADO prior to pursuing other sources of information or clarification. One participant identified contact with children's social care as a potential source of background information and to decide whether a single agency investigation or joint investigation would be initiated. There was an expectation of the decision regarding investigation of the allegation being multi agency within two participants' descriptions, and to be made in consultation with children's social care for another.

The substance of the contact with the LADO varied from an expectation that they would decide what action was to be taken, to participants who described informing the officer of how they planned to respond to the allegation. One participant described seeking agency personnel records regarding the worker prior to making this contact. Only one described an alternative approach which was to discuss the allegation with the worker to obtain their account as an initial response. Beyond this they did identify that they may need to report the allegation to the LADO and described the relationship as one where they would inform the officer of the actions they were taking.

In responding to the vignette some (3) drew on their knowledge of child development in describing their expectations and assumptions of the actions and responses of a child of four years. Three participants identified speaking with the child with a view to seeking more detail of the circumstances of the incident. Within two of these descriptions was reflected knowledge of consent issues, conducting interviews and communicating with children. Equal numbers identified that they would speak with the child as those who would not, those who were unsure and those who would seek information from the child indirectly via the parents. Of those who would speak to the children the information drawn from practice experience was that:

> "They'd have to be asked very quickly because their memory is very short term"

The explanation for not speaking to the children consisted of assumptions regarding what the children would or would not be able to contribute to an understanding of the incident.

The issue of interviewing very young children is a complex one. The participant who had dealt with the original incident identified that there had been a time lapse over the weekend which they described to the parent as being long enough for the child to have forgotten. Research however suggests that at three years of age children are able to provide detailed and accurate information (Wilson and Powell, 2001). Personally significant information and stressful events are remembered better than other information (Goodman, Rudy, Bottoms and Aman, 1990), and may be accurately described by children as young as three a year later (Hudson and Fivush, 1991). The participants did not

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refer to reading the child's other communication systems of behaviour and interaction with staff which was a feature of the information gathering in the original incident.

Areas of knowledge reflected in the descriptions were the procedures for dealing with allegations, disciplinary processes, and for one participant criminal evidence gathering, while another referred to knowledge of recruitment processes and experience of poor recruitment practice in early years settings. This led onto their inclusion of the content of the worker's personnel file held by the agency within the information gathering. This participant located the service in the broader inspection framework and other organisations that would have knowledge of the unit where the allegation arose. This additional knowledge provided a more holistic approach to the vignette with attention to poor practice beyond the incident and content of the allegation.

The attribute of the child as "imaginative" within the second section of the vignette was dismissed as irrelevant by three participants who noted that this had no bearing on whether the child had been hit. It was further described as a potential indicator that the allegation was being minimised. From the initial information one participant stated that they would begin from an "assumption that what Emma (child) was saying was true". As it emerged that the information from the workers was at odds with the child's account responding created uncertainty for some participants. Five participants described feeling "uncomfortable" in some way due to not being able to conclude the child's allegation. One noted that the parents were aware that their child was imaginative and while knowing this believed the allegation. This reinforced for them the need for the allegation to be taken seriously. Another focussed on the potential that someone may be hitting the child and that due to their age they were experiencing difficulty expressing exactly what had happened. This encompassed the application of broader child protection knowledge. Other descriptions made reference to it being:

> "...incredibly unusual for a child to make a malicious allegation, especially at four".

Information about the presence of another child led to mixed views about the inclusion of their information and how it would be obtained. Two participants identified they would want to hear from the three year old their story of what had happened and would seek this directly, two were unsure, one described speaking with the child's parents for them to gather information and two described an indirect approach consistent with the action in the original situation. This involved speaking with the parents generally about how the child was experiencing nursery without any direct question relating to the incident. One of the participants who described being unsure about inclusion of the three year old child related this to a lack of knowledge of speaking with children from this age group.

The boundary between information gathering to reach a decision and moving into an investigation was identified by some (3) participants. This was a limiting factor on the enquiries made:

> "My instinct or experience I guess would tell me to have a conversation
> with her (worker) but what I don't want to do is blur any investigation."

One participant who began from a position of immediately reporting the allegation to the LADO describe their expectation that the enquiries would then be made by children's social care and decisions be multi agency. This described a process by which responsibility for the management of the allegation was passed outside of the agency from an early stage. Two further participants also reflected a multi agency approach to planning the response including whether the worker was suspended either from their work or from contact with the child who had made the allegation. These participants did include some agency information gathering within the description of their role. The benefits of multi agency decision making were also a feature at the conclusion in that two participants identified the security that a formal process with others offered:

> "I would certainly want the security of having a process around me to
> make sure that I was doing the right thing and that there couldn't be a
> complaint come back to me."

The difficulty of responding to the vignette information was referred to by the majority of participants due to an absence of knowledge of the context and

actors. Half the participants highlighted that knowing the worker would assist them in the judgement and decision making:

"If you knew Sue you'd have a much better balance of knowing her behaviour, her style, instinct, her values and you could immediately think you know not sure about that or that was totally out of character. I'm not saying that you would dismiss it at that stage but I think that would help you or inform your decision making.

"Whether you like them or not is neither here nor there but if you've worked with the person or have known the person for some time you would identify traits and think I could see them doing that or no I couldn't.."

The worker's prior conduct was similarly described as being informative either positively or negatively as one participant speculated how it may influence the decision making:

"..well my view of Sue is she's been here for so many years she works well with the children we've never had any problems with her before everybody says she's a really nice person de de de de on the balance of probabilities I don't think this has happened.......On the other hand if I was saying well I've had several allegations against her before nothings ever been proved but you know several times children have said oh she hits me ..."

The potential negative consequences of knowing the staff member was also identified by one participant:

"..maybe it's not easier, maybe that does weigh on your mind too much if you do know somebody that you become blind to it."

In reaching a point in the vignette where they accepted that the outcome was inconclusive, the participants resorted to the member of staff's prior work history, colleagues experience and the managers own experience of the worker as determining any action. The "balance of probabilities" of the abuse having occurred was described as being determined based on these factors. A need to reach some "middle-ground so that everyone could be happy working in the same environment" was suggested by one participant while others focussed on the views of parents being central to the future service delivery for the child. An expectation that the child's mother would discuss the actions taken with other parents raised the issue of reputation for the organisation which had been present in the narrative of the participant who responded to the original incident:

"... there has to be some confidence that the manager would do the right thing when faced with this type of incident."

The action for the manager in response to the inconclusive enquiries included descriptions by half the participants of monitoring for a period the relationship between the worker and child, the worker's conduct and for one participant also the child's "elaborations". An alternative was described as providing advice or a warning to the staff member. This varied from advising the individual staff member about not leaving herself open to situations where an allegation could be made, to a warning to all staff regarding safe practice. Drawing the attention of all the staff to such incidents was described as sending a message that such conduct would be investigated and may discourage the behaviour. From another participant it was described as warning them that behaviour can be "misinterpreted or being misconstrued" and to "watch your back".

Attention to safeguarding staff and staff welfare featured strongly in three descriptions:

> "So you'd want to be able to support that member of staff. This would be a traumatic experience having to go through an investigation it would be an anxious time so you'd want to be able to support the member of staff at the same time as support the child to say yes we've heard what you've said but at this time there is no conclusion that we can draw"

> "The safeguards have been in place for Sue as for the victim in this case which then allows you to sort of have some position where you can go forward with Sue in relation to that she doesn't feel that she's been harshly treated by the organisation doesn't feel adversely treated and allows you to sort of deal with those issues going forward."

While another participant described the balance required to safeguard staff and children:

> "But at the same time you're striking that balance all the time because you've got to look after the interest of the staff you don't want false allegations against them and therefore them thinking they're going to be accused of things all the time. But then at the same time you're balancing that with making sure that people children especially when they are young like this that they're safe."

This heightened focus on safeguarding of staff was a feature of other vignettes. It was present in case D related to the stresses in the workers home situation and in case J where the allegation was believed to be malicious. The reasons for the greater focus on the worker's welfare than the child's in this inconclusive case is described in terms of the ongoing working relationship with this staff member.

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6.1.7 Case H – A Case of Inappropriate Conduct?

An incident of a worker massaging a young person's foot provided the content of this vignette. It was presented in two sections. The first included both the details of the actors to the event and a description of the allegation. The second section explained that the allegation was not reported to children's services until a week later. Seven participants consisting of managers from the police service, children's social care, fostering service, private nursery, NHS Hospital Trust, and Anglican Church in Southborough considered the vignette. Six of the participants expressed their first thought as being that the conduct of the worker was 'inappropriate'. The decision to move into the allegations management procedures followed quickly from this judgement of the described incident. Two participants described engaging with the young person to explain the options and supporting her make a complaint to the police. This included making direct contact with the police alongside contacting the LADO. Two participants identified immediate contact with the LADO to take advice as to whether it would be progressed under safeguarding procedures and to commence an investigation. In responding to the vignette scenario as it originally happened in a work experience context one participant identified the need to notify the school. Their expectation was that the school management would respond "much the same way as if it had happened at school".

Information gathering by participants and within the services prior to referral for investigation was not described by the majority of participants. While they identified that an interview with the young person was required there was an expectation that this would be as part of a police investigation. The notion of not prejudicing a police enquiry limited the other strands of information gathering. Only one participant described speaking with the worker to gather his "side of the story". This was underpinned by uncertainty about why the young person would have complied and removed her shoes when asked. For the remainder the behaviour of the worker in being identified to be inappropriate was based on it being potentially sexually motivated, to have involved physical contact without consent and to be an abuse of the person's role. One participant identified the age differential and power differential and that the young person was asked to do something "completely irrelevant to the job she's doing".

In applying the behaviour to their own setting two participants described situations in which police officers would have a "legitimate lawful reason to remove her shoes" linked to a drugs search. Within this scenario the participants identified that such a search would be by a female officer and not alone and should comply with "standing orders". Operating outside of these conduct parameters the behaviour described in the vignette would be regarded as inappropriate but as poor practice rather than a safeguarding concern.

Six of the participants described removing the worker from direct service contact with young people or suspension pending the outcome of the investigation. The same understandings and views on the behaviour were present as had led them to decide referral under the allegations management processes was required. Engagement with human resources services in relation to the suspension was identified by two participants.

The vignette included that the allegation had been reported to the manager in the organisation a week after the incident occurred. This delay was not felt to make any difference to the actions required by the majority (6) of participants. One described a series of potential reasons why the delay may have occurred:

> "But it might have took a week for her to come to terms with what had
> really happened. Was she covering something else up or, you know, by
> not going straight away did she think it wasn't really very important or
> did it take the time to build up the courage to tell somebody."

This process of hypothesising and speculating about potential explanations as participants tried to locate themselves in the situations of the actors to the incident was a regular feature of responses to vignettes.

6.1.8   Case J – A Malicious Allegation?

An allegation of a young child being hit by a worker who was not working at the early years setting provided the content of this vignette. It was considered by five participants from the Northvale area consisting of a manager from the Primary Care Trust, two Head Teachers, a police officer and a children's centre manager. As with all the vignettes the scenario was presented in sections. The first section consisted of a description of the main actors and the information

about the allegation as originally presented to the manager by the parent. The next two sections were pieces of information already known to the manager relating to the worker no longer being at the location and of a prior event involving the worker which had a negative outcome for the child's mother. This presentation of the case information was the converse of the sequence in the original. It enabled the influence of prior knowledge to be explored in an alternate way to that in the vignettes of Case A and Case B where the prior knowledge was presented first.

The initial reaction to the allegation information was connected to information gathering for the majority (4) of participants. The initial thoughts of the fifth participant focussed on the behaviour being a disclosure of physical violence from which they progressed direct to referral to the local authority designated officer. The three actors in the scenario featured in the first thoughts of four participants with two focussing on the worker although for one this was an indirect reference as they formulated the questions they would want answered in relation to the incident. One participant wanted an account from the mother and grandmother, followed by information from the child and worker. This was the only participant who included speaking to the child in the course of the consideration of the vignette. Another participant who's first expressed thought related to the child was querying what more information the child could provide. They did not proceed with this train but shifted their focus to seeking an account from the worker and subsequently described contacting children's social care in advance of speaking with the worker. At a later stage they returned to the matter of speaking with the child again in cautionary terms and not as an action to be pursued.

The response of the majority (3) of participants to the behaviour as alleged was to quickly refer outside the organisation to the LADO. One participant described seeking background information that the agency held regarding the worker and child before taking this step. The remaining two described strategies of seeking more clarity regarding the allegation and its circumstances to establish its veracity before making a decision that referral on was warranted. One participant did not think that based on the information presented there was sufficient to take further. This was in contrast to another who projected it

forward into an investigation and identified the need to consider the criminal and disciplinary aspects.

In response to background information presented in the second and third sections of the vignette, which the manager in the original situation would have known, the approaches of participants changed. Once aware that the worker was not in contact with the child at the time of the alleged incident the strategy described by all involved a focus on information from the mother and grandmother and the agency held records. Two referred to the ethnicity of the worker and speculated whether there could be a racial motive to the allegation. The participants tried to make sense of why such an allegation could have been made. In doing so they posed questions and speculated from the perspective of the actors. The questions and ideas ranged from notions such as the worker seeking out the child to hit him, which the participant who offered it described as "far-fetched", to the more frequent consideration (3) of mistaken identity. A prior incident between the worker and family; something about the service that was concerning the parent; and the potential of the allegation being fabricated were also speculative explanations. The inconsistencies and gaps in information were predominantly described in terms of questions to be posed to family members. Review of agency records to confirm the whereabouts of the worker featured in two accounts while 'assessing the reaction' of the parent to information that the worker was not at the work site was highlighted explicitly by two and by description from a third.

The presentation of information back to family members varied. One described a quite challenging approach:

> "I'd say right, okay, if I investigate this fully, and I find that it's a malicious allegation then clearly that would have serious implications for you. But I'm not making this as a threat I'm just making you aware of it."

While the remainder of participants continued in the mode of seeking information and trying to make sense of why, and in what circumstances, the allegation could have arisen:

> "It's then a case of going back to the parents and saying well our initial indications are that Haz wasn't there, is there any more information that you can give us in relation to it."

"So I, I need to talk a little bit more to Joe's mother and grandmother about, I need to tell them that I know that can't be, that it can't be possible and is there something else on their minds. Can they, you know, tell me a little bit more about what they think happened bearing in mind that it cannot have been this member of staff, and then I need to see what the, what the reaction is. .... I need to approach it in a way that they tell me what's really going on."

Guidance from the LADO in responding to the circumstances within the vignette was described by one participant while two identified that they would share with this officer their proposed strategy and seek agreement. For one participant this contact would only be made if the parent persisted with the allegation once aware that the worker was not working within the service when the incident was reported to have happened.

The final section which provided an explanation of an earlier incident involving the worker and family moved the participants into consideration of a malicious allegation. For two participants this was an immediate response to the history. For the remainder it became another factor within the decision process. One identified that despite the history it did not mean that the child had not been hit and described continuing with investigating the allegation including consideration of personnel information of prior concerns or allegations. For three participants full knowledge of the background information would have resulted in them not progressing enquiries about the allegation. Two participants did not rule out the alleged behaviour on the basis of the history and described progressing enquiries. For one this would be determined by whether the parent could provide any additional information to support the report of the alleged hit.

The role of external advice in relation to the allegation featured in the descriptions of four participants including it being "a multi agency decision led by the LADO" not to investigate. Other points of advice that would be sought were human resources and the union. The union contact was for support for the worker. The need to attend to the welfare of the worker in the circumstances of the vignette featured in all accounts. In some (2) this included support to take action against parents for making the allegation although there was a lack of detailed knowledge about any action that a worker subject to a malicious allegation could take. In the circumstances of a malicious allegation made by a

young person one participant felt that a malicious allegation would make it difficult to believe a future one even if "serious and genuine".

The influence of knowledge of the actors to the situation and experience of the setting was captured by one participant in explaining:

> "But it's easier if it's a member of staff, you know. I know my parents that are trouble. I know those that are likely to do something vindictive and something nasty. And you sort of, you can be pre-armed and pre-warned and you sort of have a feel for things beforehand don't you. Well you do when you've worked somewhere like this as long as I have."

The lack of this contextual knowledge of the situations and the personal qualities of the actors was identified to make the task of decision making more difficult.

None of the participants advocated suspension at any point in the vignette. The descriptions of actions by all participants included information being shared with the worker about the allegation having been received, the actions taken, explanations sought, and to provide support. The workers right to know what had been said and what had been recorded about his/her conduct and the importance of "keeping them in the loop" was identified within descriptions. For one participant this included informing the parent that the allegation would be shared with the worker. These features of the response to the vignette are in contrast to the events of the real incident.

CHAPTER 7: Key Findings and Reflections on the Study

7.1 Introduction

In designing the study it was anticipated that the descriptions of judgment and decision making by participants who were recounting their experience of real cases would have some differences from those responding to the vignettes. The real decision making was socially situated while the vignettes in being de-contextualised were devoid of the pressures of the working day, and the intimate knowledge of the setting, the workers, the children and young people and the organisation. The consideration of the same case information using the two methods provided a means of exploring these factors which would not necessarily be conscious to those immersed in the situational and environmental context when the allegations were originally encountered.

A frequently cited limitation of vignettes as a technique in research is the distance between the vignette and social reality (Barter and Reynold, 1999; Hughes and Huby, 2002). Integral to social reality is the continual interactions with others and the meanings derived from social relationships. For this study the combination of real instances and the de-contextualised vignettes of the same events served to reveal the influence of social relationships within the initial judgements and decision making when allegations were received. Assumptions made about 'knowing' the actors to a situation and their likely conduct was an influencing factor within judgements particularly when the alleged behaviour of the worker or situation was ambiguous. A second theoretical limitation put forward regarding vignettes is that they reveal only how someone may believe they would react and that this is not necessarily how they would actually behave (Hughes, 1998). In this study it was the consistency of responses from participants from different agencies within the same area which suggested that an established practice culture may exist based on local interpretation of the national guidance.

The chapter begins by discussing the three themes which emerged from a comparison of responses in the two phases of the study. The themes are the influence of personal relationships and prior knowledge in the decision making, the definitions of harm, risk and unsuitable conduct and how they are applied to

professional behaviour, and the influence of local interpretation of national guidance.

The second section of the chapter provides a selected reflection on the learning from the conduct of the study. Two principle learning points are discussed relating to the recruiting of participants during the fieldwork and an unanticipated factor of timing in the completion of the study which served to highlight the relativism of social policy research. The study concludes with consideration of the implications for practice of the findings from the study.

7.1.1 The Influence of Prior Knowledge

History and emotion are known to influence perception and cognition and are therefore important in decision making as already discussed (see Chapter 3). Schwarz and Clore (2007) suggest that feelings serve as a source of information in their own right. In relation to the study the narratives from participants would suggest that these feelings include not only the obvious elements related to the worker and child, but also the approach of the parents, loyalties to the organisation and its reputation, the type of behaviour alleged, and how a situation is appraised and the inferences drawn from individual accounts. The role that history and emotion played in determining the responses to the allegations is captured within the theme of prior knowledge. It includes that related to immediate preceding events and the prior knowledge of the individual actors to the incident, particularly the working relationship.

This influence of prior knowledge was most apparent in the two cases where an incident the previous day in one case, and expectation of an allegation in the other, preceded the allegation. For both these cases the majority of participants encountering them as vignettes adopted an approach different to that of the original. Within the judgements made the potential for the two actors in each situation to understand the other's perspective was identified to be more conducive to the interests of the young person and worker in the longer term. In one case the mother of the young person had expressed a wish to deal with the allegation 'in house' and reach a compromise. This was not however how the allegation was addressed and a formal response was pursued. Participants encountering the case information as vignettes responded to the content and

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details of conduct that constituted the incidents between the young people and the workers. Causal inferences that preceding events were the reason for the allegations did not feature in the judgement process. In actively disregarding the earlier information the participants reached a different judgement outcome and proposed a conciliatory approach. This would suggest that personal preconceptions can influence how a concern is understood. It is however recognised that in both 'real' cases the decision to refer to the local authority designated officer was as much a result of a fixed interpretation of the guidance as the coming together of two incidents and a value judgement about the young people's motivation for making an allegation.

The influence of prior knowledge was broader than that related to the two cases where identified events had preceded the allegation. The narratives from some participants included reference to 'knowing' their workers, and judgements about whether the conduct was in keeping with prior behaviours. For participants encountering the incidents as vignettes the relevance of worker's prior conduct and the young person's relationships with staff were an important source of information. Whether the incident was the first of its kind or followed previous management advice as part of a pattern was described as informing the judgement about the level of response required. The more ambiguous the potential cause or description of the incident the more frequent was expressed the importance of an employees work history. Beyond this, within the majority of responses to vignettes, was participants' conjecture that they would find making a judgement easier to deal with within their own services due to 'knowing' the actors in the situation. The relationship history with the actors and the assumptions it generated about knowing whether the conduct was likely were as much a consideration within the decision making as information gathered from the actors and other sources about the incident. Learning from institution and other abuse inquires involving professionals (Brannan, Jones and Murch, 1992; PSCB, 2010), and research with professional perpetrators (Colton and Vanstone, 1996), have however identified the difficulties of recognising the risks that a colleague may pose to children.

While there was a consistency within responses which supports the theme of the impact of prior knowledge on decision making one case did not wholly support

this finding. In the case of a parent alleging a physical assault against a worker not present, the participants in receiving the case details as a vignette were provided with historical information subsequent to details of the alleged behaviour. Having started to formulate hypotheses about the case and plans about gathering of additional information these were not immediately abandoned by all participants when the historical information was provided. The influence of the first information received appeared to result in a minority of participants persisting with their first response. In the original incident the manager had this background preceding the allegation. As previously noted the historical information did not result in a disregard of the allegation or produce a lesser or informal response to the original incident. The action taken was that for an allegation meeting the *Working Together* (HM Gov, 2010b) criteria. This was based on prior knowledge and experience of a separate case which had been significant for the participant and for the organisation over an extended period.

7.1.2   Problems of Definition

A second theme within the findings of the study is the problem, or at least uncertainty, regarding definitions of 'harm' and 'unsuitability'. The *Working Together* (HM Gov, 2006, 2010b) guidance states that when related to the behaviour of workers the threshold is below that of significant harm. Located within a discourse about 'safeguarding', which is a broader concept than child protection, the level or seriousness of conduct which could constitute harm or unsuitable behaviour is far from clear. The dilemma for managers in complying with the guidance, and which was a priority for practitioners who contributed to the construction of the study, is this question of the threshold of behaviours and actions that are included. The notion of degrees of abuse which underpins the concept of a threshold in relation to familial abuse is more difficult to apply to behaviours of people employed to act in the best interest of children.

The expectation within the guidance is that senior managers in organisations will determine whether conduct meets the criteria of harm, criminal or unsuitable. If it does not then the organisation can deal with the concern internally without recourse to the local authority. Identifying that one of these criteria has been met initiates referral to the local authority designated officer

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and a course of action which could result in the allegation, even if unfounded, appearing on the employee's future Criminal Record Bureau checks. This initial determination of whether an allegation meets one of the criteria is therefore of importance for the worker and the organisation which will need to report on progress and outcome. It is also of importance for the child or young person who does not have equal power or status to the adults employed to provide care, support, instruction or education. Their ability to influence the definition of the problem beyond making the initial report depends on the early decision made. How an interaction or event is understood, if and how it is defined as a problem, how it is described and discussed when relayed on, and what is seen as an appropriate response are key responsibilities for the senior managers in receiving and responding to an allegation. Individual perceptions and values become central to the decision making as reactions to human behaviour are influenced by elements other than just the behaviour.

As already discussed the socially constructed nature of child abuse involves decision making which is always subjective and relative. 'Harm' and 'unsuitable' are not fixed or objective states uniformly understood across, or even within, professional groups. Horwath (2000) has previously identified that there is no agreement between workers and managers, even within one professional group, about what constitutes abusive behaviour. The experiential accounts from participants in this study, and the response to vignettes, would suggest that understandings and perceptions of all but the most serious are as much about the meaning attached to behaviours as the behaviours themselves. Participants in responding to the vignettes identified 'intent' as a determining factor in the level and type of response required to some of the physical behaviours. This is at odds with findings of other studies which although focussed on institutional abuse have identified that 'mitigating circumstances, intent and severity' (Barter, 1999) or if the abuse occurred accidentally (Thomas, 1990) is irrelevant.

Consideration of the actual harm that the children or young people experienced was not a significant feature within the decision making. Intent on the part of the worker, speculative projections about what could have happened, recognition of poor or naïve practice, and reputation maintenance featured within the

narratives of the real incidents and participants responses to the vignettes. The one serious physical abuse allegation and those of a sexual nature produced the greatest degree of consensus. For the young person alone in a taxi with the driver, as soon as the story included physical contact of tickling and touching her knee participants immediately moved this into the formal allegations procedures. The importance of not intruding into a situation which could require a child protection investigation was prioritised in responses. The remaining three cases of physical contact and the child left in a car unsupervised attracted mixed responses highlighting the difficulties of determining what constitutes 'harm' and 'unsuitable' in the absence of an actual harm having been perpetrated or occurred.

The language and terminology of abuse and neglect when used to describe conduct which falls short of appropriate or good practice creates tensions within this area of safeguarding practice. The words 'harm' and 'unsuitable' are highly emotive when applied to low level inappropriate or naive conduct. So too is the word 'malicious' when used to describe a young person's account of an incident in which they feel they have a grievance but in which they may not have been subject to abuse or experienced actual harm. The descriptions of behaviours carry different meaning and nuances depending on whose perspective an incident is viewed from. The word 'kick' sounds very different to 'a tap' and while both involve the same action reflect different emotional and value responses to the same event. When subsequently categorised and recorded as an allegation of physical abuse the incident takes on a different meaning again. The formal naming of low level concerns in terms of child protection categories of abuse would seem to overstate the level of risk and harm involved. The sample of cases considered within the study is small but does suggest that the application of the procedures to low level concerns rather than attempts to mediate an understanding may not always serve the best interest of either the young person or the worker.

7.1.3 Agency Policy, Local Procedures or National Guidance

The *Working Together* guidance advises that the procedures are applied with 'common sense and judgement'. It goes on to state that:

"However it is important to ensure that even apparently less serious allegations are seen to be followed up and that they are examined objectively by someone independent of the organisation concerned" (HM Gov, 2010b Appendix 5 para 14).

Within the guidance this is identified to be the local authority designated officer if the allegation meets one of the criteria of harmed, criminal offence or indicates that the person may be unsuitable to work with children. Senior managers in organisations are attributed the task of determining whether reported conduct of staff meet these criteria. If it does not then the concern raised can be dealt with internally by the organisation. The *Working Together* national best practice guidance is however interpreted and implemented at a local level.

Local interpretation and local training and practice emerged as being factors within the decision making of the cases explored in the study. This is consistent with studies of familial abuse which have revealed that local thresholds for access to services and numbers of children with child protection plans vary between areas and workers (Spratt, 2000; Christopherson, 1998). The study identified differing patterns of response to types of conduct which varied more between the two areas than between different professional groups. The resort to pushing the decision making 'up' was a feature in the Northvale area in relation to the original decision making and in response to the vignettes. This same practice was not a feature of descriptions by participants from Southborough.

While participants from both areas reflected a process of consulting with others, participants from Northvale described the following of instructions and the making of non-decisions with responsibility passed to the local authority designated officer and deferring the decision regarding the type and level of investigation to a multi agency meeting. This reduction in professional autonomy could be seen to reflect what has been described as the 'proceduralisation' of child protection (Parton, 2006). Procedures provide a set of rules derived from formal knowledge to be applied to individual instances or cases. Within areas Local Safeguarding Children Boards have responsibility for 'developing policies and procedures' based on the national guidance including those 'to ensure that allegations are dealt with properly and quickly' (HM Gov,

2010b, par 3.22). This allows for local interpretation of the national guidance to be translated into local procedures which are relayed to practitioners within training. The study did not set out to examine the way in which the two areas had chosen to interpret the national guidance but it emerged within interviews as participants described both their decision making process, and prior experience and training about allegations management. Some participants described that there was a need to be seen to 'do the right thing'. This notion has previously been captured by Howe (1992) and Dingwall et al (1995) in terms of making a 'defensible decision' in relation to child protection generally. While Jones and Gupta (1998) have identified the weakening of professional confidence and autonomy as a result of the culture of blame that operates around child protection.

Research commissioned by the Association of Directors of Children's Services to explore safeguarding pressures (Brooks and Brocklehurst, 2010) included that three local authorities in identifying reasons for the increase in safeguarding activity specifically named the more formal responses to allegations against staff. It is unclear why three out of eighty seven local authorities identified this aspect of safeguarding work and whether it may reflect a particular application of notification requirements to the local authority designated officer producing higher reporting. In the two areas that featured in this study the rate of reporting in the Northvale area was double that in Southborough when considered in relation to the child population.

Within the nine cases that formed the source material for the study were two cases that were initially dealt with outside the LSCB allegations procedures. Both were dealt with internally by the organisations in which the allegations arose, robustly and without delay and resulted in disciplinary actions against the workers concerned. In both cases the workers were immediately suspended and one was subsequently dismissed. Neither of the organisations had knowledge of there being formal procedures for the management of allegations. It would appear that even in the absence of such knowledge that awareness of risk to young people, when brought to attention, can produce a response which seeks to minimise the risk for both the young person and the organisation. The notification to the local authority designated officer which followed the

organisations' initiation of their disciplinary processes did not change the outcome. In one case a disciplinary hearing had already been convened within a week of the allegation having arisen. For the other case the establishment was a commercial organisation unfamiliar with requirements around the safeguarding of children. The young person on work experience was afforded the same protection as an employee with her concerns taken seriously and acted upon.

In considering the three themes which emerged from the study it would seem that an approach which focuses on the best outcomes for the child or young person may provide managers with more flexibility in interpreting and responding to the actions of workers. Whilst the welfare of the child or young person needs to remain central to the processes it may be that using formal responses for only those incidents involving actual or likely harm may better serve their best interests and that of people working with them.

7.2   Reflections on the Study

In concluding the study it is necessary to review the aspirations at the outset and to reflect on what was achieved and how the study could have been improved. In this final section the reflections which have been ongoing throughout the conduct of the study are captured within three elements. The first concerns the recruiting of participants for the study which provided a valuable learning point within the fieldwork. The second involves the issue of timing both to complete research and for the relevance of the learning. This aspect was not considered in any detail at the outset but due to social policy developments became a factor as the study's conclusions coincided with renewed political attention to the arrangements for the management of allegations against people working with children. Finally some reflections on the key messages for practice are presented suggesting issues that may merit further exploration by professionals involved in the management of allegations and the Local Safeguarding Children Boards with responsibility for the effectiveness of local practice.

7.2.1 A Matter of Design

The aims of the study developed with practitioners have been fulfilled. The study has captured a small sample of real allegations made against

professionals. The participants' narratives and the analysis have made available to others the processes of judgement and decision making which precede referral into the formal Local Safeguarding Children Board arrangements. These reveal referral of a range of behaviours from serious physical assaults to ill-informed practice and include an allegation made by a parent which appeared to be without substance. The description of responses to the real cases and vignettes has provided some understanding of the influence of the local context along with the emotional and moral judgements about behaviours and individuals which influence decisions. The study did not seek to determine what level of seriousness should or should not be included within the formal allegations arrangements. Participants were prepared to share their experiences of receiving and responding to an allegation and make this practice available to others The considerations of participants regarding what they would do faced with the same situation opened up debate as to whether there was anything different that could have been done in the circumstances. This was done without attempting to assess the effectiveness of the practice described.

While achieving its central aim, the study, if it were repeated, could be enhanced by inclusion of a broader range of allegations from which to explore the dilemmas in decision making for managers. The initial planning had included a larger sample size for the first stage of the data gathering. Slow recruitment of participants, as explained within the fieldwork section, prompted a modification of the study plan. This limited the instances of real allegations, the forms of abuse, variations of seriousness and organisations represented. A larger number of allegations than had been anticipated were referred indirectly. The nature of the data being sought excluded these allegations thereby reducing the potential participation in the study.

The existence of prior working relationships with the local authority designated officers resulted in some complacency on my part in maintaining the relationships with these 'gatekeepers' (Denscombe, 1998) to the field of study. Once the initial discussions had taken place and their support enlisted the ongoing contact between participants being referred was minimal. Burgess (1984) identifies that access is a continual process, a point developed by

Denscombe (1998) in identifying that it should be viewed as an "access relationship" because access is renewable not a single event. A greater investment in the relationship with the gatekeepers is one of the learning points from the study and a greater presence within the team who had direct contact to the field.

In addition in relation to the analysis of data, an earlier introduction and practice with the qualitative data analysis software programme QSR NVivo 8 would have enhanced fluency in its use. This would have aided fuller use of the capacity of the software programme and may have added to the findings reported.

7.2.2 A Matter of Timing

The brief history of abuse by professionals (Chapter 2) concluded at the end of the Labour administration. It did so because child protection work as a whole became the subject of a major independent review (Munro, 2010, 2011a, 2011b) initiated in June 2010 by the new Coalition Administration. In a separate process the management of allegations also became the subject of renewed political attention. The Conservative support of the NASUWT campaign for the anonymity of teachers facing an allegation has a long history (Barnard, 2000), having been proposed previously as an amendment to the Sexual Offences (Amendment) Bill, in 2000. During 2010 it found expression within the Coalition policy outline (HM Gov, 2010a) with a promise of anonymity for teachers facing allegations and "other measures to protect against false accusations". This was presented alongside messages about strengthening discipline and returning authority to head teachers. These measures subsequently featured within the Schools White Paper (DfE, 2010a) and the Education Bill laid before Parliament on the 26th January, 2011. The Bill included extending authority to search pupils for materials identified as "likely to be used to commit an offence". A survey by the Association of Teachers and Lecturers during September 2010 of two hundred and twenty members reported that forty one per cent thought that the extension of search powers would lead to a worsening of relationships with pupils. Almost thirty per cent anticipated a negative impact on relationships with parents and carers and a rise in the number of allegations against staff (ATL, 2011).

The Schools White Paper stated the intention to issue a "short, clear, robust guide" regarding teacher's powers to use reasonable force, powers which had been re-stated previously in the *Education and Inspection Act, 2006* (HM Gov, 2006c). In relation to the powers to use force and restraint the White Paper referred to a survey of four hundred and two schools which revealed that almost half had a 'no-touch' policy (Piper, 2006). It suggested a lack of confidence of teachers in using these powers and fears of malicious allegations. Responses to a Freedom of Information request by over half the local authorities revealed that during 2009 there were one thousand seven hundred allegations against school based staff, more than half of which were of physical assault or inappropriate restraint. One hundred and forty three staff members were dismissed or resigned and two hundred and two were subject to disciplinary procedures. A low level of malicious intent from complainants was noted with fifty allegations recorded as being false or malicious (BBC, 2010). The nature and number of allegations, and the frequency with which they are substantiated, unsubstantiated, false or malicious, in the absence of centrally collected national data, remains a matter of debate. The figures quoted appear to vary according to the argument being presented.

The White Paper proposed further guidance to ensure that allegations do not automatically lead to suspension, reporting that "many head teachers" had felt the only option was to suspend a teacher while investigating an allegation. The multi agency guidance (HM Gov, 2010b) does not advocate suspension unless the allegation meets a threshold of potential significant harm, criminal action, or of a seriousness to warrant dismissal. This small scale study would suggest that factors such as dissemination of accurate information about the details of the national guidance and encouraging confidence in decision making when conduct is of a lower order of seriousness are as important to this process as the issuing of more guidance. There have however been six new guidance documents for schools issued for consultation on the 4th of April, 2011. Published under a heading of 'ensuring good behaviour' they include 'screening, searching and confiscation', 'use of reasonable force', 'behaviour and discipline' and 'dealing with allegations' (DfE, 2011b).

The Schools White Paper had implications wider than the schools workforce. It included that consideration would be given to applying some of the measures to the wider children's workforce. These may include the removal of a requirement for employers to disclose malicious or untrue allegations when providing a reference and introduction of reporting restrictions that will prevent a teacher, or other professional's identity being revealed until the point they are charged. Underpinning these measures is the suggestion of a large numbers of malicious allegations by young people (NASUWT, 2009), an argument not supported by other reports (DCSF, 2009; BBC, 2010). The findings of this study would suggest that low level concerns are being included in the formal responses to allegations. It may be that through increased autonomy and confidence in the initial decision making that such incidents could be dealt with internally within the organisations. The potential for mediated outcomes would reduce the need to formally categorise the outcome as founded, unfounded, malicious or untrue which can create barriers between young people and those who work with them. This has increased importance as the guidance document issued for consultation on the 4th of April, 2011 to the schools sector on *Dealing with Allegations Against Teachers and Other Staff* (DfE, 2011b), included sanctions such as exclusion if allegations are believed to be malicious and refers to the use of powers under the Protection from Harassment Act, 1997 in relation to unfounded or malicious allegations.

The outcome of both the review of child protection and of the passage of the Education Bill 2011 has, at the time of writing this report, still to be seen. These developments and the changing political context provide a reminder that the arrangements which have been the subject of the study are a product of their time and that the professional response to allegations as captured within the descriptive accounts are symptomatic of a broader range of issues. The interventionalist approach which created prescribed procedures is being challenged by a discourse about reduced central prescription, reduced bureaucracy and increased autonomy for professional groups such as teachers and social workers. Changes to the statutory guidance with a reduction of prescription are being proposed (Munro, 2011a, 2011b) while the language of safeguarding is giving way to a return to child protection (DfE, 2010b) with its narrower focus on risk and harm. The completed study is therefore concluding

at a time of debate and change in the practice that has been the focus of the study. In providing the particularised knowledge from participant's narratives of their contextually informed experience it is hoped that the findings will contribute to the debate as practice is considered and changes introduced.

7.2.3 Implications for Practice

In reflecting on the implications of the findings for practice the small scale nature of the study is recognised and that practice will vary as much between Local Safeguarding Children Board areas as was found between the two areas that hosted the study. The findings do however provide pointers for practitioners and Local Safeguarding Children Boards to consider in relation to local practice. The first of these concerns the incidents of reported allegations amongst specific vulnerable groups. The sample of cases was too small to draw any conclusions about the children who make allegations or professionals against whom they are made. The cases did however include a disproportionate number of children with special educational needs and children in the care of the local authority compared to the child population. There could be many reasons for this. Local attention to the frequency of allegations or practice concerns for specific groups of young people may help inform Local Safeguarding Children Boards about the training needs of staff in contact with these groups of children.

A second key message from the study was the impact of the translation of national policy and guidance into local procedures. The study found that the influence of local procedures, and the messages and training delivered when they are disseminated, were significant factors in professional responses. While this is the purpose of procedures the study findings suggested that when too prescriptive they do not allow for professional judgement and autonomy to respond flexibly in the best interests of children. The rigorous response to incidents found amongst participants who were unfamiliar with the allegations management procedures suggests that the promotion of sound basic safeguarding children principles supports good practice. Amongst these principles the study findings would suggest including an awareness of the potential for flawed judgements if based upon personal relationships and expectations of 'knowing' workers, volunteers and paid carers, and what they

may or not be capable of. The historical perspective and research with professionals who have abused children provide a reminder of how adults in positions of trust have abused children over extended periods undiscovered.

The tension between the ongoing revelations of abuse of children by people in educative and professional caring roles and the professional associations' presentation of large numbers of malicious allegations would seem to be reinforced by the inclusion within the formal processes of low level incidents. Local Safeguarding Children Boards in responding to these findings may benefit from considering whether the level of incidents reported in their area as allegations meet the threshold of seriousness to which all professional groups can commit. Effective implementation of the *Working Together* (2010b) allegations management processes is central to ensuring a rigorous and robust response when incidents occur that have caused harm to a child, involve a criminal offence or indicate that a person is unsuitable to work with children. Their application to incidents that do not meet these criteria has the potential to undermine their effectiveness by fuelling a negative portrayal when young people raise concerns about aspects of the services they receive.

Appendix A

Title: Request to host research on decision making when allegations are made against people who work with children

Author: Caroline Rhodes

Date: 17th October 2007

Status: Request

Confidential: No

I am a student undertaking a professional doctorate at Sheffield Hallam University. I am proposing to undertake a study exploring the initial judgements and decision making of managers in LSCB organisations when faced with an allegation against a member of staff, volunteer or paid carer. While much has been written about decision-making and thresholds for intervention in response to abuse of children within their families, there is an absence of research into the complexities of the decision-making when abuse is alleged by professionals or volunteers working in children's services.

The study aims to:

- Provide insight into the behaviours and actions of people working in children's services which are being reported into the formal arrangements for managing allegations; the types of behaviours reported and how they are viewed and understood.

- To make available detailed information about the sources of knowledge, organisational expectations, assumptions, or other factors which inform the judgements made by designated senior managers in children's services when making decisions about allegations of abusive, criminal or unsuitable behaviour by staff or volunteers towards children.

- It will consider if there are organisational differences in the factors taken into account and the thresholds that are being applied in different statutory and voluntary organisations when concerns are raised about the actions and behaviour of staff.

- It will explore the wider social and organisational responsibilities and tensions for managers faced with allegations against fellow members of the children's workforce.

The study will be qualitative, explorative and descriptive. It is intended to gather data by means of semi structured interviews with managers within two LSCB areas regarding their decision making in response to reported allegations. It is proposed to use a sample of ten cases from each of the LSCB areas. Anonymised vignettes will be constructed from these real cases to provide the material for further interviews with the managers. Access to case recordings will be sought to provide additional data regarding how the allegation is framed, and what is understood as it is reported between organisations. No personal identifying information regarding the child, family, or person against whom the allegation is made will be recorded. The focus of the study is the decision making of the managers not the individuals involved in the alleged incident. Interviews with managers will be audio recorded for accuracy.

Participation in the study will of course be optional for managers referring allegations against staff. Informed consent will be obtained prior to the managers' details being provided for inclusion in the study. I will inform the managers of my professional background but that I am undertaking the study as a student. There will be no attempt to mislead or deceive the participants. I will remain aware of the position of the participants as senior manages in organisations and of the research effect of being asked to explain their decision making. Following the interview I will provide a transcript of the recording to the managers.

I will fully comply with the Department of Health's Research Governance Framework for Health and Social Care. Independent Scientific Review will be carried out by Sheffield Hallum University which will include a risk assessment. At the outset of the study it will not be known in which organisations allegations may arise during the study period. In view of this the requirements of the National Research Ethics Service, NHS, for ethical approval will be fulfilled (NRES, April, 2007). The research will be entered on the

National Social Care Research Register and I will provide my most up to date Criminal Records Bureau check to the XXSCB Chair and Manager.

What is the benefit for XXX Safeguarding Children Board?

At the conclusion of the study XXSCB will have available for scrutiny and debate a detailed descriptive narrative of the managers' accounts of their decision making, the factors and knowledge which inform and impact on the decision making, and information about the organisational variations within the participating organisations.

Recommendations

1. The XXSCB to formally agree to host the proposed research.

2. The XXSCB recommend participation in the study by member organisations.

Sheffield Hallam University

Participant Information Sheet

A study of decision making when allegations are made against people working with children

Caroline Rhodes, Research Student, Sheffield Hallam University

Tel no: 0787 6146334 or caroline.rhodes@goyh.gsi.gov.uk

I would like you to participate in a research study which I am undertaking for educational purposes. Before you decide you need to understand why the research is being done and what it would involve for you should you agree to participate.

Purpose of the study

The study is about the initial judgements and decision making of managers in Local Safeguarding Children Board organisations when faced with an allegation against a member of staff, volunteer or paid carer. While much has been written about decision making in response to abuse of children within their families, there is little research into the complexities of the decision making when abuse is alleged by professionals or volunteers working in children's services.

The study aims:

- To make available to L.S.C.Bs. information about the behaviours and actions of people working in children's services which are being reported into the formal arrangements for managing allegations; and
- To provide detailed information about the knowledge and factors which inform the judgements and decisions made by managers in the different LSCB agencies.

This study has been endorsed by the Local Safeguarding Children Board.

What will participation involve?

If you agree to participate in the study it will involve two interviews of 60 – 90 minutes in length. These will take place 4-6 months apart.

The first of the interviews will focus on the decision making process in respect of the recent referral you have made to the Local Authority Designated Officer regarding a member of staff. The second interview will focus on similar incidents that have been referred by other managers in LSCB organisations. It is intended to involve twenty managers from two LSCBs in the study.

The interviews will be audio recorded to ensure accuracy of the information. You will be provided with a transcript of each of the two interviews. The audio recordings will be destroyed at the completion of the study.

What will happen to the information?

All information that is gathered as part of the study will be handled and processed in accordance with the Data Protection Act, 1998. Information will only be used for the purpose of the study and will be stored securely. The confidentiality of the information about the allegation you have reported will be maintained. A verbal recording of the alleged behaviour or incident that prompted your referral will be made but no information will be sought or recorded which will identify the individuals involved in the incident.

Your interview when transcribed will be assigned a code. Your details will not appear within the data or final report. The content of the interviews will feature within the report prepared for academic purposes and for the LSCB. This will include direct quotations and passages which you will be able to identify but which will not be identifiable by other people. You will be provided with a copy of the draft analysis of your interview and given an opportunity to comment on how your information has been presented.

What if there is a problem or I wish to withdraw?

Taking part in the study is entirely voluntary and you are free to withdraw at any time without giving a reason.

If you have any concerns about the study or comment or complaint about the way you are dealt with during the study your concerns will be addressed. The LSCB Chair/Manager......................... can be contacted at ....

What happens next?

If you wish to participate in the study please enter your name and contact details on the Consent Form you have received with this Information Sheet and return it to the Local Authority Designated Officer. This will be forwarded to me and I will contact you to make an appointment to meet as soon as possible.

If you do not wish to participate in the study you need do nothing further with this form.

If you are unsure and there is any further information you would like about the study in order to decide whether or not you wish to take part please contact me. My contact details are at the top of this Information Sheet. Alternatively you can discuss it with the Local Authority Designated Officer.

Thank you for your attention to this invitation to participate in the study.

Sheffield Hallam University

Participant Consent Form

A study of decision making when allegations are made against people working with children

Caroline Rhodes, Research Student, Sheffield Hallam University

Tel no: 0787 6146334 or caroline.rhodes@goyh.gsi.gov.uk

Please initial box

1. I confirm that I have read and understand the information sheet dated 20th November 2007(01) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I understand that the interviews will be recorded.

4. I agree to take part in the above study.

_____   _____

Name of Participant   Contact Details

_____   _____

Signature of Participant   Date

_____   _____

Signature of Researcher   Date

When completed, 1 copy given to participant and 1 for researcher site file.

Appendix D

Sheffield Hallam University

Interview Schedule

A study of decision making when allegations are made against people working with children

The interview will include the following areas in relation to the allegation against a staff member/volunteer which you have recently reported to the Local Authority Designated Officer. Some of the issues may not be relevant to you and can therefore be omitted. There may be additional issues which from your experience you have identified as important to the decision making process. These are very important to the study. The list provided below is just a general guide for us to use and does not limit the content of the interview.

I am interest to hear about:

  a. the context of the allegation when brought to your attention;

  b. the allegations content and context;

  c. the process of determining what action to take, from initial reaction to referring it into the formal procedures, including the knowledge or any guidance used;

  d. whether you consulted other people and in what ways this affected the decision making;

  e. any previous experience or training regarding managing allegations against staff and how this was used to inform the decision making process; and

  f. issues you identify as important in relation to your role in managing allegations, or this study.

Appendix E

Participants' Descriptions of Their Experience and Training Code from NVivo

<Internals\1st Interviews\Interview A> - § 5 references coded [10.35% Coverage]

Reference 1 - 0.86% Coverage

I think we do need training because I think all of this ... I mean the new Working Together procedures is not long in and we've not done any specific training on that and so we all base our experience on our previous experience.

Reference 2 - 3.72% Coverage

And so.... my other role because XXXX is so small   there are only three of us at this level and so I also have agency decision-maker role for fostering in XXXX so I see the other end so any of the investigations that go through the full procedure and eventually come to fostering panel for a recommendation about whether they should continue as foster carers or not   ultimately comes to me for a decision. So for example about 18 months ago   a recommendation came back from Panel and I was actually unhappy about it.   I actually felt that Panel didn't have all the information that they should have done; and they actually made a hung decision   they actually wanted more   a longer process and investigation which I sort of agreed with them but I actually felt these foster carers should be suspended during the course of the investigation rather than carry on. We got an independent investigator in to have a look at it and ultimately those foster carers where deregistered   de-approved or whatever.

Reference 3 - 2.88% Coverage

So when I asked about training you talked about it just generally but in relation to you and your decision-making in this case I don't know if you've had anything specific training?

We've not had any specific training. No

Or whether it's experience and just general knowledge?

Yes it is   yes yes well all your historic child protection training comes into play doesn't it obviously.

Right

But apart from that we've not had any specific training on this   I suppose that helps having..... having an experienced LADO (laughs) in the organization. But no I think we... I think it would help particularly with some of the ......because we chair the strategy meetings for the other professionals so if there's an allegation against a teacher or a school person.

Reference 4 - 1.25% Coverage

It's perhaps difficult really to be clear about what it is that influences and the other thing because you bring everything on board with you   you bring all that practice all those years of practice behind you and sort of all those bits of training that you did over the years sort of all add up to the reason why any decisions are made.

I mean I ......I would have liked training on allegations against professionals I mean I think that would've been hugely helpful (laughs). It does worry me sometimes that things come in so quickly and especially small local authorities don't have the capacity to be able to respond to everything that comes in. We sort of do things by the skin of our teeth a lot of the time   but I don't think for that there are any poorer decisions made.

<Internals\1st Interviews\Interview B> - § 4 references coded [6.59% Coverage]

Right it's two things really (laughs) it's a lifetime of experience (laughs) and training right er   The experience part (pause) I've been teaching for 30 years   yes 31 years now and and during that time I've been since 1989   so that's nearly 20 years I've either been a Head of Year or then someone amongst the senior leadership team and as a result of that I've had lots of dealings with various incidence involving such students or students with staff   and when you have an incident like that you've always got to sort of have witnesses and have statements so I'm use to that type of witness gathering.

But then also within the Local Authority er they've put on training in child protection and in particular recent training with regards to safeguarding that's been put on by the Local Authority Designated Officer.

Right.

And I've been to those sessions so that was why then I also knew about the fact that this is now seen as significant because of course at those erm sessions it was then said by the Local Authority Designated Officer any allegation against a member of staff has to be reported.

But it has to be reported   so that was how I   I knew about it   as well as from the experience point of view. There was also that other element of having been on that course   cos probably with not going on the course   I suppose the thing I wouldn't have done would have been to pick up the phone and told him on the Monday that there had been an incident. I might have done that later on obviously after I'd had the meeting with the parent on the Tuesday and then, because that wasn't a productive meeting   it was not a meeting of minds (laughs) at that meeting so I therefore may well have er contacted him after that.

Right

But I think the fact that I'd been on the course and therefore contacted him beforehand I think was the best thing because then it wasn't like I'd tried to sort something out myself and then alright that's failed so then ring him. I'd actually contacted him first before any meeting took place.

I think the key thing really is people making sure that they have been on that course with regards to safeguarding which all local authorities I believe now run. I assume that's what happens 'cos our Local Authority runs it.

<Internals\1st Interviews\Interview C> - § 7 references coded [15.82% Coverage]

So to set it all in context because I'm going to talk about the most recent one but I have done a number of these. The big one was my Deputy Head an accusation was made against my Deputy Head in June 06. At that point I knew nothing about procedures I knew nothing about procedures because it was never anything which I had encountered. It was through that experience that I learned the procedures.

I had been through a trial a court case against another member of staff I knew the procedures upside down inside out and had actually done presentations to other colleagues on the procedures with the Safeguarding Board. So I have more of a managerial perspective of how to manage an incident. I've actually done quite a few presentations to different people and spoken obviously not about my first experience 'cos one couldn't do that but just about how to manage an incident. And that's why I knew that decision had to be referred on. But I'd been on the training I've had training about it all Heads and line manages have had and we have route maps and referral maps but I just knew it had to go. I think the phrase that stuck in my mind from the training is compliance is not an option.

That's the little phrase that I have kept at the back of my mind that I know that if there is something physical alleged to have happened between a child and an adult it must go compliance is not an option you just take it straight forward

Other Heads may have received this and if they haven't had my experience they may not have been so clinical and clear about how to deal with it and I hope that by doing some speaking to groups of Heads and Managers that they can actually think oh I remember her talking about this saying compliance isn't an option that you must at all times report it up.

There was never any doubt that this had to be reported because I'd spent two years in the middle of this very public it went national it hit the TV it hit the papers the radio the lot and every step along the way I had worked with

professionals and realised the value of following procedures and that they are there to protect everybody.

If we go back to the first case on the Monday this is not this case this is the one the year before the allegation was telephoned to me on the Monday afternoon by HR and Social Services and a strategy group was convened. I went along with total disbelief as I think 95% of Head Teachers would. It was a massive massive allegation. By Wednesday my office was crawling with police demanding things and at that point I realized that I was a very small player in this and that I just had to make sure that everybody had what they needed. And I realized at that point that you follow procedures you don't try and do it your way. And I think because of that magnitude of that experience that the next time it came up I went straight through with it.

And that's based on my experience because in the first case we saw a little tip of the iceberg and gradually things were peeled back and peeled back and peeled back and the whole picture appeared months later. I suppose I've learned that you may have a little chip or a little piece and not to assume that that is the entire situation. That may be just be one little corner and other things may be revealed I've learned that as well. Don't just accept everything full stop. It may be indicative or a sign or it may be a key pointer to something else that's what the first case taught me

Well I've done with the departmental and multi agency Safeguarding Board training and I've done sort of refresher training.

Is that around the allegations process against foster carers?

No it's general safeguarding multi agency training and I've done that in the past and I've done the ....I've repeated it as a refresher.

Right

When the allegations against carers staff volunteers and carers came out there was a presentation on those procedures at I think it was at our city wide managers meeting anyway there was a presentation introducing the procedures.

Right

Obviously we were expected to become …should familiarise ourselves especially from fostering because it's much more relevant within fostering than it is to the general fieldwork population and unfortunately I've already had cause to use them ..on a number of occasions.

Reference 1 - 2.15% Coverage

Because at this point we really didn't think it was a child protection issue. We'd followed procedures we'd even phoned up the guy that is responsible for the policies and procedures at our national office and it was all considered it wasn't a child protection issue. We thought we'd done everything we possibly could. From checking everything out it didn't appear to be a child protection matter.

Right so from your experience it didn't appear to be a child protection matter.

No at this point I did get a statement from the mother (looks through file) if I can find it (reading notes) She was very grateful that we were looking into the situation. She ….let me see…she said that the support worker was very upfront on his return when he took the child back….(reading own notes)

Reference 2 - 1.40% Coverage

I felt ..I knew that she had to know the information and she knew that I was green anyway   I think. But I did get.. she did thank me in front of the Trustees for doing a good job. She sort of let me take the lead but she would have stepped in had I not done it right   I know that   if I'd not followed the right procedures. So she was aware and I could tell her ears were pricking up every time there was a conversation or I was doing anything   but I felt confident doing it   I felt as if I was doing the right thing.

Reference 3 - 0.98% Coverage

I haven't had training no but I do know about that. I used to do the admin here so I am aware of the policies and procedures because I use to read them and I know where they are. I can't remember them all but you sort of pick up if something isn't right and I think I'll just check that out I'm sure I've read that somewhere but no I've not had training.

Reference 1 - 1.76% Coverage

I've had a similar incident or there was an incident an allegation last year   of which I   as the representative responsible for transport   became involved and Xxxx (LADO). I met Xxxxx (LADO) then for the first time   having again not really known where to pass information   but ….Xxxx who I work along side who is Head of Access he had suggested we speak to Xxxxx (LADO) on that stage. And so I then went through the whole process with him and I was very clear that if I had any queries about safeguarding children and protection that Joe really should be the person I called.

Reference 2 - 0.99% Coverage

I'm not sure have you undertaken training specifically around managing allegations.

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No

Right

I'd welcome it though (laughs)

Right

I'll like to separate the emotional bits (laughs) from the policy and procedures definitely. Certainly we are going to set up some training for the taxi drivers which I'll attend but that will be in terms of awareness raising for them. Yes.

<Internals\1st Interviews\Interview G> - § 6 references coded [14.80% Coverage]

Reference 1 - 1.23% Coverage

I think it depends again on what sort of person you are yourself as to whether you sort of look at things very matter of fact which is how I am. And I sort of looked at things and I was quite confident in my own mind that I didn't think the member of staff was a danger or anything like that. Whereas Ruth was getting the parent and she was sort of feeling a little bit frustrated as well   because it was 'what do you want us to do', 'tells what you want us to do and we will do it'. But Mum didn't know what she wanted us to do.

Reference 2 - 2.34% Coverage

So again I spoke to Xxxxx (LADO) and he said to me you know you've got different people and he said to me what are the staff like. And said I can tell you right now they wouldn't cover from for her   they would not cover for her. And he said no.

So that was all part of your thought process?

Yes I suppose had it been a member of staff and the only person there who had witnessed anything was her best friend then you might think well is she covering for her; and that puts another doubt there. But there were four members of staff and I know every one of those members of staff would not have covered for **that** member of staff.

Right.

So I was pretty confident.

So knowledge about your staff group informed some of your decision-making as well?

Yes yes I suppose knowledge of your staff to know whether you think they would cover for another member of staff. I mean they shouldn't even if it is their best friend but you know human instinct is that you cover for people don't you. But I was 100% sure that they would not cover for her.

I think the fact that I've dealt with parents and children for such a long time maybe helped but nothing particular. I've never ever had an allegation against any of my staff before so that was totally new. I've done my safeguard and I've done my enhanced but I don't think any of that really helps. That's more towards signs to look for if a child comes to you. I don't feel that particularly helped me in any way. I think it was just sort of   you look at it and you think right then what can I do. Above all   well not above all   but   along with protecting the child   and listening to the member of the staff   protecting the nursery   protecting my business. If something like this is true   and it all goes to court and it all gets out that could ruin us. So you've got that in the back of your mind as well and its sort of I've got to get to the bottom of it I've got to know. Right   what do we do? I can only speak to the people who were here 'cos I wasn't here. I've got to build up a picture and find out what's gone on. I've got to speak to the parents because I hadn't spoken to the parents at this time when it was first going through my mind. And then I will ring this advisory line because that's why they've given us this card and the number to do so, and I will just check that I am doing everything that I should be, there's not anything else that I could be doing.

So were you aware that there are specific procedures around allegations?

No I didn't know there was. No I didn't know there was but I just presumed that there would be something there (laughs). I didn't know what they were   and I just presumed there would be something there and so said I will take advice and it may lead to the fact that you may have to be suspended but I don't know so I'll have to find out. So having the Safety Net number that was good   it was brilliant and I'm pleased to know that it is going to go nationwide. Xxxxxx (LA) piloted it and it's going to sort of go nationwide   and it's great   because we've never had anyone that we can ring just for advice. We've always had obviously child protection numbers but you feel as though you've got to be 110% sure before you go to the child protection officer, whereas the Safety Net number is just an advice line. So it is just somebody you can ring and you can say, can I just run this past you, and you feel as though you're not launching any sort of allegations or any complaints or anything like that, but it's something there to help you   and I do think that's good   that's there's something there to back you up a little bit. And the rest of it I think you just go through with what you feel you should be doing.

The way the parents come at you is possibly a lot of how you react back. But guidelines of what you do would be great (laughs). You know, even if it said 1 gather all evidence, 2 ring this number. If it said something like that it would be good because you don't know and you just go on your own instincts on what you think you should be doing.

It's just something you do. It was just something that I felt I should keep her informed. There is nothing that states you must keep your member of staff

informed. It's just that I felt at the time it was better to keep her informed .She was still here   she was still working. I'd asked if she should be suspended and Xxxxx (LADO) had said no. So I knew she was alright to be here. I knew all my checks and everything were done and up-to-date and everything, so I knew everything like that was all covered. Not that it really stands for much does it? You can do a check one day and they can go out and do something the next time but I knew everything I could have done was in place. So it is then just doing   I think   what you feel you have to do it and the way you are lead by the parents and the incident that happened. We kept nothing from Mum we didn't try and hide anything we told her we had spoken to Xxxxx (LADO), we told her she could inform the police if she wanted to. It was just ...you've just got to be up front with people haven't you. Be up front with them; tell them what they can do, tell them what you're doing and hope that it gets worked out. Luckily it was pretty minor sort of thing anyway. Whether you'd have dealt with something much more serious in the same way I don't know. I mean if you'd seen a member of staff do it instantly that member of staff's suspended and you yourself would inform the police. But I hadn't seen it   I wasn't here I had a child's word against a member of staff's word. And it was ...a balance.

<Internals\1st Interviews\Interview H> - § 3 references coded [22.79% Coverage]

Reference 1 - 4.58% Coverage

So I then spoke to Xxxxx, who's our principal education officer. He's also one of the lead trainers for working together for safeguarding children. So if I'm concerned about something I'll talk it through with another member who has more experience than I have to think about where do we go here with this particular case. And ..we felt that it was ...it was a good case for the LADO to be involved with. So the Local Area Designated Officer...the Local Authority Designated Officer. And then once I spoke it through with him then the whole procedure kicks in as to the investigation was stopped at Xxxxx, Xxxx (LADO) went down and stopped that. The Local Authorities procedures are then ..then are followed.

Reference 2 - 13.28% Coverage

Can you tell me a bit about what informed that decision and what things you took into account, what was important in that decision making?

Yes   I think in talking an issue through there's the obvious, is there a child at risk ...at immediate risk. So you're weighing up whether on not anything more could happen to the child. In this instance I knew that couldn't be because Xxxxx had already removed her from that vulnerable situation so she was placed in a different part of the company. So the child wasn't personally at risk any more, any further risk. There's also ..you have to think about the wider risk that if somebody's done this to one person they may well do it to two or three people or it may well have happened before. So for the next people who go on work experience and for the wider group you need to think of the impact it could have on them as well. So you weigh up... I suppose we weigh up the likelihood of risk to the individual and then the likelihood of any further risk and really it's not my position to deal with that but actually to pass the information on.

Right, so what informed you about the need to pass it on?

Previous incidents where we've had where we've felt that a child ..the child is no further at risk and we hadn't viewed the situation in its entirety. Children's Services have a much wider view of these types of incidents and previously we had held on to information until we felt that there **was** a risk to an individual and we should have passed it on much much sooner. So I suppose our experience in dealing with these issues previously had said hang on, whilst the child's fine this is a bigger risk so we need to send it on.

So is that your own personal experience or are you reflecting the experience of other people you spoke to?

I think it's our own ..it's in dealing with these types of incidents before, so previous incidents that I have dealt with where individuals have been at risk, I think you reflect back on your practice.

Reference 3 - 4.93% Coverage

Right. Okay, you've mentioned about your previous experience and training. I'm not quite sure what training you've undertaken in relation to these ..when allegations occur.

We do the Working Together training that the Xxxxx (LA) put in place. So as a child protection officer I do that training every two years. So that's part of my training there. The Xxxxxx (LA) also ran some workshops on the role of the Local Authority Designated Officer. I didn't attend those; our Head Teacher attended those sessions then cascaded information to me so I have all the power points and information about what the role of the Local Authority Designated Officer is. Because ordinarily it is the Head that would make the contact for ...any information ..to contact Xxxx)LADO).

<Internals\1st Interviews\Interview J> - § 2 references coded [5.01% Coverage]

Reference 1 - 1.43% Coverage

But how would you know that that then doesn't translate to the new guidance when you've never been through that new guidance or that support system, you know what I mean. So that   that was informing our decision at that point to do that.

So as soon as it came to your attention that prior experience informed your decision?

Well it was both really from the minute we were told I looked with staff members here in terms of where was he. Where's the CCTV dddd dddd. So you go through a process.

Reference 2 - 3.58% Coverage

So you were aware of the LADO procedures were you?

We were aware tentatively of the LADO procedures not the full context of it.

Right.

Do you know what I mean. If I explain   because we've been involved in other situations advocating for other children in other settings outside of this Authority. So I can talk to you about some of those in terms of how they've applied the LADO in other areas or not as the case may be   do you know what I mean.

Right

So we were aware from that context. We were not fully aware about the process of non-suspension   because we felt it was open to .. it might be written but it's open to change sometimes with authorities. So it was on that basis really that we had that in mind the whole time they we were considering the system. The staff have gone on the safeguarding training.

Right

LADO had never been raised on the safeguarding training as part of that.

Right

The way I found out about the LADO was   and all the community nurseries to the extent that we have   was because we were asked to advocate in a case outside of this Authority for a child who'd … a male staff member had put his fist in his face he alleged. And the head teacher when I went to the review meeting I highlighted what the child had said and the head teacher said to me   that use to happen a lot before I came here   but not so much nowadays.

Appendix F

Noting the Impact of Feelings Code from NVivo

<Internals\1st Interviews\Interview B> - § 1 reference coded [3.02% Coverage]

Reference 1 - 3.02% Coverage

Cos that's the other thing as well   because that was   that was one of the other problems about it being in France   that when you can sit down with someone a member of staff and try to reassure them   and you're not saying look I believe you and I'm   I'm you know   obviously this couldn't happen and things like that erm but at the same time you have got to try and reassure that member of staff and quite often that is easier to do face-to-face because obviously you can see people's reactions etc but when you're just on the end of the telephone you know and someone's in France it's then very difficult. Their isolated from it   they're still having to deal with the situation because obviously they've got the student there plus the other students so they are still going to have to sort of manage that erm so that makes it more difficult and so you have to think quite carefully about what you've got to say to that member of staff. 'cos again you want to reassure them but at the same time you don't want to be saying anything that's like you know pre-judging what the outcomes going to be

<Internals\1st Interviews\Interview C> - § 5 references coded [5.53% Coverage]

Reference 1 - 1.36% Coverage

Forget the relationship with the teacher forget the relationship with the child   it's the allegation   it's the procedure. I'm protecting myself   I'm protecting my member of staff by putting it on up because if it is false then it'll be discovered to be false. You've got to have faith in the system.

Reference 2 - 0.61% Coverage

It's like what you mentioned the fact that I didn't get emotionally involved I didn't take sides with either side. You can't do that.

Reference 3 - 1.57% Coverage

I'd seen something so   I don't know   what's the word I'm looking for .. it was just such a huge event (voice breaking, clears throat) seeing the whole process through it was nearly 18 months from start to end and you know, oh yes I had the thought of 'of my god here we go again' and 'why me', but I just knew what needed to be done and did it.

Reference 4 - 0.63% Coverage

But I'd done all my doubting. I'd done all my soul searching from the first one. And I may come across as very cold and very calculating.

Reference 5 - 1.35% Coverage

But I see this as protecting everybody involved and the procedures and if there is something that you've got to do then you've got to do this one right. But no I have

done all the soul-searching   the questioning that this can't possibly be true let's try and explain it away. No I've done all that.

Reference 1 - 1.08% Coverage

The support worker was a little bit upset   he knew he had done wrong   and there was a couple of comments at one point that I couldn't be sure if the child told the support worker or the support worker witnessed the comments from the child to his mother about this passer-by.

Right

The support worker was nervous when informing me about the incident and he was talking very disjointedly...

Reference 2 - 0.23% Coverage

The mum said that the support worker was very upset feels awful and has regrets.

Reference 3 - 0.78% Coverage

Well first of all at the start of the interview we told him that it wasn't a child protection issue because we thought that would relieve him because I really think he thought it was. He was upset about that   he actually left the room because he couldn't handle it   he was so relieved.

Reference 4 - 1.73% Coverage

Well I was trying to take any personal out of it, because he's a likable sort of person he is a nice support worker. And I was trying to be matter-of-fact and fair and my manager is a good role model and I think she was doing exactly the same. There was nothing personal. We gave him time to leave the room, to reflect on what he'd said and come back. We thought we gave him every opportunity to explain himself. He did bring another support worker with him, and he thanked us after that. How did we feel? Well we really needed to deal with the issue, it had to be dealt with and we knew that and personalities couldn't come into it.

Reference 5 - 0.76% Coverage

I did for a little moment maybe think I hope we are doing the right thing here by keeping him on, would he do it again. I hope he doesn't let us down. So there is that little niggle, and I'm aware of it and I'll be looking for it, whether that's rights or wrong. For each person

Reference 1 - 1.10% Coverage

Yes, I felt physically sick,

Right

I always feel physically…. well in the cases I've had to deal with this because ……clearly we have a duty of care to the children, but I'm also acutely aware that when allegations like this happen and allegations are made that it turns peoples lives upside down totally. So it always really fills me with absolute dread… And the first thing I thought of was that I need to speak to Xxxxx (LADO).

Reference 2 - 0.80% Coverage

I don't think I had any doubts that the right decision was being made and that speaking to Xxxx (LADO) at the outset was the right thing to do. I think I knew in my heart of hearts that as soon as I made the phone call to (LADO) that we would be suspending the taxi driver but was just mindful of the impact that can have.

Reference 3 - 0.60% Coverage

I'll like to separate the emotional bits (laughs) from the policy and procedures definitely. Certainly we are going to set up some training for the taxi drivers which I'll attend but that will be in terms of awareness raising for them.

Reference 4 - 0.94% Coverage

You mentioned that about your initial feeling of wanting to be sick but I didn't dwell on that very much and in terms of , I'm not quite sure how if that affected ..obviously it didn't stop you because we went on to hear about all the things that you did, but in terms of how you then dealt with that.

It was long-lasting, it affected me for the rest of the day.

Reference 5 - 2.23% Coverage

I suppose we live in times when it's all over the papers. And I have children myself so. ..the point …you've brought out is that actually Xxxx (LADO) …when confronting the taxi driver, when talking about some of the   you know ..there is a very defensive nature when you're in that type of interview, well I did this. And a lot of stuff gets dragged in in terms of what's happened in the past and Xxxx just said, well I've got a 14-year-old, well I've got a daughter, and if any allegation was made if anybody   if I thought anybody was doing anything untoward her then I'd be very ang (didn't finish word)…I don't know what I'd be whether I'd be angry off the top of the scale or be very calm and considered and so I suppose you put yourself in that position   and so I suppose I put myself in a position where .. if that was my daughter what type of result and output would I want.

Reference 6 - 1.05% Coverage

, I know Jimmy the taxi driver; I don't know Julie, but I know Jimmy. He strikes me as a standard genuine straight up normal type of guy. And you transpose yourself into that and think God if that was me. How would I want to be dealt with, would I want to have a fair hearing be treated with respect and dignity until proven. So you're torn between all these things   and I think that probably got me for a bit.

So whilst I went home, it did pray on my mind in thinking God I wonder what, you know, ..someone's life has been turned upside down and potentially two people's lives have been turned upside down. You know Julie with being potentially abused and an allegation founded or unfounded that had yet to be proven or otherwise and he was dealing with that at home knowing that he couldn't transport the children the next day either and questions would be asked why isn't Jimmy transporting us and why isn't that happening and all of those things bring up all sorts of other negative emotions. So that's why I felt a bit like ...

I think don't underestimate the emotional triggers in making those decisions. Maybe I'm just a bit more maybe I think about it a little too much I don't know but ... I don't work directly in that arena. Social workers who work in it all the time I'm sure they'll have much more ...different emotional experiences. An awful lot more training needs to happen. Had I not known Xxxx (LADO) then God knows where I'd have gone with it.

<Internals\1st Interviews\Interview G> - § 5 references coded [3.86% Coverage]

I found it hard to... I found it hard to believe that this member of staff would have done anything as such.

But then the member of staff has been with me quite a number of years. I wouldn't ...I wouldn't protect a member of staff. I'm not close to them in that way, do you know what I mean. But I also felt quite sorry for her in the fact that, it was like.. well how do you protect her as well as the child because she was having to go through all this all these allegations and she's like I haven't you know I haven't done anything of the sort. She told me about the incident and it's her word against the child's word and obviously I take the child's side to try and find out what's happening. So it's quite a confused time really.

But we did get to a stage from ....she did get to a stage where it was getting quite fraught and quite frantic and I think Xxxx the manager actually took most of that.

It was stomach churning. Well it had been ...I mean ... obviously Xxxxx rang me Friday night. So for a whole week basically, I mean, you know ..till Monday your mind you're thinking like what on earth has happened. I have one day off and something like this happens. And then like I get in and obviously parents being very distraught that's quite upsetting, and staff being upset and also kind of angry as well so I'm trying to explain to them that they've got to try and be a bit kind of empathetic about it really. You know,

how would you feel if that was your child, what would you do. It's difficult. So it was stressful very stressful and quite upsetting actually.

I'm quite a calm person anyway, things don't affect me easily. Xxxx's quite an emotional person so things do affect her, affect her a lot easier. Parents I think saw Xxxx more as the first port of call rather than me   so she was getting the brunt of it.

What happened was then that he was asked to come in and he was formally suspended without prejudice and was explain that there had been a concern raised against him and that the centre had taken the decision to actually suspended him on full pay without prejudice, nothing else said. Obviously he was very upset and obviously trying to find out what the concerns were. We were trying to avoid any contamination and that is what we would do in every situation and not engage with it. So he was then asked to leave withdraw from the premises. We then notified social services. ...What happened we went through the paperwork got the paperwork ready for social services. I keep saying social services cos I'm in the old school   the safeguarding team. And then we were waiting for a response to come back. So we had the response through.

Appendix G

Vignette B part 2 code from NVivo

Case B - Paul   Part 2

The next day Lisa and another member of staff were in a room with a group of young people including Paul. The other member of staff was talking about what they were going to be doing the following day. Lisa was handing out leaflets at the same time. As Lisa walked past Paul he had his feet in the way and she just kicked his foot to get him to move out of the way. Lisa called the Manager to say that Paul was alleging that she had kicked him

Well she did kick him and that's not appropriate. You know you don't kick somebody to make them get out the way you asked them. But she's reported this herself so I've already got her version of events. So I would ask Paul's worker to ascertain Paul's version of events and to speak to the other member of staff to see what they had observed and put that together as to whether that's classed as safeguarding or inappropriate care. On the face of it it's inappropriate care. So the worker involved needs to be very clearly advised as to this is not appropriate and then any action after that would depend on whether or not there'd been any involvement previously.

Right

If there had been any concerns previously about it (Someone enters, interview paused).

So when you say about inappropriate care is that something as a manager you would deal within the service, that you would advise a member of staff about?

I mean you're making a judgment call as to whether that's abusive safeguarding issue or whether that is care concern issue. On the face of that information   and if what Lisa said to me as her manager and what Paul said to his worker and what the other member of staff said   if that supported the view of what's been said then I would I .. I would be dealing with that as a manager with the worker about that was inappropriate behaviour inappropriate action. I would not on face value see that as a safeguarding issue   but it is a concern   a care concern.

Right so in terms of what level of response do you think you'd pitch it at? I'm trying to understand something about different thresholds of response so is that the sort of thing that would be just advice to the member of staff or is that like a warning?

I mean like I say it would depend on whether there had been issues about this member of staff before, about her care and the actions she took. You know, I would want, .. it would also depend on whether Paul wished to take his complaint any further. So ...I think if it's just that she just said come on shove

over then you know I'd actually ..and there haven't been any previous concerns about this worker then I'd be advising her that this was inappropriate shouldn't be making sort of physical contact in that way you should ask not you know not basically kicking. But if if when it was looked into it looked as though actually she'd really kicked out at him in anger well then I think that actually takes a different threshold that then becomes disciplinary. So it would depend it would depend if it was just ...not usually any concerns about this member of staff and she was just saying come on shove out the way then I'd be just advising her in supervision that actually that was not appropriate and that she should apologize to the young person. But it would also depend on whether the young person wanted to take it further. It would also depends on ..it's already open the worker has told you herself the lad's alleged himself it's already open for conversation. So I can actually check out is there anything more. Did this look vicious or was its just meant to be innocuous and then judged accordingly.

<Internals\2nd Interviews\S02 &S05 Interview re Vignettes> - § 1 reference coded [4.04% Coverage]

Reference 1 - 4.04% Coverage

Who kicked his foot?

Lisa

Lisa called the Manager to say that Paul was alleging that she had kicked him

Ooo but she did kick him

According to this.

That's abuse then and there are witnesses isn't there as well so there's an incident.

It depends how she kicked him really. There's kicking and there's just sort of...

It didn't say she pushed his foot out the way.

How old is he?

He's 15.

You know some people might do it in a jokingly way come on move your feet and it could have been misconstrued

But you can move somebody like that or you can kick them can't you

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Yes but it's how

But it says kicked it doesn't say pushed his foot out the way does it? It would still have to be all checked out and sort of ... statements taken from the other people in the room.

Yes, it needs investigating,

But if it did happen as it as it was alleged

As it sounds

Then Lisa has committed abuse on Paul (pause).

I would want to interview all the other people in the room, because there is kicking and there is kicking.

There's also that he could have put his feet out on purpose to make it look as if he'd been kicked. You cannot really say any more until you've spoken to everybody on that one really.

No no

Okay.

We don't know the story

If she had done it then yes we'd know what we would do .. but we'd need to check.

Okay, so if she had?

It would be abuse and she would be reported

And she'd be disciplined.

She'd be disciplined and put on the list for abusing a client.

Right

So she wouldn't be able to work with children again or vulnerable people.

Right so when you talk about a list what do you mean?

It's the...

there's a ....

for children there's a ..what is it ? (pause)

The POCA list, ... would it go as far as a POCA list? There is a list

It could do it would have to go to them.

It would have to go through child protection and CSCI

Right

And if they did deem it yes then it would go on the POCA list.

Right

There's also another list in Sheffield as well. And that's ..it would be care protection who would decide which list they would go on.

Care protection where are they located?

It's sort of safeguarding children.

The safeguarding children unit in Sheffield is that who you're meaning who you'd contact.

Yes, we'd have to

It's CSCI regulations.

<Internals\2nd Interviews\S03 Interview re Vignettes> - § 1 reference coded [9.86% Coverage]

Reference 1 - 9.86% Coverage

I suppose in this yes you can see what Lisa was doing (Pause) But like I said in the other one ..I don't think she should have kicked him because she's leaving herself wide open to allegations. I'm sure that she's not gone up and kicked him but you know has pushed his foot out of the way. So yes I can see why she's done that but I don't think she should have done. And if he's making an allegation that she's kicked him yes she possibly has and she shouldn't have she shouldn't have done that. I suppose it depends on how far the allegations go doesn't it.

So based on that information about an incident is that something you would expect the manager to deal with internally or refer on?

Is this supposed to be in a school?

The cases are just general incidents so it's what you would think of the behaviour and the appropriate level of response based on the information you've got.

I think at that yeah ....I mean who has he made the allegation to the Manager?. No cos Lisa has called the Manager. So who's he made the allegation to?

He made the allegation to another member of staff.

To another member of staff oh yeah, right. I wouldn't say it was normal no cos she should not have kicked him she should have asked him to move his feet. So maybe the Manager would try and deal with this but if the staff were (pause) If he wants to take the allegations further I think then it's took out of the Managers hands then it's got to go further. I suppose really the manager should try to deal with it because I could see I could see what she's done. But then again I think she's been a bit silly in the fact that she has literally kicked him out of the way. So I think I'd try to smooth things over but I don't think there is anything else the Manager can do she shouldn't have kicked him. But if he says he's not happy with that then they'd have to take it further.

Well she had kicked him hadn't she? So you know that type of physical intervention, you know ..I think it's wholly inappropriate as well because there has to be boundaries and professional boundaries doesn't there in interactions and modelling behaviour for young people as well particularly young people who may be vulnerable and developing their own appropriate and inappropriate forms of behaviour.

So what sort of action would you thinking as a manager should be taken and how you would respond to this?

(Long pause). I don't know I think in this instance an external intervention might be needed really. I think it needs to be referred out of the organization referred out to somewhere else for review   say to the Safeguarding Team.

To refer to the Safeguarding Team, right. Could you explain why you think that would be necessary in terms of the information that you've got there.

I think because of the the nature of the young person's age is one. The fact that he'd been accused of shoplifting the day before and that she had said that he was doing that and that she was dealing with it. So I think it's like a power thing here. That's a concern cos how do we know that he was doing that and maybe this was an intervention by her in retaliation to get him in control to show who's the boss. And I think that kind of imposition is of concern really   you know what I mean. I think it needs to be externally reviewed really and if it is only a playful kick then let it be proven to be a playful kick by somebody independent   an external view. I think that would be necessary really and allow Paul to to actually highlight those concerns.

If that was referred to me now .. well I'd ..as a ..bearing in mind I'm not Lisa's manager if that was within the police that was that situation she worked within the PDU she worked with someone and she's now kicked him… Well in that scenario you haven't got a criminal assault there. It's inappropriate behaviour you don't go round kicking asking them to shift or whatever but it's not actually a physical assault …it it's not significant harm. But I would still record the fact I'd still share it with the LADO and I would have a strategy discussion with the LADO to say this is what we propose to do .. and the fact but I wouldn't even refer that to Professional Standards to be quite honest.

No keep your feet on the ground with that one refer it to the LADO as you say. I'm not so sure you'd do a video interview with the kids (laughs) for something like that or would we have to do?

It depends how how it's been reported and what the involvement was I suppose. But certainly if that .. if that's ..cos normally this sort of thing would come through say from social care or somebody's told somebody else and they've referred it back in.

But as Xxxx (participant) say's I think we could deal with that internally as inappropriate behaviour.

Right. Would the fact that there had been the previous incident the day before influence your decision making at all. The fact that Lisa had been dealing with him in a different context when the young person was in trouble and then an allegations was made against her influence your decision making?

Yeah

I wouldn't   I'd deal with that separately. It's inappropriate that she does that. That's one part of it. She's been told about that. The .. cos she'd be working with these people day in day out I'm assuming and then this is a separate thing that now she's ..now you're looking at that in isolation. Just because she's ..he's got into trouble and she wants to deal with it that isn't right the right course of action so that's been dealt with. Now this is a separate , that's the way I look at i, this is a separate referral.

Right.

I'm unsure I'm unsure what ..I'd need more information about it from the 15-year-old as to what .. I mean the first bit ..the first scenario you gave me about the shoplifting I can't see what the issue was.

It's to do with the fact that the young person he was in trouble, and the following day made an allegation against the same member of staff saying she kicked him. Would one influence the other in relation to the decision-makingl?

Yeah I might be wanting to be finding out from both Paul and Lisa would the ..get to the root of the problem between them if there was a problem between them before I did anything else. I'd want to find out more   I'd want to find out more.

Right.

And obviously tell LADO because we're looking at it but I would still look at that as an internal issue.

So at this level it's still be something that you'd report to the LADO

Yes

Oh yeah we'd still share the information I haven't got a problem with that. But certainly

But we wouldn't launch a criminal investigation

Not as such a low level thing. ..Cos .. it may well be that somebody's tasked to talk to Lisa and Paul to get their version of events

<Internals\2nd Interviews\S08 Interview re Vignettes> - § 1 reference coded [9.49% Coverage]

Reference 1 - 9.49% Coverage

Okay so what we've got is ..and I'm not quite sure the relevance to this part of Part 1 but certainly in Part 2 you've got a group of staff   a group of young people   so you've got ample witnesses of the event. You've got Lisa walking past Paul   he maybe had his feet in the way but you know that that sometimes happens. To kick his foot to get him to move it out of the way seems inappropriate and Lisa's actually admitting to that by calling the manager to say that Paul was alleging that she kicked him. So you've got independent verification of what happened by virtue of the witnesses. Now if she did kick his foot out of the way that's inappropriate. It's inappropriate behaviour   it's subject to internal disciplinary measures. I would think that that's probably sufficient in this case. If she's saying it didn't happen again I would check with the witnesses. I'm not quite sure what the issue is here   it seems fairly straightforward to me.

Right

I'm sure is going to get complicated in a moment.

No. So in terms of dealing with that as a manager you're identifying speaking to the worker, speaking to the young person, and the other people who were around..

I would speak to the child because you want to understand what the allegation is that's the first port of call. I'd then speak to Lisa to find out what her version of

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events was. It sounds as though the two are coinciding here that Lisa is saying she kicked him that Paul's saying she kicked me so there's no discrepancy there. So you're then faced with a judgment about well was that action appropriate. Well clearly it wasn't appropriate so I'd be dealing with Lisa as a member of staff and this is a disciplinary act. If I had two accounts at variance if Lisa was saying well no I didn't kick him I tripped over his foot and Paul is saying no she kicked me then I would go for verification from some of the other people who witnessed the event.

So the fact that the day before the young person and the worker had also been in a difficult situation where that worker was having to deal with the young person being in trouble, does that come into your thinking at all.

No no .. I think certainly in our Children and Adolescent Mental Health Service you could imagine like this happening maybe not the shoplifting but some event happening one day that you've got a a member of staff having to deal with a difficult incident in relation to a particular child. The following day maybe influenced by what's happened the previous day but equally you just deal with it on its merits that day. You don't look for deeper meaning unless it's fairly obvious. It's possible that Paul had his leg sticking out because he is feeling a bit miffed with Lisa. It doesn't it doesn't mean that you start kicking him about to get him to move his feet. You walk round it or tell him to sit up because it's dangerous what he is doing.

<Internals\2nd Interviews\S09 Interview re Vignettes> - § 1 reference coded [8.50% Coverage]

Reference 1 - 8.50% Coverage

Well I'm still thinking about why I haven't got enough information from the first part because as .. when for me in ..in the first part I was sort of thinking okay so Paul is a young person she works with and in the supermarket where did she get that information from? Was she there or you know where was that information from. And when she said that she was dealing with it personally I'd want to know a little bit more about what she was planning to do. And I'd want more context of that situation. So that's for the first Part.... Of course Lisa's sort of saying that Paul was alleging that she'd kicked him and there were other people in the room. I I'd sort of want want to explore a little bit further about what was happening in the room who was in the room who had seen who had seen want had happened and the situation just to get a clearer picture of exactly what had happened.

So who would you be wanting to speak to? Would you be wanting to speak to Lisa direct or, who would you be wanting to speak to, to get that information from, the young person or the other people?

Yes I'd I'd what I'd do is sort of sit down and sort of plan this out a little bit. So who was the other member of staff in the room I'd sort of want to .. what's Paul's view of what happened and then Lisa's explanation of what had

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happened to try and explore it at that level to try and resolve it at that point   but certainly you need to take Paul's account into ..into vie, it's how you'd do that.

Any thoughts about how you'd do that?

Sometimes   because obviously I'm thinking about my role and where I fit with young people   there may be other people around that actually know this young person better than me. It might be that I do it but there's somebody that's more familiar that he's likely to be less guarded with because you want him to be open and honest you know   and not to feel as well that   because if it is a false allegation that they can just be be honest   and and so I'd explore whether I was the best person placed to talk to Paul or whether there was somebody that   that was better placed to do that   but not either of the two that are involved in and around the incident.

Right.

So somebody totally objective.

Right. And in terms of speaking to Lisa and the other member of staff, who would you expect to do that?

If they were   right ..because I   I always think   this is how I describe it you've always got to have somewhere to go. So if Lisa was a practitioner in my team I would look at talking to my team managers about doing that. And I'd also probably have a discussion with the team manager about ..their usual practice. So exploring some of that   you know   how do they usually practice   has there been any previous concerns. Just trying to get a sense of   is this something that's been raised before or is this just something totally new you know that you've never had complaints or anything before. So, if they're a practitioner I'd be asking one of my team managers to look at that in the first instance so that I can retain that objectivity at that point. So there's a next stage to go if needs be. Does that make sense?

Yes. So you'd be looking at that information gathering within your service.

There are people I know I could draw on.

Okay so this is the next part of the story.

Okay in this situation we   we would need to know where Paul was making the allegations that Lisa had kicked him because if that's going to be taken further we would need to have a complaint from Paul that this had happened. We would then follow up the allegation against Lisa via her line management structure in whichever project or place of work she was in. At this point it's that information searching to find out how credible the allegation is and whether it's going to

effectively stick or not. If it   if it is going to be the subject of a   a real complaint we would want to maintain the neutrality at this point. I would probably   but not always   inform the Archdeacon   but it would depend on the context of where this was happening on the setting.

Can you give me an example of what would make a difference?

Yes. What would make a difference was if it was in a project with its own youth work line management structure it would need to be dealt with in that way via their complaints procedure which may or may not come to us   in which case I would be working with the manager who's going to be managing this complaint. Making a joint decision about how the complaint is investigated who does it.

Can I just close this window because I'm having difficulty hearing?

Yes of course.

So when you say about establishing about whether it's a complaint, what does that involve? Is that only if the person decides to make a written complaint or is that if they raise a concern with somebody?

It could be either yeah   yeah   but obviously in order to deal with this we need to know what what Paul is complaining about and why he believes that Lisa has kicked him here. So that bit of investigation needs to happen   and then Paul you know needs to be asked about how he feels about the process and what needs to happen. And then we would go on from there. But I mean on the face of it we have two conflicting explanations of a piece of behaviour that needs to be decided on so it needs further investigation. At this stage I would be unlikely to contact the LADO but may well do so later depending on the outcome of the initial investigation.

Okay. So when you say about gathering information, would you be speaking to Paul?

I wouldn't no.

Well what would be happening? How would that information be gathered?

Again it would depend   it would depend on the context and organization where this is supposed to have happened. So if it's in a separate youth group with his own management structure that would be dealt with by one of the managers there.

So one of the managers there would talk to Paul?

Yes

Who would speak to the worker, would that be the same person?

Probably but that would depend on their own structures.

Right

Yeah as to who would do what and how well staffed they were. They may only be one person who is able to to do this there may be several so the roles would be split in a way depending on need. If it was a a smaller group without any formal management structure it would need to go to possibly the member of clergy running the parish, or a another appointed to to do this role. But that would have to be decided by discussion because a member of clergy may feel that they're unable to to do this for various reasons.

Right.

Skills and training being one of them.

Right.

So they would need to take advice, and we would need to look at where this, where this should go.

So in the example you gave of the youth service if the manager there had spoken with the worker and the young person, would they tend to come to you?

Yeah yes we would have discussion about the best way forward. If Paul was maintaining the allegation that she'd kicked him and that was believed then effectively that's an assault. So it may be at that point Paul needs to be helped to make a formal complaint to the police.

Right.

But again he needs discussing he he's a young person so there would need to look at involvement in support of parents in this situation as well. So so a number of strands that we would have to work on to decide what the best way forward would be. If Paul certainly if Paul was alleging that she'd kicked him in the way of an assault rather than a sort of nudge to get his feet out of the way we would certainly want it investigated by a statutory authorities, and at that point then we might have I I would need probably need to have discussion with the LADO but again not necessarily at that point.

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Appendix H

Vignette G Part 1 code

Case G. Part I. Emma is female, four years of age, and white British. Sue is white British, female, 33 years old and works with children. Emma's parents arrived at the office and told the Manager that they had been out for a barbecue that afternoon to a friends' house. Emma had sat on her Mum's knee and said that Sue had hit her. Her Mum asked her again what she had said, and she said Sue had hit her. Emma's Mum had delved a little deeper into what she was saying. Emma said that she had been in the toilet, and she'd got the soap and was washing the mirrors and Sue had come in, shouted at her, told her she was a naughty girl and hit her.

Right okay so we have a four-year-old who may attend some sort of day nursery.

Yes an Early Years provision.

So Sue must be a member of staff there.

Yes

So ..we had a little girl who mother reports as having been hit by this member of staff. Her Mum claims that she asked twice and again very clearly Emma has said Sue has hit her and when Mum delved a little deeper again Mum's report at this stage is that Emma had been in the toilet now we don't know whether it's just a single toilet that ..or whether you know it's a series of toilets and then you go and wash your hands outside the toilet as such but as a four-year-old you would help a four-year-old to the toilet. A four year old would probably ask to go to the toilet and a member of staff would probably help them I think. I've forgotten what young people can do but I think you would genuinely help a little kid go to the toilet. So it's not surprising that Sue was in the toilet with the little girl. But the fact if Sue was in the toilet with Emma and Emma got the soap and was washing the mirrors there is then.... oh yes Sue had come in and shouted at her sorry got that bit wrong. So Emma had clearly gone into the toilet by herself (laughs) done her business came out to wash her hands and decided to wash the mirrors the mirrors at the same time. Sue came obviously to see what she was getting up to and found her with soap all over the mirror and was cross and hit her. This is a clear allegation against a member of staff no question about it. I would if I were Sue's manager I would ..notify the LADO and just explain to the LADO what I was going to do from now on was ..I don't know whether Emma's got a social worker or not or whether she's just in Early Years provision so so she may already have a social worker or we would we would certainly want someone who who knows Emma well to sort of have a word with her. Difficult to say but anyway Emma needs to tell her tale to somebody else. Sue needs to ..not Sue the Mother needs to give that permission for that but it does sound like Mum's keen for an investigation to take place and and we cannot have a

member of staff in an Early Years setting hitting a child. So if she continues to say that she was hit by this Sue then ..then you know there would be a management investigation and Sue would be suspended (laughs) until that's happened. What the ...whether the LADO would want a strategy meeting or not I don't know, but that would be up to the LADO to make that decision really.

Is there any other actions you'd take? You've talked about notifying the LADO, asking for the child to be spoken with. And the adult to be spoken with?

Well yes obviously depending on what little Emma has said and depending on again the knowledge that we have but we would assume that we would make the assumption that what Emma was saying was true. And clearly yes, a management investigation would involve interviewing Sue and and seeing whether there was anybody else who perhaps witnessed the events and again if it's a if it's the row of toilets there might have been somebody else there or there may have been some reason why a four-year-old went to the toilet on their own (laughs). I keep forgetting about whether ... yes I think four years olds you'd still help them go to the toilet wouldn't you make sure they'd fasten themselves up properly.

So when you talk about a management investigation I just want to make sure I've understood what you mean. You're talking about interviewing the member of staff and interviewing anybody else that might have been there. Is there any other information that you think you'd need to look at?

Well there would be you know .. there would be the usual sort of checks we would have to ...because she's a member of staff we'd have to assume there was an up to date CRB and that the recruitment processes were correct when she when she was appointed cos often what you find with Early Years settings is ...is sometimes the recruitment has not been good so when you delve into recruitment you find that there's no references or CRBs you know and people have been appointed. So I don't know whether this is a local authority resource which you would hope that they were all in place but that's not always the case either. Or whether it's a private setting who ..and if the private setting is pushed for staff and they've taken on agency staff and all those things haven't been done properly. So that would be the first thing and clearly if if you know if a strategy meeting were to be held that would involve the police and that would involve whether there was any sort of criminal investigation to take place on top. You know there's all sorts of ...this could follow-on it all sorts of ways but you would imagine that she would be suspended until the investigation had been completed.

Right okay soon as that happened I would then interview Sue talk to Sue and ask her you know this allegations been made what's her version of it what's

her view of things   what does she think.   And at that time thinking this is something I may well have to report to the local authority designated officer again because I've got an allegation made against a member of staff. But first of all I'd talked to Sue first and get her side of things.

Right

Reference 1 - 6.57% Coverage

The fact is that it has happened out of school and it's happened at a friend's house and I would have a conversation with parents and ask them if they have had a conversation with the friend who I presume is this Sue and depending on what was said then I would probably advise the parents to go to children's services.

While the disclosure is outside of school at the friend's house it is about a member of staff, someone working with children.

So it's meant to be a member of a staff?

Each one of them is about someone who's working with children. So it's a matter of approaching each one of these as if it was a member of staff, like Sue was a member of your staff.

So I've got to image it was a member of my staff?

Yes

Well if it was a member of my staff then I would take a different point of view. If it was a member of my staff I would have to speak to the parents listen to what they've said and then if they are accusing one of my staff of hitting their child then I would have to go down the referral route.

Right so what would that involve?

I would go to the LADO   I would speak to the LADO at that point.

Right so as soon as they made that first disclosure to you that they were saying that it was a member of your staff. Okay, so this is a next bit of information in the case.

Reference 1 - 2.78% Coverage

Immediately there, ..that's an escalation ..through to Xxxxx(LADO) and his team. I need to speak with Sue. I need, ... a statement needs to be taken in terms of the information gathering.

So when you talk about escalation does that mean you'd speak to Xxxx (LADO) first?

Yes yeah yeah

What was that based on?

You see the difference is in here in case A and C there's ...the thing that differentiates it for me   which is   why I may well be wrong on B   is that there has been actual physical contact. It's the actual physicality of it and the risk and the danger that comes with that. The risk and the danger here (Case B) was .. is as big in many ways but it was about not doing your duty, not carrying out something. But in this one it is actual physical abuse, potential physical abuse in terms of hitting. So, the allegation as it stands there is incredibly serious   just in terms of what's going on. I would I would speak to Xxxxx(LADO) just to say that I'm going to speak to Sue yeah yep.

Right okay so in the situation then we'd be talking to ..we would need to talk to ...no I wouldn't need to talk to Emma. If the information's been given by the child we would need to talk to Sue and say and try and find out why were there any difficulties in the relationship with Emma that was leading to her to act inappropriately and we would still make a referral to children's services. Would we make a referral to children's services cos it's not within the family. Who is Sue employed by?

These are just generic case studies. So it's just some children's services organization. A children early years provider, children's centre, foundation level stage or pre-school provision. So this is someone who works in an early years type setting.

Right so in that case then if she's someone working in that type of provision I suppose I come back again to the local authority designated officer.   Having talked it ...yeah I'd go to that officer again and say that we have a situation in school where this   a parent has come in given us information we're concerned about what would your advice be next.

Would you do that first or would you speak to Sue first?

No I think I would speak to the officer first and then on the advice from the officer would then presumably carry out an investigation and ask Sue   but I think I would clarify that first with the officer.

Sue is actually employed in children's services and works with children

We don't know what what relationship she's got to Emma. (Reads information to end). So we've got three concerns A shouting at a child, B ...denigrating a child and C a physical assault of a child. Right well if I was the SMO for the area Sue was employed with I would be wanting to find out what Emma's Mum's role is in terms of Sue's employment. So how have we heard heard about this from Emma's Mum and and Dad. What Sue knows about Emma's parents coming to the office if anything and what Sue's employment current employment history with the organization is but my initial thoughts would be Sue works with children this is an allegation against a professional I'm going to have to discuss this with the LADO. But I want to find out what information as an organization we hold before I have a discussion with the LADO within within the day.

Okay. So is there anybody that you'd be thinking you'd need to contact?

I'd be wanting to talk with A Sue's line manager not say anything to Sue at this stage at all and B it's not clear whether the manager that Emma's parents have spoken to is Sue's line manager so I'd also want to hear from the manager exactly what Emma's parents have said whether he's documented that and what the parents expected outcome of this is. What the parents have been told and also if there's any professional or social role between Sue and Emma? You know is this something that we need to protect this child from right now? Is Sue somebody who regularly looks after Emma? She obviously knows her well if Emma had come to sit on her knee oh no Emma was sat on her Mum's knee wasn't she?

Yes

Yes so I want to know how Sue knows Emma. What her ..what we know about her through her personnel file what her line manager knows about her exactly what the manager has been told by Emma's parents word for word pretty much and what Emma's parents have been told and whether Sue knows anything about the allegation.

So we're, we're saying here that that Sue's a police officer that's what we're taking it from the angle of.

Yes

My thoughts here would be that the initial report is one that ..there is a a report of abuse of a child which would be assault. At this stage the consideration

is that ..what is the degree of the assault and are there any injuries pointing to the fact that an assault has taken place. If there are no injuries at this stage there is a consideration for what is the evidence to point to an assault having taken place and that would be two matters initially which would be the report to mother in terms of the report from mother and the second one would be obviously in relation to the child's testimony in relation to to being struck. In terms of considerations there'd be the multi-agency consideration in relation to consultation with social services with an equivalent manager there in relation to the allegations that have been made and the best way an agreement about the best way to progress it. The summary I have given previously would be just how I would see it as a police officer about a report of a crime having been committed. The second issue would be how you would actually deal with the Sue who is a police staff officer were presuming it's a police staff office.

Yes could be anybody who works for the police service.

There's obviously consideration about what to do in relation to them. My consideration would be that first of all have the discussion with social services in relation to the way forward have an agreed way forward in relation to it and I think following on from that there would then be consideration about how to treat the police officer or police staff member in terms of considerations that you would do.

So you said that you'd contact social services.

Child protection the child protection team I mean obviously it might not fall within there remit they might actually just address it back to us and ask us to deal with it as a simple when I say simple it's simple and it isn't .. as a as a crime investigation that's carried out by by the police in relation to this matter.

Right.

You'd need to get more information before you make any decision I'd definitely not rush off for example and start thinking about suspension of Sue because at this stage you just have one uncorroborated comment really in relation to it you've obviously got it might be a complaint to the mother which is always a key factor but the difficulty you've got is that unless you've got any injuries or you've actually got the child's testimony in some form that you can progress it it's hard to see how it will progress. There are two issues there is a crime investigation and there's obviously the disciplinary investigation. For both sides really you're going to need more information before you can't take the matter any further from my perspective as a manager investigator.

So is that information that you would seek out before you refer to children's social care, child protection, or is that something where you'd have the conversation and then you'd seek out the information.

I think there is early consultation. I think I would seek the consultation about the best way to progress it and agree with progressing it and then following on from

that we'd take the action. I wouldn't take the action necessarily before before we actually had the consultation. I don't think when there are issues like this it's not particularly time critical that straight away you have to for example take action in relation to Sue. You've got the opportunity to collect the evidence first I think in this scenario so but I think it would be important with social services to get an understanding is it a joint investigation between police and social services or is it going to be a police only led investigation so we'd look at it from that angle.

Okay so Mum's reported this to me about Sue that Emma has told her that she'd been in the toilet she got the soap was washing the mirrors Sue had come in and shouted at her told her she was a naughty girl and hit her. So the first thing that I'm thinking cos I'm talking to Mum is that I need a little bit more detail on that a little bit more information. So I'm going to talk to Emma's Mum about how how how she feels we can do that. She may actually have a little bit more information than that so she may give me a bit more information. ..It's quite a difficult one because it's really so general. I think in this case because she's actually talking about physical abuse she's saying that that that Sue has hit her I think one of the things I'm going do fairly quickly is take some advice from the LADO. I'm going to actually phone and and explain the situation. But I really would like a bit more detail on it so that's what I'm struggling with at the moment is where I get that detail from.

So what sort of information would you be looking for?

I want to I want to know a bit more about what she means by she hit her you know whether we are talking about a smack whether we're talking about she came in and tapped her because she wanted her to hurray up or what what she means by hit. And I'm not saying to Emma's Mum that any of that is right I just want to know you know. ..Did she come in did she hit her hard enough to to leave a mark did it hurt did she just tap her you know what does she mean by she hit her. I want to know a little bit more about the context you know what did she shout at her about what did she say you know ..why did she say she was a naughty girl.

Washing the mirrors with the soap.

Well that's what we are assuming because that's what we're hearing but I want to know you know did she say ..is that is that what she said. Because what Emma's said to her Mum is that she was washing the mirrors and Sue came in and shouted at her and told her she was a naughty girl and hit her but I don't know that it's because she was washing the mirror. I think I'm sort of assuming that because of what Mum's said so I want a little bit more detail on that. I'm

hoping that Mum has a little bit more detail on that   has a little more detail on that   okay.

So would you be thinking of speaking with Emma to find out?

I'm sort of, ..I'm struggling with that cause she's four and I don't want to push her on this

Right.

I think I would talk to her Mum about how she would feel about Emma   me talking to Emma and getting a little bit more information with her Mum there and sort of having a chat about what had happened. What I don't want to go into is an investigation at this stage which is why I want to take some advice. You know where do we take this. But I do want some more information.

Okay

So assuming that Mum says yes that's okay it's all right for Emma to talk about it and I can ask her what happened then yes I'd talk to Emma   and try and get her to explain to me or show me even what had happened to ...you know what she meant by that she'd shouted at her and that she'd hit her. ...And depending on the outcome of that conversation I might speak to Sue at that stage or I might go straight to somebody like Xxxx(LADO) and say okay what do what do we do now and take it down that route. Because it would depend very much on what the answer was. I'm struggling here because I don't get the context and I don't know exactly what that means   you know what she means by what she's said. She's clearly distressed you know it's clearly something that's upset her and I would take it serious   very seriously. I obviously know Sue so I know what she's like   I know you know what she might be doing here. I'm not going to make any assumptions but that would obviously put some context around it whether this appeared to be so completely out of character that I do need a lot more information about it.

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