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SOCIAL WORKER EXPERIENCE OF FATAL CHILD ABUSE

ABSTRACT

This research study used Interpretative Phenomenological Analysis to examine the lived experiences of four social work practitioners who have been directly involved in cases of fatal child abuse. The research examines how the tragedies impacted upon the workers in both personal and professional capacities and locates those experiences within the relevant organisational context.

The study reveals that all the workers were significantly affected in different ways by the tragedies. ***Although there is some evidence of good practice it is evidence that the*** *emotional and support needs* ***of the workers*** *were largely ignored by the organisations in which they practiced. The study reveals that following the children's deaths, the supervision the social workers received was often inappropriate and inconsistent and the Serious Case Reviews that were undertaken further contributed to the isolation and blame already being experienced by the workers involved.* ***The research examines how*** *such factors as media responses, organisational culture, working practices and the serious case review system, combine to provide a means by which systemic failures are minimised and ignored in favour of attributing blame to the actions or inaction of individual social work practitioners.*

INTRODUCTION

I began my career in social work as a children and families social worker in 1997. Although I have never been directly involved in cases of fatal abuse, shortly after qualifying I had peripheral involvement in a situation where a child had suffered serious physical injuries to the extent that his life was in danger. My reflections upon the case centred on the impact of working with such high levels of risk and uncertainty and the potential impact that the events had upon me personally and professionally. My interest in **actively** researching the lived experience of social work practitioners involved in cases of fatal child abuse began in 2006, shortly after I had completed the Advanced Course in the Management of Unexpected Childhood Deaths at The University of Warwick. During the course, a range of professionals including coroners, paediatricians, paediatric registrars and perinatal pathologists provided insights into their roles and responsibilities in relation to the child death review process. Whilst There is in no way any suggestion that the practitioners were unaffected by events, I reflected upon how "clinical" and emotionally detached the narratives appeared. My reflection began to focus on how such accounts would potentially contrast with those of "non-medical" personnel or parents who had experienced the loss of a child.

Whilst not in any way seeking to minimise the potential trauma associated with the death of a child, it is fair to surmise that serious injury and death, however tragic, are an expected and unfortunately regular occurrence within an accident and emergency department or special care neonatal unit. Even within some areas of social work practice, for example a palliative care or children's disability setting, the death of a client is an unwelcome, yet not unexpected occurrence. However, within statutory children and families social work departments such events represent the extreme "sharp end" and thankfully rare aspects of professional practice, and the sudden,

unexpected and often violent nature of the child's death potentially culminates in increased feeling of stress and trauma for social work practitioners involved.

Based upon my own personal and professional experiences, I developed the opinion that a research project that explored the lived, "human" experience of social worker involvement in cases of fatal child abuse could potentially make a contribution to several areas of social work practice. My aim was to step outside of the formal, procedurally driven review process and explore in detail the "lifeworld" of those involved.

LITERATURE REVIEW

Fatal Child Abuse and the Media

As early as the denunciation of the social work practice of Diana Lees in the case of Maria Colwell (Corby, 1993) through to the more recent tragedies involving Victoria Climbie (Laming, 2003) and Peter Connelly, there has been a continual media vilification of social work practice, resulting in what Goddard and Liddell (1995, p.357) describe as "child abuse and child abuse issues being largely examined through the lens of moral panic". Wilby's (2008) study examining the media portrayal of social work reveals the extent to which some media publications will seek to highlight both individual social worker and agency failings. Such media reports have extended to publicly naming the individual practitioners involved; the names of Lisa Arthurworrey, Sharon Shoesmith, are now synonymous with perceived poor practice and symbolise the human faces of what are perceived to be both individual and systemic failures.

Fatal Child Abuse and the Social Worker

Literature directly relating to social worker experience of fatal child abuse reveals surprisingly little research and in particular, very little British research,has been conducted in this area. Some of the earliest insights into the subject are provided by Olive Stevenson, whose 1979 reflections on her involvement in child abuse inquiries, among them the Maria Colwell inquiry, acknowledges that "the launching of an inquiry is like casting a huge stone in a pond. The ripples spread outward often involving many who do not expect it and more important, in ways they did not anticipate (Stevenson, 1979, p.3). It is perhaps the meta-analysis of 35 English and Welsh, child abuse enquiry reports undertaken by Reder et al (1993) that begins to show the impact of cases of fatal child abuse upon social work practitioners. Known as the "Beyond Blame" project, the research is "an attempt to get beyond the blaming stance often adopted when children known to statutory agencies die at the hands of their caretakers" (Reder *et al*, 1993, p.1). Although focussing predominantly upon the analysis of the systems operating within child protection tragedies, Reder's study begins with the recognition that "not only does the death of a child horrify us but front line professionals, especially social workers, have become extremely sensitive to the critical and often mindless rage that is heaped upon them at the news that a another child known to statutory services has died (*ibid*)".

Stress, Trauma and Support

It is difficult to imagine a more tragic event than the death of a child. Even when the death is expected, for example as a result of terminal illness, it is not purely the loss of the child themselves but the loss of the son, daughter, brother, sister, footballer and dancer to be that we may mourn. It is the irretrievable loss of promise, it is the end of potential, it is the establishment of an "empty historical track" Klass (1988,

p.13). Regehr and Chau's (2002) study begins to provide some insight into the personal impact of child deaths upon social work practitioners. An important feature of the study, is its acknowledgement of the sweeping impact of child deaths and of how the predominantly negative repercussions associated with the tragedies, permeate at individual, agency and community levels, ultimately influencing and increasing negative media perceptions and exacerbating the policing functions of child welfare practice. The study also acknowledges that despite having a significant and predominantly negative impact upon several aspects of social work practice and social work practitioners, "no studies have focused on the impact of child death reviews on child welfare workers" (ibid, p.888).

Gustavsson and MacEacheron's, (2002) study begins to examine how the sudden, unexpected death of a child may be more difficult for the worker involved due to such factors as the traumatic nature of the death and the fact that the worker may have no time in which to prepare for the loss. Although referring to the suicide of children known to social services, the study reveals how existing feelings of guilt and sadness experienced by the social worker may be further compounded by the reactions and responses of significant others. Not only is the worker involved confronted by his or her own emotional responses to the incident but also a situation where "professional judgement is questioned as workers wonder how they missed the warning signs" (Gustavsson and MacEachron, 2002, p.908)..

Jan Horwath (1995) and Sue King (2003) both writing in the peer reviewed journal Child Abuse Review, have published separate research papers which develop some of the issues raised. Jan Howarth's paper, by the author's own admission, is aimed at eliciting comments from other authors and researchers, and acknowledges the need for further, more extensive research into the subject. Horwath conducted an

unspecified number of face-to-face interviews with frontline practitioners who had direct experience of being involved in cases of fatal child abuse. These reveal how the impact of the fatalities permeates negatively throughout the social work team involved and affects not only social work practitioners but support workers and other allied professions.

The Child Protection System

The Munro review of Child protection (Munro, 2011) lends weight to the view that current child protection system is overwhelmingly process and target driven while at the same placing unrealistic and narrow expectations upon social work practice. The report's views are echoed by further studies. A mixed method survey undertaken by the union UNISON in 2009, described current working practices as "a ticking time bomb in child protection".

Revell and Burton (2016, p.1587-1601) describe the importance of supervision "for practitioners to be effective, they require the support of an effective supervisor to assist them to share some of the feelings evoked by difficult practice encounters. Transparently processing such feelings in a safe and supportive environment can assist workers to maintain, or regain, equilibrium". However a 2009 survey of 422 social care professionals surveyed 28% said they received no supervision at all and 31% said the supervision they received was not adequate for their caseload (Community Care, 2009, p.46).

Revell and Burton also question the efficacy of some supervisory practices particularly in the context of child deaths and Serious Case Reviews highlighting the fact that "for a social work supervisor, working within the same organisational context as the practitioner, the same bureaucratic and

emotional stressors apply; therefore, they are equally besieged by the same pressures".

Overall, the literature review reveals a general acceptance amongst researchers that there is a lack of research relating to the experiences of social workers involved in cases of fatal child abuse. In addition, surveys of social work practitioners indicate that the current overall working environment is far from ideal and falls short of the nurturing, supportive workplaces which are conducive to fostering and developing safe and effective working practices. Many of the studies cited provide telling insights into the subject yet overall the voices of the practitioners involved are notably silent.

METHODOLOGY

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

The research study involved semi-structured interviews with four social workers who have been directly involved in case of fatal child abuse. Interviewees were required to be qualified social workers who were practising social workers in the UK at the time of the child's death. All Interviewees were required to have been working as the

worker or co-worker with the child and their family, before, during and after the child's death. No restrictions were placed on the timing of involvement with the child and family, or on the time that had passed since the child's death. Although the child death review process and the lived experience of the social workers involved within the process are discussed during the interview, it was deemed not to be essential that all of the social workers who were recruited were involved in a review. Not all cases of fatal child abuse are subjected to review and potentially significant amounts of valuable information may be lost by the imposition of such criteria. Pseudonyms for interviewees and individuals are used throughout the entire research process.

Using the transcribed interviews as data, the **researcher identifies** "emergent themes". Such emergent themes consist of recurring thoughts, images, feelings, metaphors or statements made by the **individual** interviewees. Upon completion of the analysis of each individual case the four cases were analysed collectively in order to identify areas of connectedness, convergence and polarization between each of them. These collective themes are then known as Master Themes. **The master themes are developed from the clustering of themes present within each interview. These are presented in the form of a narrative, consisting of direct quotes from the research interviews and additional notes from the researcher, designed to aid clarity and understanding. During this section the experiences of the social workers involved in the study are interpreted.** Smith describes this as the "interweaving of analytical commentary and raw extracts" (Smith, 2009, p.110) that aims to provide a clear account of the lived experiences of the individuals involved. **In keeping with the essentially interpretative nature of phenomenological research, this analysis consists entirely of the researcher's**

own interpretation of the participants' accounts. In order to add validity and rigour to the research process this section of the report has been shared with two social work academics who were asked to comment on whether the conclusions drawn from the analysis were credible and had been extracted through a clear and logical process.

The study aimed to provide a holistic, in-depth account and analysis of the social workers experiences in relation to:

- The perceptions of their relationships *with* and the assessments *of* the children and families involved in the study;
- The feelings and emotions associated with hearing about the children's deaths and how events impacted upon the workers in both long and short term and personal and professional contexts;
- The social workers' perceptions of the support and supervision they and their colleagues received post event;
- The social workers' experiences of participating in a review or inquiries into the children's deaths.

Ethical Considerations

Prior to undertaking the research project and in line with University policy, a full research proposal outlining the research aims, objectives, methodology and ethical considerations was submitted and approved by Universities Research Ethics Committee.

Participants were recruited by placing information on Social Work Professional discussion boards and professional interest internet sites. All respondents were informed that:

- Participation in the research would be entirely voluntary. No form of financial or other reimbursement would be offered.
- Participants would be fully informed of the purposes of the research as well as details of the data collection, research format and dissemination process. The rights to withdraw and the potential risks and benefits of being involved in the research were fully explained and acknowledged via a written consent form.
- **A total of eight participants responded, all were White British Females. Four applicants were rejected. Two of the rejected applicants voiced concerns that they might be identified or their careers would be adversely affected by their participation. Following discussions with them I suggested that even if they held the slightest concern about being involved they should not participate in the research. One of the other applicants was not a qualified social worker and the other was involved in a situation where the child had been seriously injured but had not died.**
- All of the social workers who were interviewed were white females who were working in statutory social work teams in England at the time of the child's death.
- All of the social workers were **qualified and** experienced **social** workers with levels of experience ranging from 4 to 15 years.

- Three of the social workers who were interviewed were working in statutory children and families’ referral and assessment or duty teams and one social worker was working in a generic neighbourhood team, with child protection responsibilities, at the time of the child's death.

- Three of the social workers involved first came into contact with the children and their families via duty visits, before adopting case responsibility, the remaining case was allocated via case load allocation.

- All of the social workers are still employed in social work related professions. Two of the workers are now in social work management positions and two are practising in none child protection social work roles.

THE CASES

Anna was the co-worker for a new-born female named Rebecca. The case was originally allocated to Anna due to concerns relating to maternal drug misuse during pregnancy. As a result of those concerns and recognition by the mother of the impact of her drug taking upon Rebecca, she was voluntarily place into care. Rebecca died at the age of three months as a result of a physical assault whilst under the supervision of her new carers.

Beth had been Kieran's social worker during the year prior to his death. Kieran was a teenage boy who was known to social services due to concerns relating to neglect and physical abuse by his birth parents. Throughout her involvement, Beth had persistently yet unsuccessfully argued for higher levels

of support and protection to be provided for Kieran. Kieran died as a result of hypothermia.

Claire was the social worker for Sarah, a 6 month old child. During a duty visit Claire noticed suspicious marks in Sarah's feet and unsuccessfully attempted to seek a Place of Safety Order for Sarah. These concerns were not acted Shortly after the visit Sarah was killed by her Mother's partner.

Donna conducted an assessment of an unnamed child, whose Mother had previously experienced domestic abuse. The assessment of the family revealed no safeguarding concerns, however the children's' mother failed to disclose that she had entered into a new relationship with a man who later physically assaulted and killed the youngest child who was aged 18 months.

FINDINGS

Master Theme One; Voices Unheard: *Initial involvement, assessments and relationships with the children and families involved in the study.*

The interviewees recalled very different experiences when working with the children and their families prior to the child's death. Beth maintained a close and on-going relationship with Kieran, a 17 year old boy who had a history of familial physical abuse and neglect. Here she describes her relationship:

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

During her account, Beth repeatedly states her opinion that Kieran's situation was typified by a consistent lack of urgency by social services towards his needs. Anna who had an on-going professional relationship with a substitute carer who later killed a child in her care describes her experience:

"We were picking up these concerns about this woman, she seemed quite brittle, babies were fed, they were well dressed… but…not a great deal of warmth I thought, not a nurturing mum, I'm not happy, she comes across as cold and steely and I asked for another placement for my baby. I was told "no". This mum never smiled, she never smiled. That's one of the things I said to fostering, she has not got a smile in her that woman"

The metaphors and descriptors used by Anna in relation to the carer involved in the case are particularly interesting. Her use of terms such as *brittle, cold and steely, lacking warmth, never smiled,* emphasise how Anna perceived the personal characteristics of the carer. Anna's commitment to a child centred approach to her work and her feelings towards Rebecca are evidenced by the fact that throughout the interview she refers to her as "my child" or "my baby":

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

"She was not right for my child"

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

Donna's account illuminates the often unpredictable nature of "front line" child protection social work. Her descriptions highlight the likelihood that not all child

deaths are preventable and that blame for the deaths cannot always be attributed to individual, professional or agency failures.

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

Although Donna spent only a short period of time with the family her interaction clearly left a lasting impact upon her. This idealised image of the family held by Donna contrasted with with the reality that the youngest child in the family would be murdered by the mother's new partner only a few weeks after her visit.

"I think I trusted them in a way that I got the stage where I had to say I could not have done anything else on that visit and actually, I did a good assessment and I do think I did a good assessment but I still wish I could have done something that could have stopped what happened. Like anybody would do somebody that perhaps saw a road traffic accident happening in front of them might have thought, if I had done something I might have…that's human nature"

Throughout her account of the events surrounding the child's death, Donna frequently refers to her assessment of the family situation, she constantly searches for any omissions in her own assessment that may have prevented the tragedy happening. Donna perceived that both for her own wellbeing and for her future practice, that however initially traumatic, the identification of an error in her judgement or an omission in her assessment would enable her to "move on" and end her on-going search for closure:

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

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

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

All of the social workers who were interviewed spoke of their frustrations at being unable to convince other professionals of the need to take urgent and decisive action in each of the cases :

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

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

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

Three of the social workers accounts reflect a prevailing sense of powerlessness, anger and frustration. In each of these cases, the workers were able to formulate informed judgements about the risks posed to the children; however they were unable to secure decisive actions as a result of those judgements. The exception to this situation was the case of Donna whose assessment had not called for further action to be taken.

Master Theme Two: The Pain of Knowing. ***The feelings and emotions associated with hearing about the children's deaths and how events impacted upon the workers in both long and short term and personal and professional contexts.***

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

"We got a call to our one of our out of hours to say that this baby err had been admitted. She died (long pause) on the kitchen table…I think they might have resuscitated her, they got her to hospital and we got mum there straight away. It's all a blur that bit. It's absolutely a blur. I couldn't breathe, I could not breath and I

could not get any information, I wanted to know what had happened, it all happened at the weekend it was out of hours dealing with it. The police officer said "do you want a drink?" and I said I don't know, I don't know what's gonna happen? When I found out this baby had all those injuries… that's when I could not breathe."

Even though a significant amount of time has passed, since Rebecca's death, these images and details have clearly left a deep and lasting impact upon Anna and serve as a vivid and powerful reminder of the event. Despite what was very clearly a traumatic emotional incident, an experience so intense that it physically impacted upon Anna, she immediately continued in her social work role, "shelving" her own inner turmoil and providing Rebecca's mother with emotional and practical support.

Claire's recollection of how she was informed of Sarah's death is startlingly brief and dispassionate:

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

Sarah's death happened several years ago, yet for Claire the overriding emotion was still one of anger. She consistently recalled her frustration at how almost every aspect of the case was handled.

Donna was the social worker who had experienced the most recent fatality, her experiences of being informed of events contrast sharply to the other participants in the study. It appears that this initial, planned and personalised

interaction set the tone for a sharply contrasting experience when compared to those of Anna, Beth and Claire.

"My manager rang me and said that this had happened over the weekend. She rang me to let me know that should it be in the news given that I had done the last assessment only six weeks before. It may well be something that I have a complete panic over or would want to know so she gave me as much information as she had in regards to it so that I was aware…It was very good and she did say that there would be a full investigation and everything that was done with regards to my practice would be looked at and the department's practice but try not to stress too much but obviously you do don't you?"

Donna's account provides a clear indication of good practice, clearly in this situation, the manager involved conveyed as much detail as possible and made an attempt to address Donna's concerns.

Donna describes how the events had impacted upon her as a social work practitioner but also in terms of her personal life and relationships. Her recollections are both profound and moving, they echo of change, and transformation and they reflect the wide range of experiences and emotions she associates with the fatality:

"You could not be the same person…to experience working in an environment where you have had a link with a family that has tragically, horrifically lost a child, and to carry on doing what we do. It's not a job is it? You cannot call social work a job. You don't log on and off. Yes, it has changed me; I think yourself as a person and your own relationships as well changes. Strangely enough I'm not in one (laughs) I now have my own barriers up around things so it does change you as a person, but how could it not change you? If it didn't change you then it would be worrying really.

You do think about it, it does come back to you. It is something that will never go away

Anna also speaks of the isolation she experienced:

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

Master Theme Three: The Blame Game. ***The experiences of participating in individual management reviews or inquiries into the children's deaths.***

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

Beth*: My last LA they were more interested in the blame and how to not be highlighted as a failing authority that should have done something. It seemed to me it was more like they were more interested in making the good bits look good and the bad bits to be watered down…all corporate*

Anna: *Fascinating how the local authority became a self -protecting tool to look after itself. Blame culture in the local authority is alive and well and thrives like a cockroach"*

Beth: *They were talking about the way in which they could get themselves out of it rather than learning from it…Blame was pinned believe me, it was pinned, yes, yes, funnily enough you know, you look through the case notes, there's no supervision,*

no action on there, but the managers still get to stay in post, how is that? How does that work? Where's the accountability for them not offering what they should be offering to the ground workers?

Use of terms such as "tool", "machine" and "cockroach" encapsulate the workers sense of the cold, impersonal nature of the local authorities during the reviews. Each of the social workers who presented a negative view of the SCR process, emphasised how, in their opinion, the local authority, appeared to ignore their individual needs and distress and did very little to negate or minimise their feelings of alienation and isolation. Anna provides a clear example of this in her assertion:

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

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

"It was very structured to be fair; it didn't take a lot of my time and it didn't drag me down or anything because the way it was dealt with right from the beginning. The Service Manager was very supportive but not to the point where she would have covered up any bad practice or anything; she was perfectly just on the ball, really right with the level…very compassionate but appropriate…it was very much a learning experience…at no point did I feel like they were questioning me like I had

done something wrong. I felt it was very supportive. I really felt supported; I developed a really good relationship with the strategic manager after that.

Master Theme Four; No Further Action. ***The social workers perceptions of the support and supervision they and their colleagues received post event.***

Following notification of the children's death no immediate support or counselling was offered by the local authorities to any of the social workers involved. It is possible, that as a consequence of not being offered support in the workplace many workers turn to their friends and families for support or to informally offload their thoughts and feelings, however such a situation is often problematic:

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

All of the social workers who were interviewed spoke at length of the different forms of managerial input the received:

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

Anna, Claire and Donna all cited their line mangers and social work colleagues as playing key roles in providing support and comfort following the children's deaths.

Anna: *My line manager was amazing, she was amazing, she looked after me and then I was able to look after the team. I had a debriefing with my line manager who looked after my feelings and helped me to realize that I hadn't killed this baby and we looked at what could we have done different, I took a lot on board".*

It is evident from the interviews that the children's deaths impacted significantly upon both the individual social workers involved and the teams in which they worked. A recurring theme emerged that the empathic understanding of co-workers played a pivotal role in improving some aspects of social work practice as well as providing networks of support for those affected by events.

Anna: *"We had a staff meeting in our team, to support the SW who was ripped apart, ripped apart, and err I think we got closer as a team, around it…Your conscious of, of each other's needs, your conscious of how each other is feeling. Your conscious of, you know your empathic to each other".*

THEORETICAL ANALYSIS OF THE RESEARCH FINDINGS

The theoretical analysis of the interview data reveals that a combination of political, procedural, media responses, managerial behaviours and interpersonal relationships, combine to exacerbate the negative impact of the children's deaths upon individual workers and the social work teams in which they practice. **There is also evidence within the study, particularly in relation to the experiences of Donna that appropriate responses by individuals and agencies can help to lessen the negative impact upon the workers involved.**

Several examples within the study indicate that the grief they experienced as a result of the loss of the children was disenfranchised by the organisations in which the

practiced. Defined by (Doka, 2002, p.4) as “the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported”, disenfranchised grief becomes the assumption “that a particular individual does not have the right to be perceived or to function as a bereaved person. The important point here is that disenfranchised grief is not merely unnoticed, forgotten or hidden; it is socially disallowed and unsupported” Corr, et al (2009, p.257). As the study has provided a holistic overview of the lived experiences of the workers involved and placed those experiences within their personal and organisational contexts, it is possible to analyse how and in what ways the interplay between intraneous factors, consisting of individual judgements, decisions and emotions associated with the event and extraneous factors, consisting of SCRs, managerial actions, the disenfranchisement of the social worker’s grief and media and political responses to the event, have impacted upon the workers involved. Using examples from within the study and supporting literature from a variety of sources, this process will now be described and analysed in more detail.

The Role of the Media.

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

Anna's and Beth's feelings have been replicated by a number of other social work practitioners who have themselves been directly involved in case of fatal child abuse. Martin Ruddock, the allocated social worker for Kimberley Carlile who died in 1986, recalls his "conflicting emotions" at the media and public inquiry response to his involvement in the case. His impassioned and deeply moving account describes the isolation and anxiety he experienced amidst the "tabloid clamour for personal blame and revenge" (Ruddock, 1987, p.14).

Political Context

It is suggested here that in conjunction with the negative media portrayal of social **work, a combination of political factors linked to the review and policy contexts of fatal child abuse, negatively impact upon the social workers involved. It has been suggested that rather than addressing wider learning or systemic issues, and in order to pacify any perceived moral panic, inquiries: "Serve to appease public disquiet. They demonstrate that government (central or local) is not being passive; they symbolize the reassertion of moral order; and they serve to define the nature and causation of child abuse in ways which detach it from wider social processes and responsibilities" (Parton, 1981, p.391)**

The views of Parton emphasise how, within inquiries, both the demonization of child abusers and the highlighting of the practice errors of individual welfare professionals, serve to detract from many of the more complex and challenging issues associated with the wider societal recognition and responses to child abuse.

In connection with the views Parton, several authors (e.g. Reder, 1993, 2004, Van Heugten, 2011) have emphasised how child abuse inquiries and serious case

reviews in particular, also focus upon areas of individual, usually social worker malpractices, that are perceived as directly contributing to, or at least fail to prevent the deaths of the children involved. Such assertions are evident within the study; from the perspective of the interviewees they either personally felt responsible or perceived that they were made to *feel* responsible for failing to prevent the deaths of the children. In addition, the interviews provide several examples of individual social work practitioners being directly blamed for the children's deaths. It is reasonable to suggest however, that the "individualisation" of blame in relation to both the perpetrators of the abuse and the workers, served to detract from the wider systemic issues involved.

Anna, Beth and Claire provide a number of instances where, in their opinions, the local authorities in which they practiced used the SCR process to mask deficiencies in such things as service provision, supervisory process and managerial accountability. The format of the reviews themselves, in the cases of Anna and Claire consisted only of "closed" questioning and prohibited them from providing their own personal accounts and experience of events. There is evidence in the interviews that within the SCR review process, some of the workers were simply asked such (closed) questions as whether certain assessments and case recording had been completed on time? Or if the appropriate number of statutory visits had been undertaken? Such questions do not then seek to elaborate upon the quality, context or the inter-personal dynamics that were in operation during those visits and assessments.

Interpersonal Relationships

Any discussion relating to the impact of fatal child abuse upon social workers, must also address the inter-personal relationships that may potentially serve to reinforce the feelings of blame they experienced. At a personal level, the social workers describe how there emerged a professional distance between the social workers directly involved in the events and some service and team managers within the authority. Anna, Beth and Claire perceived that managers and management system were also exempt from the attribution of blame following the reviews, thus creating further "distance" between the individual practitioners and their organisations. They question why the lack of staff support and supervision, reduced training opportunities and poor or no decision making from management was not highlighted within the reviews and how no managers or senior managers were deemed to be accountable for their actions and inaction.

Conclusions

The accounts of the individuals involved represent only a small fraction of the numbers of social workers who have been directly involved in SCRs and child abuse fatalities, despite the fact that all of the workers recounted a number of instances where colleagues have endured similar experiences it must be acknowledged that the representative sample is still very small. Although support is to be found within the recollections of Sharon Shoesmith and Martin Ruddock et al, care needs to be taken before making broad practice analogies. However, it is a reasonable affirmation that those social workers who were interviewed describe their experiences of a working environment in which remain largely unprotected from professional scorn and the public admonishment and a review system that asks

same largely irrelevant questions to the wrong people. Potentially the voices of those individuals who are able to make the most telling insights and contributions to our learning are denied a voice. Based on the experiences of the social workers, local authorities are able to ignore the wider systemic practice issues by deflecting attention towards the individuals who are directly in contact with the children and their families. In addition, SCRs create only the illusion of action; detracting from the wider need to address the underlying aetiology of a deeply serious and emotive social issue.

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