ACCOUNTABILITY AND EFFECTIVENESS IN SOCIAL SERVICES MANAGEMENT. AN EVALUATION OF INQUIRIES INTO NAI DEATHS 1973-1982.

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SUMMARY

The thesis sets out to explore the functions and processes of formal inquiries into the non-accidental injury (NAI) deaths of children known to social services departments in England and Wales. NAI inquiries are discretionary and non routinised, they are expensive and disruptive to organisational behavioural relationships. They bring into sharp focus the public accountability of social workers to the client, social workers to departments, departments to the local authority and the local authority to the public. There have occurred during the period 1973 to 1982 approximately two formal NAI inquiries per annum. The thesis examines the impact NAI inquiries have had on the management of child abuse within social services departments. It does so in terms of the development and use of child abuse practices and procedures, the utility of the recommendations of various modes of NAI investigative processes from the viewpoint of practising managers and explores some of the reasons why one NAI death may warrant an investigation while another NAI death may not. The primary emphasis of the research methodology is based upon a qualitative approach to data analysis. The research strategy comprises the following: a content analysis of twenty two inquiry reports published during the period 1974 - 1982, a questionnaire survey of social services departments an analysis of which provides a snapshot of child abuse policies in practice (1980-1983) and data on views and opinions of practising managers as to the impact and utility of inquiry reports. The final part of the strategy comprises a case study. The study focusses specifically on one social services department that as a result of one NAI death in 1976 was the subject of seven investigations over a period of four years.

KEY WORDS

SOCIAL SERVICES
NON-ACCIDENTAL INJURY
INQUIRIES
MANAGEMENT
ACCOUNTABILITY

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NAI deaths is an emotive area to explore. Throughout the research period I have received support from three women, Jane Skinner, my supervisor, Mary Sharp and Brenda Burrell.

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At the end of a stressful number of years my thoughts turn to my mother and father, Kath and Watcyn Jones, who have assured me throughout my life that the pen is mightier than the sword . . .

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ABBREVIATIONS

AD	Assistant Director
ADSS	Association of Directors of Social Services
AHA	Area Health Authority
AMT	Authority Management Team
ARC	Area Review Committee
BASW	British Association of Social Workers
CC	County Council
CRE	Commission for Racial Equality
DHSS	Department of Health and Social Security
FSU	Family Service Unit
INLOGOV	Institute of Local Government Studies.
LB	London Borough
LASSD	Local Authority Social Services Department
MBC	Metropolitan Borough Council
MP	Member of Parliament
NAI	Non-Accidental Injury
NALGO	National Association of Local Government officers
PSSC	Personal Social Services Council
RIPA	Royal Institute of Public Administrators
SHSW	Senior Hospital Social Worker
SOLACE	Society of Local Authority Chief Executives
SW	Social Worker
SSC	Social Services Committee
SSW	Senior Social Worker
DPP	Director of Public Prosecutions
NSPCC	National Society Prevention of Cruelty to Children

Chapter 1 Introduction

Where legislation extends substantially the field of public responsibility (Rawstron 1980) the consequences can rarely be predicted with certainty. The commentators on and supporters of the Seebohm (1968) recommendations for a new unified social services departments could not foresee that departments would have a high public profile, heightened not through public confidence but through public criticism of their failure to prevent child deaths. When local authority social services departments were created in 1971, the new unified department had ultimate responsibility for promoting the welfare of children and of investigating and enacting statutory powers in cases of child abuse and neglect. These powers are exercised through the agents of social services departments, the social workers. The new social services departments provided an organisational base for the emerging profession of social work, whose powers were greatly enhanced in relation to children by the Children and Young Persons Act 1969. The profession obtained a legitimate base. With increased powers and responsibilities came an increase in public accountability. Formal non-accidental injury inquiries brought into sharp focus the accountability of departments and individuals within departments to the public.

The Uncovering of child abuse.

There is no agreed definition of child abuse, nor fully accurate ideas of its incidence (Jones 1982, NSPCC 1982, Creighton 1984). The phrase "battered baby syndrome" was first coined by Kempe (1962) to describe a condition researched by members of the American medical profession (Caffey & Silverman 1945, De Francis 1956). The application of this

label and the recognition of a "new" social problem is associated with the work of Kempe and his colleagues at Denver. Recognition of the syndrome as a "problem" developed slowly in Britain. It was not until the 1960's that the issue was brought to professional attention (Griffiths & Moynihan 1963). During 1965 the British Medical Journal carried three articles on "battered babies" (Simpson 1965, Roof 1965, Russel 1965). The uncovering of the syndrome and its subsequent research became located within the medical profession.

In 1969 the NSPCC set up a Battered Child Research Unit, the orientation of the unit owed much to Kempe and his colleagues. Child battering became conceptualized as a medical-social problem (Castle 1975), the NSPCC became identified as the local agency. In 1972 the NSPCC produced a report which stressed the importance of multi-disciplinary approach to child battering and recommended the establishment of central registers of cases of suspected abuse at local level (Castle & Kerr 1972). In the foreword of the report child battering was likened to a 'contagious disease' where the parents 'are so grieviously inadequate in coping with the demands of the parental situation.' In its annual report for 1982, the NSPCC linked poor parenting to a form of depression dating from neglect in childhood and pointed to a cycle of deprivation in which neglected children grew up to become neglecting parents (NSPCC 1982). Parton (1985) argues that the discovery of child abuse served the needs of professionals within the medical profession in America and within the NSPCC in Britain (Parton 1985;48-68).

The uncovering of child abuse in Britain took place within the context of changes in the orientation of social policy (Hall 1975, Jordan 1976).

The "cycle of deprivation" thesis (Webb 1975) encompassed the NSPCC's view that child abuse was the result of psychological pathology (Wasserman 1967). In May 1973, a conference took place at Tunbridge Wells. It comprised members of the medical profession, legal profession, social services and the police. The aim of the conference was to bring together professionals involved in and working in areas where child battering was becoming more apparent. The intention was to share information and raise awareness amongst professionals of the phenomenon (Franklin 1975). The group of distinguished experts gave the problem legitimacy (Parton 1985;76). An outcome of the conference was that the "problem" became more broadly defined. The more inclusive term 'Child Abuse' replaced the term "battered baby syndrome."

Child abuse has a plethora of definitions. There is however general agreement that child abuse is characterised by harm to a child and may involve death. Child abuse encompasses, neglect, failure to thrive, emotional abuse and sexual abuse. The term incorporates both clinical and social definitions.

> "the validity of the judgement of just what constitutes 'abusive' or 'neglectful' behaviour is clearly a matter of degree, ultimately involving the parameters of 'normal' or 'acceptable' and 'aberrant' or 'harmful' parental behaviours" (Giovannani 1971).

Sheppard (1982) in an expressed intention to "drawback readers from blindly following the road to Denver" puts forward a critique of the interpretation of child abuse as individual pathology. The perspective he argues underpins traditional social work. Thus while research explanations as to causation vary, it is argued that the variations largely reflect differences within the same pathological framework. For

example "parent as victim" (Court 1975, Chapman 1977, BASW 1978b), "environmental factors" (Gil 1969), "family functioning" (Smith 1975), "parental psychopathology" (Cameron 1966, Merril 1969) and behaviour characteristics of the child (Nurse 1964).

A similar point is made by Carew (1979) "certainly the framework and assumptions adopted in child abuse research are also characteristic of traditional social work," (Carew 1979;349-26). A major focus of a traditional social work approach is casework, described by Perlman (1970) as,

> "The distinguishing mark of casework as a helping mode in social work is that it takes as its unit of attention and concern the individual instance, a person or a family. The person or family considered to be a prospective user of help via the case work process is one who is experiencing some problem in his relationships with one or more other persons, or in his satisfactory performance of one or more role tasks" (Perlman 1970;132).

Casework consists of a number of stages; investigating the problem, assessing and diagnosing the problem, and treating it or providing goals (Perlman 1970; 158-167). According to Sainsbury (1970) the caseworker is concerned with the "interpretation of normative and prescriptive values which are seldom seriously debated." Individual social workers have to extract the 'facts' of a case and fit these 'facts' into a framework for action (Hardiker & Barker 1981). It must be noted that to date (1986) family systems work has displaced psychotherapeutic casework as the method of social work. 'Facts' of a case can be distinguished from 'factors' of a case by the use of a theoretical framework "those who tried to create a theory out of facts never understood that it was only theory that could constitute them as facts in the first place" (Stedman-Jones 1967). Individual social workers employ professional judgement in their assessment of a case. The judgements emanate from their perceptions of the complexity of the case.

The judgements are (according to some commentators) implicitly or explicitly justified by reference to a particular researched perspective (Sheppard 1982), or view of social reality (Hardiker and Barker 1982).

A criticism made of the 'profession' of social work is that it has no particular and unique body of knowledge of its own (Chapter 2). Child abuse is a complex phenomenon; what comprises child abuse is informed by an array of disciplines, for example, medicine, psychology, sociology. Defining and addressing the phenomenon is problematic for social workers, a fact that a number of NAI inquiries have acknowledged (Most notably the Maria Colwell Inquiry 1974 and the Lucy Gates Inquiry 1982).

The Phenomenon of Child Abuse Inquiries

Approximately 90% of child abuse cases do not result in a child's death (Harris 1986). A small percentage do and an even smaller percentage are the subject of a formal NAI investigation. For social services departments in the discharge of their responsibility to promote the welfare of children there is no publicly acceptable level of failure. Two NAI inquiries took place early in the 'life' of the new social services departments (Bagnall 1973, Naseby 1973) but these did not generate public interest nationally. The death of Maria Colwell in 1973 however, caused a national scandal. Parton (1985) views the publicity surrounding the death of Maria Colwell and the mobilising of professionals, notably the "Tunbridge Wells Group" as being discrete activities in that one did not inform the other. Yet they became inextricably linked in the public consciousness "while the timing of Maria Colwell and Tunbridge Wells was coincidental the combination was explosive" (Parton 1985;77). Child abuse emerged in 1973 as a highly

emotive and complex public issue.

The legal model put forward by Carter (1974) simplifies the complexity. If the abusing parent is found to be responsible for the murder or manslaughter of a child the appropriate response is to punish him, for the abuser(s) has clearly transgressed the norms of society. A child's murder or manslaughter becomes an NAI death principally if the child is known to a social services department, the department that has statutory powers to protect children. It follows that in any NAI death there are two "units" to be held accountable, the abuser(s) for perpetrating the abuse or neglect and the social services department for failing to prevent the abuse or neglect. Early research suggested that precisely because social services departments were involved with the family and the child, criminal justice did not take its full course. Of a sample of 134 battered children (including 21 who subsequently died) 81.6% of parents were not prosecuted for battering their child, of this group 81.4% of these cases came under social services supervision (Smith 1975;178-9).

In the reports analysed in the thesis (Chapter 5) a social services department had been in the majority of cases closely involved, procedurally, with each child (chapter 5, tables 12 and 13). Implicit in this involvement is the notion that the deaths could have been prevented. In each of the reports criminal proceedings were enacted against those accused of abuse or neglect (Chapter 5, table 9). In not one of the NAI reports examined in the thesis was a social worker or a department charged with contributory negligence. However the part played by the departments and individuals within departments was commented upon unfavourably in the press and the judge during the

summing up of criminal proceedings. A combination of media pressure and judicial remarks was a major factor in local authorities instituting in a majority of cases formal inquiries. (Chapter 5 table 8). These inquiries were conducted in a quasi legal way, for example taking evidence by the examination and cross examination of witnesses who may have sought legal representation. It is BASW's view that an NAI death results in two trials, the first concerned with those accused of causing the child's death carried out in a court of law, and the second concerned with the culpability of individual social workers and departments, carried out by a 'mock trial' through a committee of inquiry (BASW 1982).

Twelve years on from the Maria Colwell Inquiry (1974) the debate as to the appropriateness of inquiries as methods for investigating the complex issue of an NAI death continues (Harris 1986). There have occurred since 1973 an average of two formal NAI inquiries per year. If inquiries are non effective as some commentators state, most notably BASW (1982), then the question is raised as to why there appears to be a belief both by departments and by the public in the efficacy of NAI inquiries (chapter 3). The latest inquiries into the highly publicized deaths of Jasmine Beckford (1985) and Tyra Henry (1985) demonstrate the continuing concern of society and the continuing belief in the efficacy of formal inquiries at times of crisis, and the continuing criticisms voiced by commentators (Harris 1986).

Published NAI inquiry reports are public documents, tangible proof of a departments accountability. The thesis is concerned specifically with an examination of published NAI inquiry reports and the impact NAI

inquiries have had on the management of child abuse within social services departments in England and Wales. Chapter five of the thesis examines the content of inquiry reports in terms of a number of themes which include "the influences upon the decision to hold an inquiry," "the accountability of the abusers," "the organisational focii of inquiries," and "procedural issues" as identified by each examined inquiry report. Chapter six examines the role and utility of NAI inquiries as perceived by practicing managers within social services departments. The chapter examines child abuse policies in practice and analyses the impact NAI inquiries have had on the management of child abuse within departments, during the period 1980 - 1983.

It is stated in the thesis (chapter 3) that the reasons for instituting formal NAI inquiries may not be made known (Marre 1978). The case study (Chapter 7) traces the negotiations within one local authority that surrounded the instituting of seven investigations all concerned ostensibly with an NAI death that occurred in 1976. The study brings to the fore issues examined in the thesis, such as the impact of local government reorganisation on departments, the future of a "Seebohm director," and the use of inquiries as political tools. Chapters 2 and 3 of the thesis set the context within which the phenomenon of child abuse inquiries is examined.

CHAPTER 2 Professionalism and Bureaucracy: The Organisation and Management of Social Services Departments

To be highly critical of the present as a justification of the need for change, to be over optimistic about the future as an incentive for following particular recommendations and to urge speedy transformation from one state to the other is a primary aim of committees of inquiry (Bulmer 1983). All these were characteristics of the Seebohm Report (1968). The Report recommended the creation of large unified departments, that in the local authority scenario set by Maud (1967), would be able to attract more resources, provide a clearer and more comprehensive pattern of accountability and responsibility and would generate adequate training and recruitment of staff. The new Social Services departments would "meet the social needs of individuals, families and communities" and would ultimately provide a comprehensive "effective family service" (Seebohm 1968: 117-138).

The Report put forward in normative terms an optimistic future scenario. However it failed to address in a substantive way the organisational design that would enable the new departments to fulfill the Seebohm optimism. Supporters of the Report's recommendations created a wave of enthusiasm for the new service (Thomas 1973). It was in 1970 that the 'wave' came up against the realities of administration. The Seebohm Committee's recommendations were translated into the Local Authorities Social Services Act (1970). The Act envisaged that no extra staff or money would be required for its implementation and did little more than transfer powers and duties from constituent sections of the local authority to the new unified department. The appointed day for its full

introduction was fixed for the 1st April 1971.

From such beginnings, the chapter examines the evolution of social services departments with particular reference to the issues of professionalism and accountability.

The creation of the social services departments (1971) provided an organisational base for the developing profession of social work. Appendix L. of the Seebohm Report (1968) contains figures to show that social workers numbered less than 11% of the total employees of welfare departments, and that only one in five had full professional qualifications. Throughout the 1960's there was a growing trend towards the common training of social workers regardless of their work setting (Younghusband 1959). Common training was a factor contributing to the occupational group's recognition of a common specific identity, and in 1971 the British Association of Social Workers (BASW) a professional association for qualified social workers was formed.

Few studies existed at that time (when the Seebohm Committee was collecting evidence) into the nature of Social Work (Holman 1970). As a consequence of the paucity of information, the role of social work was never fully explored by the Seebohm Committee (Sinfield 1969). However, one study of how social workers spent their time found that much time was spent on unproductive work and much of the productive work did not demand high skills (Scottish Education Department 1963). As early as 1915 Flexner had argued that social work could not claim to be a profession as it had failed to standardize its methods, had a poor academic reputation and did not possess an educationally communicable

technique. Instead of applying professional knowledge and skills to deal with social problems, Flexner argued that social workers did little more than refer their clients from one agency to another. Flexner was articulating a view of social work in America and it was not until the 1960's, in Britain, that a group identifiable as social workers began to emerge.

The creation of the social services departments dramatically enhanced the promotion prospects and salaries of social and welfare workers. It has been noted that social work associations and academics and politicians closely associated with social work were the most outspoken critics of the pre-Seebohm administrative arrangements (Thomas 1973). Fifty eight childrens officers, seventy nine welfare officers and three social work teachers were amongst those who were appointed as Directors of the new departments in 1971 (Smith 1972). Sinfield (1969) questioned the basis of social work pressure for the development of a unified department. "A citizen reading the report (Seebohm) might indeed conclude that it had little to do with his own needs or rights in the modern welfare state" (Sinfield 1969, Thomas 1973). This point is amplified by a latter day commentator who concludes that the Seebohm Report was conceived and written from the standpoint of aspirant professional social workers (Wilding 1982). Certainly those appointed to senior management positions were professionally qualified social workers (DHSS 1976b). This set the tone for management appointments, there occurred a predominance of qualified social workers in senior and middle management roles. The largest single group represented in management were staff from the former Childrens Departments. The implications of having specialist social workers in management roles was not at the time

thought through. Other options such as employing non qualified staff in management posts or of appointing managers from outside of social welfare, were not seriously pursued (Hallett 1982;34).

In this way services to children and young persons became a primary professional orientation of the new departments. The statutory powers of social workers in relation to this client group were greatly enhanced by the Children and Yougn Persons Act (1969). The Act gave local authorities wider responsibility for children either potentially or actually in trouble; for community homes and intermediate treatment, for progressively taking over from the probation service responsibility for court inquiries and supervision orders and for implementing care orders.

Thus in 1971 the basis of the new departments had become generally established. Senior and middle management (a possible consequence of the 'knock on' effect of appointing directors qualifed in social work) comprised professionally qualifed social workers. A significant group of these were drawn from the former Childrens Departments. The departments became orientated towards the development of services to children and young people. The Children Act (1969) greatly increased the statutory obligations and responsibilities of local authorities and hence social workers in relation to this client group. In this way the emerging profession of social work gained legitimacy. "Managerial priorities and personal preferences happily coincided to give emphasis to work with children and families" (Bamford 1980).

In 1972 a study was carried out in four area offices in Southampton Social Services Department and was repeated in 1975 (Neill et al 1973 &

1976). The Study found that in 1972, 57% of social workers were professionally qualifed compared to 49% in 1975. All senior Staff held professional or relevant qualifications in both periods. By 1975 the proportion of unqualified fieldworkers had doubled from one fifth to two fifths.

In 1972 social workers carried specialised case loads. The Former child care officers held much smaller case loads than ex-social welfare officers. The majority of social workers thought specialisation would continue indefinitely and preferred this. By 1975 most had mixed views. In 1972 the vast majority of child care cases were in specialist case loads, this had altered to one half in 1975.

In 1972 no attempt was made to separate dormant cases from active cases. Most field workers felt under pressure. The feelings of stress were attributed to unsorted case loads, unclear goals for social work intervention and lack of criteria for assessment, allocation and closure of cases. These findings echoed a study conducted in 1965, which found that there was a lack of generalised professional goals among social workers working in one county borough (Parker & Allen 1969).

In both 1972 and 1975 most of the social workers in the Department, given a choice, preferred to work on child care cases. Only a quarter wanted to work with other client groups. Yet the majority of the Department's case load consisted of the least preferred groups and only quarter of the case load consisted of child care cases. In 1975 field workers continued to feel under stress. They attributed this to problems in deciding priorities and standards, lack of clerical services

and anxieties about communication with management.

Between 1971 and 1973 the public sector was in the throes of reorganisation. Social services departments had little time to establish systems of intra-departmental and inter-agency communication and co-operation before local government and National Health Service restructuring. What emerged from the Southampton study was that social workers in the Department were in a state of ambivalence over professional goals and responsibilities. In 1975 there were clearly emerging signs of disaffection with management (these issues are explored in greater detail in Chapter 7 of the Thesis). Social services departments generally, were facing exaggerated expectations of rapid growth followed by a period of abrupt retrenchment, heralded by the first substantial cuts in December 1973 (Glennerster 1976, Webb 1980). The emerging profession of social work was exhibiting a lack of cohesion combined with limited public support for its activities. The most consistent illustration of this lack of support can be found in the succession of "Battered Baby Scandals" that have dogged the social services departments since 1972 (explored in Chapter 5 of the thesis). "So it is that the nation goes from one reorganisation to the next conceptually ill-equipped and I believe floundering" (Rowbottom et al 1974). Much of this disaffection focussed on managing professional groupings.

One of the debates that has characterised management research of public sector welfare organisations is concerned with the issue of professionalism, and has centred around two points (i) should professionals manage themselves and (ii) can non professionals manage

professionals. There is at present a move in the public sector towards the employment of general managers to manage professional services as evinced by the recommendation of the Griffiths Report (House of Commons 1984). However the literature concerning the social services shows that these debates are far from being resolved (Mitchell et al 1983).

Social Workers and Professionalism

Professionalism has been described as "a phenomenon of all industrialized societies" (Hughes 1963). Commentators have sought to explain and to characterize the development of professions and isolate factors that differentiate professions from other occupations. The 'trait' approach based on a consensus model of society (Flexner 1915, Greenwood 1965) assumes that various professional unities exist and that professionals within these unities can attribute to their status a set of characteristics that distinguishes them from other occupations. Greenwood (1965) listed five elements constituting the distinguishing attributes of a profession - systematic theory, community action, authority, an ethical code and a professional culture. Freidson (1970) rejects the notion that professions have innate or general characteristics. Stating that a profession is an occupation which has assumed a dominant position in a division of labour, so that it gains control over the determination of the substance of its own work, (or of work close enough to its field to be regarded as a potential challenge to its dominance, Wilding 1982), Freidson's argument implicitly rests upon a conflict model of society, that is society is an arena in which competing groups struggle to secure their own interests. Professionalism is under this view a form of occupational control, characterized by autonomy and control over terms of work.

However the term "profession" is essentially imprecise, Becker (1971;92) sees it as being a symbolic and honorific title "profession is a collective symbol and one that is highly valued". A similar view is expressed by Hardcastle (1977;14) "it is the ideal of service or of a calling, with the practitioner standing above the sordid considerations of the market place." Some commentators conversely would argue that occupations termed professions organise themselves specifically to attain market power (Parry 1974, Illich 1975, Larson 1977).

Professions can be viewed as communities with shared interests, common symbols and ideologies (Goode 1957). A counter view has been put forward by Bucher & Strauss (1961:330) who, as a result of studies within various professions where spcialization had developed, concluded that "in so far as colleagueship refers to a relationship characterized by a high degree of shared interests and common symbols, it is probably rather rare that all members of a profession are even potentially colleagues." This point is further expanded upon by Jamous & Peloille (1970) who describe professions as being loose segmental organisations, finding expression in differing attitudes to: client relationships, the purpose of professional associations, the functions of training. Professions in their view, represent struggles for dominance between progressive and reactionary groupings. A view expressed by Titmuss (1968;72), professional people, "whether they be doctors, social workers or teachers are pre-eminently people with status problems."

Debates as to the nature and origins of professionalism only partially address the emergence of the profession of, or the development of the

semi or aspirant profession of social work. Social workers on the other hand, have sought to justify their claim to professional status on the basis of specific knowledge and skills passed on through training and experiential learning (Toren 1969). The professional association (BASW) has produced a code of ethics (BASW 1975a), regularly produces a professional journal ('Social Work Today') and is generally consulted on matters concerning social work by the DHSS. The Association up until 1978 admitted only qualified social workers. A minority of social workers are actually members of BASW (9,000 a third of all social workers) though the Association continues to see itself as the voice of social work (BASW 1982). The emerging profession of social work exhibits segmental differentiation between those who are qualified, and those who are not, those who specialise and those whose brief is generic. The professional association contains within the pages of its journal, from 1974 onwards a history of debates as to the nature of professionalism, the role of management and the function of training. From these debates it appears that there is, fifteen years on from the creation of the social services departments little cohesion within the "profession".

The typical work environment is a local authority social services department. It has been argued that within this environment certain functions are attributed to social workers, "the front line troops" in the war against poverty, providing material and financial assistance to clients (Jordan 1974). The role of social worker is according to this view one of agent, acting on behalf of the hierarchical and bureaucratic structure of local government services (Rees 1975). It is this role of agent that inhibits (in the view of some commentators) full professional

status being accorded to social work (Mitchell et al 1983). Put in organisational terms, according to Kakebadse (1982) this is the dilemma for professionals oriented towards developing a task culture in a role culture dominated organisation (Kakebadse 1982;137). Rowbottom et al (1974) could find no inconsistency between the idea of professional freedom (discretion) and hierarchical management organisations within the social services departments they studied. This was attributed to the status of the social work profession. "The more advanced the profession the more difficult it is to sustain a managerial relationship across a professional boundary" (Rowbottom et al 1974;274). That is, the newly emergent profession did not or could not take part in the same kinds of confrontational displays as was found between the medical profession and the National Health Service hierarchy. It is important to bear in mind that doctors per se do not dominate the management of the National Health Service, whereas qualified social workers de facto dominate in a positional sense, management within social services departments. BASW (1975b) neatly side-stepped this fact by defining social work as direct work with clients and maintain that employment of social workers in better paid management positions had devalued social work practice and drained qualified staff from it.

Hey (1980;64) concludes from her research that social work as an "independent practitioner" profession has some way to go before society grants it such status. "It is no doubt an indication of public concern about the competence of social workers that they have been called to account for their actions in numerous cases, particularly in non-accidental injury incidents being brought to inquiry." She goes on to state that inquiries may be seen as important opportunities for the

future development of the profession as they place pressure on social workers to explicate their objectives "which will in turn lead to greater clarity about the boundaries of social work".

The Organisation of Social Service Departments

The publication of the Seebohm Report (1968) generated discussion on managerial and organisational matters. There was a consensus amongst contemporary commentators (Hopkins 1969, Barker 1969, Algie 1970) that whenever possible the new departmental structures should not fall into a "bureaucratic trap" of producing tall hierarchies, inflexible and unadaptable to changing conditions.

The Local Authority Social Services Act (1970) stipulated only that the local authority should establish a separate committee for social services and that a chief officer be appointed to act as director of social services. Apart from these requirements the internal structure of departments was left to local authorities to decide. Consequently there is great variety in the arrangements and a lack of uniformity in terms used to describe different posts and units within the departments which complicates the task of categorizing and comparing them. However one factor all departments have in common is that they are structured in the form of bureaucratic hierarchies. "A hierarchically stratified managerial employment system in which people are employed to work for a wage or a salary" (Jacques 1976;49).

A typical social services department comprises of a director, accountable to a social services committee which is comprised of elected members accountable to the local electorate. The director is

accountable to the committee for the work of all the staff in the department. The department carries out its functions through a chain of hierarchically stratified, variously designated levels of management. Each manager in turn delegates tasks and gives the necessary authority over resources to subordinates and each is accountable to a superior both for the quality of his own performance and for the work of those he manages. Thus in a hierarchy lines of authority and accountability are clearly defined. Social services departments are bureaucracies and, it is suggested by some commentators that they should remain so. "Some degree of hierarchy is needed in any organised endeavour" (Perrow 1970).

Rowbottom (1973) found that those who worked in social services departments saw themselves as being hierarchically organised in "the precise" sense, that is within a structure of successive managerial roles (A. is accountable for certain work and is assigned a subordinate B. to assist him. A. is accountable for the work which B. does for him). The work of Parsloe (1981) while supporting the claim that staff accepted the basic hierarchical structure found that they were much more uncertain about the nature of accountability and responsibility than those whom Rowbottom studied. Perrow (1970;39) in reviewing studies of the relationsip between size of hierarchy and control concludes "we cannot assume that the more hierarchical the organisation the more centralised it is." Certainly the Parlsoe (1981) study found that the relationship between Social Service Teams and the hierarchy at headquarters was not characterized by oppressive regulation, control and interference but rather by distance ignorance and alienation. Social workers saw themselves as accountable either as professionals directly to their clients or to team leaders and through them to area officers.

Beyond this point in the hierarchy in their view accountability became a vaguer concept.

In a typical department the director is usually a professionally qualified social worker, in 1976 it was found that the deputy and some 80% of area directors had a professional qualification (Personal Social Services Council 1980). It is important to note that the views of senior management as being distant and ignorant, were held by operational level staff of a hierarchy which is itself highly professionalised. The issue of "professionalism" may deflect attempts to analyse systematically the management function of a social services department. The implication is that social services departments in their function and complexity differ dramatically from other organisations and thus management training, development and approaches found in other public and private sector organisations may be inappropriate for social services departments.

The ultimate justification of an administrative act, is that it is in line with the organisation's rules and regulations and that it has been approved, directly or by implication, by a superior rank (Etzioni 1964;76). The department might produce policies that conflict with the professional judgement of the social worker. Organisations may often find it difficult to be accountable to governing bodies and responsive to the judgement of those working within the organisations. (Kogan 1974). Managers operate within prescribed boundaries, this is as true for professionally qualified social work managers, as it is for those who are not. On the basis of research evidence (Parsloe 1981) it is difficult to justify in organisational terms why social services

departments should be almost exclusively managed by professionally qualified social workers.

The Issue of Accountability

Social services departments operate within a political environment. Decisions may be questioned by any Councillor (who for example considers a constituent has been unfairly treated, or that rate payers money has been wasted); by members of a minority party who may seek to make political capital out of alleged mis-managment by the party in power, by the press (both local and national), by members of parliament, by the local government commissions and, in cases giving rise to serious public concern by a committee of inquiry.

A "goldfish bowl" effect can accrue to managers working in large public agencies because of their position in the accountability chain (Wilensky & Lebeaux 1965;246). Scrutiny of management decisions can result in a proliferation of rules a narrowing of discretionary areas and an emphasis on procedures. This process of bureaucratization (Blau 1955) is described in relation to central government in the Fulton Report (1968).

> "Public accountability . . . brings with it a constant awareness of public involvement in even the smallest decisions and the likelihood of disproportionate publicity for the smallest errors. Inevitably . . . decisions are taken on a higher level than on the surface appears to be necessary and the negotiations and discussions leading to them carefully documented" (HMSO 1968;23).

In terms of social services departments, inquiries into NAI deaths have contributed to the development of formal procedural frameworks within which child abuse is now managed. The elaboration of detailed guidance for dealing with child abuse cases is a somewhat a - typical

development. In social services departments in this area of work professional activity is closely prescribed. Child abuse procedures illustrate the permeability of social services departments, since external pressure from government and the media is influential in framing departments responses to child abuse. Hill (1972;36) notes "often formalisation will occur only when internal conflict or attack from outside forces it upon the organisation."

In the thesis (Chapters 5 & 6) the existence of and ways in which formal procedures impact upon social services departments is examined. It is noted that formal procedures can be subverted lower down the hierarchy, a point borne out in the thesis (Chapter 6), where it was found that formal operational procedures in relation to child abuse existed, but were not operated effectively by staff. This point is made more generally in Parsloe's study of Social Services Teams (Parsloe 1981).

Accountability is the obverse of delegation. The link between them is control. Control is the means through which a higher level of authority satisfies itself about the performance of its agents. In practice vertical accountability has limitations. It is not possible or desirable to secure total compliance or total control over local operations of any complexity in social services departments (Glastonbury et al 1980). Social worker's "discretion" is guided by the notion of accountability to the client and at times of a "disaster", for example after the occurrance of an NAI death, directly to the public and the department (BASW 1982). "The ultimate justification for a professional act is that it is, to the best of the professional's knowledge the right act" (Etzioni 1964;76). In relation to child abuse, the quality of

professional decision making is viewed by society as of less importance than the outcome, a child's death. This point is exemplified by the highly publicized death of Maria Colwell in 1973. The report (published in 1974) declared that no individual social worker was blameworthy, but to the press, the findings of the inquiry meant less than the fact that the child had died. Increased statutory responsibilities and the enhancement of the power of social workers in relation to children, while legitimizing the profession have brought with them a dramatic increase in public visibility and accountability.

Discretion for social workers is important. The problem is how to reconcile this with accountability to higher organisational levels. Kakebadse (1982;135) examined five non-accidental injury inquiries and found that, " in the majority of cases, senior management (including elected local councillors on the social services ccmmittee) demanded retribution for what were considered to be errors of judgement on the part of fieldworkers." One approach to reconcilliation is greater specificity in advance about what agents (social workers) are accountable for. Another approach is to rely on spontaneous adaptation, restricting intervention from above. This does not mean that 'higher authorities' refrain from trying to influence their agents - notably by supplying information and guidelines and by influencing the process of decision making locally - but that no drastic action will follow simply because the agent has failed to follow the guidelines, so long as there is no actual break down of service.

It would appear generally that social services departments have opted for the latter approach. However sensitivity to the potential results

of professional judgements in relation to non-accidental injury cases has in the case of one department (Glastonbury & Cooper 1980) led to the referring of decisions in relation to potential and actual non-accidental injury cases to higher levels. In the department 70% of major decisions in child care cases involved at least four levels in the hierarchy. The fear implicit in the maxim "there but for the grace of god . . ." (Colwell Inquiry Report 1974) appears to have found organisational expression. Caution and fear were factors cited by the departments who participated in the survey contained in the thesis, and appear to be one of the organisational consequences of NAI inquiries (Chapter 7).

Barclay (1982;128) makes the point that the longer the line management chain, the greater is likely to be the delay in obtaining decisions on issues which may directly affect the welfare of clients, "as a general principle, we believe that decisions about individual clients should be taken by the person best equipped . . . we advocate the greatest practical degree of formal delegation to front line social workers and their immediate managers." The challenge for local authorities according to Barclay is to find ways to reconcile controls with a substantial and consistent degree of delegation to social workers, which carries with it increased risk both to management and the authority as a whole, "we are not convinced that the imposition of rigid hierarchical controls can actually prevent accidents and tragedies . . . the formalization of discretion if it brings about an improvement in the working partnership of management and practice, should actually improve the quality of practice and hence reduce the risks" (Barclay 1982;131)

Management and Supervision

The Seebohm Report (1968) gave little attention to the consequences of having professionally qualified social workers predominating management within social services departments. The transition of social worker to manager was never adequately addressed. One commentator (Cooper 1980;77) has suggested that managers have tended to oscillate erratically between a conventional management role and that of a sympathetic supervisor. The haste with which the social services departments were instituted within local authorities to a certain extent demonstrates the gap between practicing managers, or those who due to promotion found themselves in management roles, and the considerable body of organisational literature that contained debates as to size and structure possibilities for the new departments.

It was in 1965 that Brown and Jaques suggested that there was an optimum separation between the general capacity of any manager and that of his subordinates. Too close and a subordinate loses respect for their managers, too far apart and subordinates lose touch with their managers. The results of studies (Cooper 1980, Parsloe 1981) indicate that Social Services departments do not exhibit optimum separation levels. Parsloe found that senior management were viewed by practitioners as being members of a hierarchy characterised by distance and ignorance. Cooper (1980) makes the point that from fourth tier down the hierarchy there is much muddled thinking surrounding definitions and interpretations of what constitutes a management role. Role confusion is typically demonstrated by the tendency of local managers (tier four, area officers) to be present at case conferences along with a team leader and the social worker whose case is being discussed.

The model of management in bureaucracies involves managerial accountability for all the work of subordinates, however wide the discretion accorded to them by reasons of their knowledge and skills. If qualified social workers, who are managers are accountable for allocating tasks and for the way in which they are performed, it follows that tasks must be defined. Given that there is an ambivalence within the social work profession over tasks and goals for social workers, qualified social workers who become managers may carry with them this ambivalence into management roles. A fourth tier area officer is accountable for running a local office which enables others to be responsible for actual work with clients. It follows that if the task of a manager is to create a setting for work this also implies the laying down of guidelines and the working out of boundaries, that is it presupposes a pro-active management approach. In the thesis (Chapter 6) the inferred management approach within departments is not pro-active but passive based on supervision and guidance. Supervision in social work terms is the responsibility of senior social workers and team leaders, "Management have not found the task of managing easy, given their lack of management training" (Cooper 1980;74).

The team leaders role as first line manager is primarily one of supervision. Supervision in social work represents an uneasy combination of educational and administrative functions. The research of Parsloe and Stevenson (1978) shows that team leaders were not viewed as managers by practitioners. While lines of accountability are relatively clear, there appears to be considerable confusion on the part of practitioners and managers over role clarification and responsibilities.

In 1971 when the social services departments were created, in general management posts were filled by persons trained in social work but not in management. The newly-emerging profession exhibited a lack of cohesion and ambivalence over goals and targets. The power and responsibilities of social workers were greatly enhanced in relation to children in the Children and Young Persons Act 1969. In this way social work was granted a legitimate specialist base. With the increase in statutory responsibilities and obligations came an increase in public accountability. Non accidental injury inquiries brought the issue of accountability into sharp relief, in the context of the unresolved dilemmas of professionalism and managerialism in social services.

CHAPTER 3 The Functions and Processes of Inquiries into Non-Accidental Injury to children

Formal non-accidental injury (NAI) inquiries into the deaths of children known to social services departments (SSDs) have taken place at an average rate of two per year during the period 1973 to 1982. ("Formal inquiries describe public/ministerial inquiries, independent local authority inquiries and independent inter-agency inquiries). Formal NAI inquiries are discretionary, and are instituted to deal with unforeseen circumstances.

It emerges in the thesis (chapter 6) that a significant number of child deaths are not investigated by formal inquiries. There is no obligation on the part of a local authority or central government to hold NAI inquiries and it is nowhere made explicit why one NAI death may warrant a formal investigation while another NAI death may not. This can be attributed in part to the fact that formal inquiries are instituted as the result of a political process, and the decision to hold an inquiry can depend on circumstances and negotiations which may not be made public (Marre 1978). The factors influencing the decisions to institute a series of inquiries in one local authority are examined in greater detail in chapter 7 of the thesis. Formal inquiries are rational approaches to complex problem solving, they are concerned with an examination and analysis of a problem scenario. The first part of the chapter will examine the general characteristics of NAI investigative processes, the second part of the chapter will discuss the functions of formal NAI inquiries.

Characteristics of NAI investigative processes.

Discretionary NAI inquiries are ad hoc. There are no procedural rules governing the format of inquiries, the composition of inquiry panels or the content and format of reports. In spite of this diversity NAI inquiries and investigations do have several purposes in common, (i) to establish the facts of the case, (ii) to make recommendations and (iii) to demonstrate publicly (either through open proceedings or the publication of a report) the accountability of staff to a department, a department to a local authority and of a local authority to the public. The discretion to hold a formal inquiry may be exercised by a minister or by a local authority. There are variations, a local authority inquiry may be held at the request of a minister or a ministerial inquiry may supercede a local authority inquiry intended or begun (for example the Maria Colwell Inquiry 1974). A local authority may request a minister to hold a public inquiry (for example the Paul Brown Inquiry 1980). Between 1973 and 1982 there have occurred five public inquiries. Four of these inquiries concerned social services departments in England. The four were ministerial inquiries but in only two cases (Darryn Clarke 1979, and Paul Brown 1980) were full statutory powers employed, the remaining two inquiries (Maria Colwell 1974 and Susan Auckland 1975) were set up by the minister without statutory backing.

In addition there are local authority, internal NAI investigations which may be convened by a director of a social services department or by a local authority chief executive to examine the operation of procedures in relation to an NAI death.

TABLE 1 A CLASSIFICATION OF NAI INQUIRIES

TYPE OF INQUIRY	LEVEL OF INQUIRY	AREA(S) OF POTENTIAL IMPACT
Ministerial inquiry into the non-accidental Injury of a Child(ren).	The carrying out of functions of a Social Services Department in a particular Local Authority.	* A specific Social Services Department. * Social Services Departments nationally * DHSS guidelines to Social Services Departments. * Professional bodies/ associations.
Local Authority Non-Accidental Injury Inquiries (formal).	The Local Authority Social Services Department.	* The Social Services Department. * Social Services Departments nationally * Local Authority procedural guidelines. * Professional bodies/ associations.
Interagency Non-Accidental Injury Inquiries. (Between a Local Authority and a Health authority) (Formal)	A local Authority's Social Services Department, with the appropriate Health Authority section	* The Social Services Department. * The appropriate Health Authority section. * The appropriate Probation service section * Inter-departmental linkages * Professional bodies/ associations
Local Authority Internal Non-Accidental Injury Inquiries	The Management and Operational Administration of a Social Services Department in respect of a particular aspect of day to day policies	* The Social Services Department * The organisation and Management of Operational Procedures

Ministerial NAI Inquiries

Level of inquiry	-	The carrying out of the functions of an SSD and other relevant agencies in a particular child abuse case.
Area(s) of Potential Impact	-	* A specific SSD * SSD's nationally * DHSS guidelines to SSD's * Professional bodies/associations.

Statutory inquiries ordered by a Minister (sometimes at a local authority's behest) are conducted by one or more independent persons. The inquiries are normally held in public and possess the power to compel the attendance of witnesses and the production of documents.

A Minister is empowered by statute to hold an inquiry: The most important provision in terms of NAI inquiries is found in The Children Act 1975 (s.98), Health Services Act 1977 (s.84). The Local Government Act 1972, (s.250 (2) to (5)) makes provision for the compelling of attendance, the power to demand the production of documents and the power to compel the taking of evidence under oath.

It is assumed that the Secretary of State for Social Services has the general power to set up an inquiry, with the agreement of the authority concerned, under s.7 of the Local Authority Social Services Act 1970, which provide that a local authority in England and Wales shall exercise its social services function under the Minister's general guidance. This was the power under which the Colwell Inquiry (1974) and the Auckland Inquiry (1975) were instituted. However, the granting of statutory power to the Minister to set up an inquiry under s.98 of The Children

Act 1975 has superseded the general power for this type of inquiry as far as children are concerned.

The Children Act s.98 is quite specific in the areas into which a Minister has the power to inquire. "The Secretary of State may cause an inquiry to be held into any matter relating to: (a) the functions of the social services committee . . . in so far as these functions relate to children, (b) the functions of an adoption agency, (c) the functions of a voluntary organisation in so far as these functions relate to voluntary homes". The statutory inquiry is not bound by procedural rules or codes of practice, but is in general free to determine its own procedures unless acting on specific instructions from the appointing Minister on particular matters, for example that an inquiry should be held in private (Marre 1978). The Tribunals and Inquiries Act (1971) provides for the making of procedural rules regulating the procedure to be followed at statutory inquiries held by or on behalf of Ministers. No such rules have been made in relation to discretionary inquiries into NAI cases, and such inquiries do not come within the provision of the Tribunals and Inquiries Act.

Local Authority NAI Inquiries

Level of analysis	- Local authorities social services departments.
Area(s) of potential	- A particular social services department.
impact.	- SSD's nationally
	- Local authority procedural guidelines.
	- Professional bodies/associations.

These inquiries are not legally constituted and have none of the legal powers for compelling the attendance of witnesses or the production of

documents. However in common with statutory inquiries they are not subject to procedural rules. All inquiries initiated by a local authority fall within this category.

There are several reasons why a local authority might convene an inquiry. An authority may seek to "put its house in order" and by instituting an inquiry may be seeking to satisfy an aspect of its public accountability (chapter 6). Or an inquiry might be set up to consider a substantial complaint made against the authority or a substantial failure in its services (Marre 1978).

Inter - Agency NAI Inquiries

Level of analysis - the local authority SSD and the appropriate health authority section/Probation Service section.

Area(s) of Potential Impact - the SSD under investigation.

* SSD's nationally.
* interdepartmental linkages (between local authority SSD and health authority, and/or Probation Service).
* professional bodies/associations
* DHSS guidelines to local authority SSD's.
* local authority procedural guidelines.

Inter-agency NAI inquiries are set up by different statutory bodies, usually between an SSD and a health authority. They may or may not meet in public or be conducted by wholly independent persons. Under Section 2 of the Children and Young Persons Act 1969, the local authority,

through its social services committee (in relation to the care and protection of children) is the main agency charged with the duty (as opposed to the power) of ensuring that any information suggesting a child in their area may need the protection of care proceedings is investigated. Thus the responsibility for child care cases rests almost entirely with a local authority social services department. The only exception is the NSPCC, an agency which has statutory powers (for example to initiate care proceedings for abuse or neglect) but no duty to exercise these powers.

Internal NAI Inquiries and Investigations

Level of Inquiry - the management and operational administration of an SSD in respect of a particular aspect of day to day policies, in relation to children at risk of abuse.

Area(s) of potential impact
- an aspect of a department's system.
- the organisation and management of operational procedures.

It is estimated that there are innumerable internal investigations of which no record is kept centrally (Marre 1978). Such investigations do not make available a report of their findings outside of the local authority administration. It is thus difficult to make generalisations about this type of investigation. There is no reason why everyday occurrences should be known outside of "the walls" of the authority concerned. Nevertheless there have occurred a number of internal investigations that have published reports. These investigations follow various formats, for example: instituted by a social services committee,

held in private, with a panel comprising the director of social services and the deputy clerk of the authority (Graham Bagnall 1973). A review panel set up by an area review committee (ARC), held in private, membership comprising the local authority's chief executive's deputy and representatives from various involved agencies (Neil Howlett 1976).

There are thus four general modes of investigation used to inquire into an NAI death. The seriousness of the issue does not appear to be the main determining factor as to the type of inquiry held. The DHSS works on the assumption that inquiries should be held under local authority auspices unless there is good reason for the Secretary of State (Minister) to intervene (Marre 1978). The 'good reasons' are not codified, thus it is difficult to explain why one child's death may warrant a statutory inquiry while another comparable incident may not.

The picture that emerges is a complex one. Statutory inquiries can occur when a matter is so serious or the voiced public concern so great that a Minister may wish to institute an inquiry (Marre 1978). Inter-agency inquiries that take place as a result of an NAI case do not differ greatly in their powers from local authority formal inquiries. Ultimate responsibility rests with the local authority. Finally, internal investigations are more routinised in so far as they are part of a local authority's internal system of administrative accountability. Each NAI death that occurs is the subject of an internal departmental investigation. It appears that if the internal reports are not acceptable to the social services committee or to the local authority a more formal type of inquiry is instituted (Patrick Jenkin 1981). One factor of importance in the instituting and timing of an inquiry is

whether an NAI death has given rise to a criminal charge. The sub-judice rule prevents a formal inquiry from being held until the trial is over. Whereas an internal local authority or internal inter-agency investigation may be held as long as it does not make known its findings in public until after the culmination of criminal proceedings.

The use of inquiries as an aid to central and local government accountability and decision making has a long established history in Britain. Some trace their inception to the Domesday Book, others to the Great Reform Bill of 1832 (Bulmer 1983). There are various views as to the utility of this government device. Some commentators see the primary role of an inquiry as being that of an arbitrator of controversial facts on complex public platforms (Hanser 1965). Others view inquiries as public relations exercises, giving the impression of activity in an often irresolvable problem area. Kennet (1937) isolated three functions of inquiries: (1) the "tribal dance" to persuade the public that something is actively happening, (ii) the "medicine hut" into which the medicine man retires for along period to suggest that something worth waiting for is taking place, and (iii) the "dog fight", started by setting up an inquiry in the first place. Cartwright (1975) amplifies these points of criticism drawing the conclusion that often inquiries are in practice ineffectual or irrevelant.

If it is taken that social services departments have a normative unity, in that they exist to fulfill a purpose and have systems and routines to achieve certain ends, child abuse practices and procedures are one part

of the machinery employed to meet a specific function: in this case the discharge of the responsibilities of a social services department in relation to children at risk. Under this view NAI inquiries can be seen as devices used to investigate the functioning of a system, and to make recommendations for improving the system. Clearly there is a mechanistic assumption underlying the decision to set up an inquiry. The assumption is that the facts of a case are knowable. The first Ministerial NAI inquiry (Maria Colwell 1974) that took place three years after the creation of social departments, produced a minority report. This report suggested that the identification and interpretation of 'facts' was neither straightforward nor clear cut. Doubts were thus raised at an early date about the ability of NAI investigative processes to analyse and interpret complex social processes. Between 1974 and 1982 a further twenty five formal inquiries (that have produced reports) have been identified in the thesis. It can be deduced that there are additional reasons for instituting formal NAI inquiries to investigate complex social issues.

Functions of NAI inquiries.

It has been stated in the chapter that inquiries are demonstrations of public and organisational accountability. In this sense they are political devices. A number of influences detected in inquiry reports (examined in the thesis chapter 5) were brought to bear upon local authorities decisions to hold NAI inquiries. These were (i) the comments of a judge during the summing up stages of the trial of those accused of perpetrating the child's death, and (ii) the type and extent of media coverage of the NAI incident, before, during and after the enactment of legal proceedings. In this way notification of the

intention to set up an inquiry can in itself partially address public and organisational accountability, by demonstrating that local authorities have "nothing to hide". Other less direct influences upon the decision to hold an inquiry, deduced from the material examined in the thesis concerned intra-organisational relationships and the relationship of social services departments to the public. Departments bound by the sub-judice rule cannot respond to criticisms and allegations made in the press of their mis-management of a case until the trial of those accused of causing the child's death is completed. This can take from five months to twenty months, at which time a department or a local authority may feel obliged to 'clear its name' in order to restore public confidence in its functioning. Inquiries may also be used as a means of organisational leverage, to discredit individuals within a department (Chapter 7 of the thesis). Kakebadse (1982;135) makes the point that in four NAI reports he examined (Maria Colwell 1974, Susan Auckland 1975, Karen Spencer 1978, Carly Taylor 1980) senior management including elected members of the social services committee demanded retribution for what were considered to be errors of judgement on the part of fieldworkers.

The Select Committee on Violence in the family stated that the primary objective of an inquiry was "to seek to establish whether or not there were any avoidable failures in any of the services associated with the case and to identify the need for remedial action or to investigate the features which have given rise to serious public disquiet, or both, not to seek to assign blame to individuals".(DHSS 1977). The purpose of inquiries from this view point is twofold, to investigate professional practice and to satisfy public opinion. If public accountability is

demonstrated by objectivity and impartiality, words associated with the enactment of justice, then formal NAI inquiries are legitimate devices. Their format and ways of conducting proceedings, give them a quasi-legal orientation. They are usually chaired by an independent person, in the majority of inquiries the chair is a member of the legal profession, and they "take evidence" from departmental personnel who may have sought legal representation. The quasi-legal orientation enhances public credibility. However, it is precisely because of their quasi legal stance that inquiries have been criticised. BASW (1982) make the point that the framework of a formal inquiry is inappropriate for the task of analysing a complex aspect of social reality. A quasi legal inquiry it is argued, has as its orientation an assumption that individuals are guilty or not guilty of incompetence in the operation of a department's child abuse system.

> "Their formal, ritualistic nature has impeded them in their primary tasks. They have become like show-piece trials, with those being investigated invariably cast in the role of defendants. Their procedures and thoroughness have often left much to be desired . . . unsatisfactory inquiries are worse than no inquiry at all."(BASW 1982;1)

There is much criticism from the professional association (BASW 1982) and from some commentators for example Glastonbury et al (1980), Jones et al (1982) concerning the counter productive aspects of formal NAI inquiries. The criticisms centre around a number of points:

(a) Formal local authority and inter-agency NAI inquiries mirror the format of public inquiries (ministerial). It is only public inquiries with statutory backing that can compel the attendance of witnesses, the production of documents and the taking of evidence under oath. The quasi legal orientation of formal inquiries leads to departments and staff within departments being put on "trial" (BASW 1982).

(b) Inquiries rely on hindsight and ultimately have a more comprehensive picture of a situation than does the professional who has to exercise judgement under conditions of uncertainty and risk within the particular situation. (Colwell Inquiry Minority Report 1974).

(c) Inquiries make recommendations but do not take into account the resource implications of their recommendations "thus most recommendations remain unimplemented (Jones 1982; 54).

(d) Public inquiries are costly, the approximate cost of the Paul Brown Inquiry (1980) was one million pounds (Gregory & Jones 1981). Formal inquiries have cost between £24,000 and £65,000 for the local authority concerned. In addition there are the less tangible costs to members of staff involved in the case under investigation, and to the department in terms of lowering staff morale and motivation (Gray 1981).

The Select Committee's view of the primary objectives of an NAI inquiry (DHSS 1977) raise a number of issues. Local authorities are legally obliged to promote the welfare of children. The ways of interpreting and implementing this broad policy objective has caused divisions within the "profession" of social work over the exact nature of the aims and objectives of child care systems. Confusion finds expression in a number of ways, in the variety of social work methods, employed in similar risk situations for example, supporting the child with the natural family, alternative family placements as a substitute for the nuclear family, specialist forms of treatment, direct intervention and non directive approaches, and the deep disagreements within agencies concerning appropriate actions in particular cases.

This is a dilemma for formal inquiries, as there is much disagreement amongst practitioners over appropriate aims, objectives and targets for social work (chapter 2 of the thesis), it is difficult for inquiries to examine what consititutes professional practice or malpractice. However, what is examinable is the operation of set out procedures and guidelines. It emerges in chapter 5 of the thesis, that each of the inquiry reports examined had as a focii two or more of the following; co-operation, co-ordination and communication within social services departments and between social services and other agencies involved in the case. The argument that a unique confluence of circumstances surround each particular NAI case can be used to deny the validity of a mechanistic appraisal of NAI deaths. "Only shrunken vision of child abuse can present it as a problem which requires the technical application of managerial procedures" (Harris 1986).

A child abuse policy consists of a number of components for example, at risk registers, case conferences, area review committees. Inquiries have examined how these systems were operated in relation to specific NAI cases. No inquiry to date has analysed in a substantive and systematic way the management function within the department under investigation. It appears that NAI inquiries interpretation of the "management of child abuse" is synonymous with the "operation of systems". The role of individual social workers is commented upon in terms of lack of experience, dereliction of duty, lack of supervision (chapter 5). However, no inquiry has examined for example, whether those in management had received management training, the management style of those in management roles, what the culture of a unit or a department was. One inquiry however did attempt an analysis of

management and corporate relationships within a local authority. (The inquiry is discussed in chapter 7 of the thesis).

> "As any professional social worker knows even a perfect administrative system is no guarantee at all that childrens' lives will be saved" (Popplestone 1977).

Successive inquiries from 1973 to 1982 have either pointed to the need for a more coherent and integrated system for managing child abuse cases (DHSS 1982) or have pointed to failures in the operation of various components of child abuse policies. Given that formal inquiries are expensive vis a vis internal local authority investigations, there has been a growing concern within social services departments to discover what a decade of formal NAI inquiries have uncovered, the "lessons to be learned" for practice. The DHSS were requested by local agencies to investigate what, overall, the lessons were. The DHSS found this exercise problematic.

> "The reports vary in both form and content. Some set out findings without giving the facts upon which they are based, some combine narrative and comment in a way which makes it difficult to separate the two. The ages of the children ranged from 7 months to 19½ years. The type of abuse was in some cases neglect, in others emotional abuse, and in others physical violence. All these factors make comparison and collation difficult . . . the nature of the material makes any strictly scientific analysis impossible" (DHSS 1982).

Since the publication of the DHSS study (1982) there have occurred two more highly publicized formal NAI inquiries (Lucy Gates 1982 and Jasmine Beckford 1985). There appears to be a belief in the efficacy of formal NAI inquiries to investigate child deaths.

It is stated in the chapter that formal NAI inquiries serve two purposes, to examine, analyse and pronounce upon the facts of a case and to demonstrate the public accountability of public welfare agencies. The

panel of inquiry investigating the death of Lucy Gates (1982) was divided on interpretation of evidence, the division led to the publication of two reports (echoes of the Maria Colwell Inquiry 1974). The "majority assessment" concluded that the social services department were to blame for the NAI death. The "minority assessment" did not apportion blame but stated that "culpability implies an inexcusable departure from accepted standards. In some areas of human activity standards can be laid down with reasonable precision. But in matters of child care there are few ground rules" (Lucy Gates). The panel of inquiry was also divided over the appropriate format to use. The director of the social services department was adamant "that social services must be publicly accountable and believes that the staggering financial costs must be offset by the ethics of public scrutiny" (Fogarty 1982). The estimated cost of the formal inter-agency inquiry was one million pounds (Carter 1982).

CHAPTER 4 Research Strategy

The thesis idea developed out of background research undertaken in January 1981 for a commissioned article. The article examined the role and utility of a Ministerial Non-Accidental Injury (NAI) inquiry, that had set out in one of its remits to investigate the style of management within a social services department and the bearing this 'style' had on the management of an NAI case that had resulted in a child's death. The research had established that Ministerial inquiries into NAI deaths (for example into the deaths of Maria Colwell 1974, Darryn Clark 1979) were one in a range of investigations into failures in local authority social services departments' child abuse systems.

Such investigations had taken place early in the life of the social services departments (created in 1971). In 1973 two NAI investigations produced reports and since that time there have been one or more than one inquiries and investigations into NAI deaths per year. These investigations could be identified because they had published reports. Certain questions began to form. If there was a consistent incidence of non-routinised investigations into social services department's management of child abuse cases:

(i) What did inquiries highlight as systems failures?

(ii) If inquiries and investigations over time isolated systems failures common to all NAI deaths, what is the role and the utility of inquiries and investigations in rectifying failures in child abuse systems?

These questions enabled the parameters of the thesis to be more clearly defined. The exploratory questions became the starting point for the identification of a data base.

BASIC DATA: SEARCH AND IDENTIFICATION.

The first task was to identify inquiries resulting in published reports from 1971, when social services departments came into existence. It was discovered that neither the DHSS nor the British Association of Social Workers (BASW) held a comprehensive list of NAI inquiries that had occurred within local authorities. In 1982 both the DHSS and BASW produced booklets on child abuse inquiries. Both studies identified some of the inquiries which had taken place since 1973. By supplementing these lists with inquiries identified in professional journals since 1971 a total of twenty nine inquiries that had produced reports between 1973 and 1982 were isolated.

The next task was to acquire copies of these reports. Success in obtaining copies of reports varied, and was not dependent upon the length of time that had elapsed between report publication and the commencement of the research. For local authority inquiry reports, requests were made for copies from each identified authority. Reports were obtained in 1982 of inquiries that had taken place in 1973, whereas a report of an inquiry published in 1981 and requested in 1982, was according to the authority concerned "strictly unobtainable". To overcome this problem of unavailability assistance was sought from the BASW professional officer who had responsibility for child care policy. With his assistance copies of each identified inquiry report were

acquired. At this point a research framework began to develop.

Research Framework

In order to pursue the exploratory questions, the research had to analyse:

(a) What the content of inquiry reports, taken from the period 1973 to 1982 comprised.

(b) What procedures and practices in relation to children 'at risk' were in operation, at the end of the period studied (1979-1982), in departments throughout England and Wales.

(c) In the view of practicing managers, had the findings and recommendations of NAI inquiry reports influenced child abuse practices and procedures within their departments.

During this period when the research framework was developing, unlimited access was gained to documents and records held by a social services department that had been the subject of seven investigations and inquiries into an NAI death in 1976 of a child known to the department. This information provided a rare insight into the events that took place in one local authority preceeding, during and after the occurrence of the NAI death. This information was included as a case study. The study spanned the period the research was concerned with, 1973 to 1982. The research approach comprised the following components:

(1) A content analysis of inquiry reports published between 1973 and 1982 (inclusive). It was considered that the information from this analysis would provide a data base for the next stage in the research process, the designing of a questionnaire to survey social services departments nationally.

(2) A complete coverage questionnaire to be sent out to directors of social services departments in England and Wales. The questionnaire sought to gain both qualitative and quantitative information on the use of child abuse practices and procedures within social services departments.

(3) A case study which set out to present a series of snapshots of events in one local authority before, during and after the occurrance of an NAI death within the period 1973 to 1982. This enabled an analysis of managerial processes and decision making throughout the proceedings of NAI inquiries.

THE DEVELOPMENT OF A FRAMEWORK FOR A CONTENT ANALYSIS.

A full analysis of public documents (which published inquiry reports are,) sometimes necessitates an examination of information not included in the document but which is germane to the issue under investigation. An assumption underlying the content analysis was that inquiries and their resultant reports exist to demonstrate accountability: of staff to the department, of the department to the local authority and the local authority to the public (chapter 5). In order to test out this assumption, report information was not supplemented by reference to information from other sources, for example from professional journals. The reports were treated as comprehensive accounts of incidents in their contexts, analysing and presenting the facts of cases. In this way it would be possible to begin to address the question, "what is the role of an NAI inquiry?"

A key word frequency approach to the analysis of report information was

considered. Such an analysis would set out to log the number of times key terms (isolated with reference to the objectives of the analysis) such as "management style", "information system" were used in the remit of each report. This figure could then be compared and contrasted with the frequency of usage of the terms in the body of the report and in report recommendations. This approach results in a high level of quantification; data can be represented succinctly and direct comparability can be established between the content of each report.

The isolating of key words in order to manufacture hard data to facilitate direct comparability between reports, would not further an understanding of the NAI inquiry process and process outcomes. This is primarily because non routinised investigations (which NAI inquiries are) are ad hoc and as such do not lend themselves readily to systems of direct comparison. The single factor common to all inquiries is that a child known to a social services department has died.

A more qualitative analysis of the content of inquiry reports was necessary to discover exactly what constituted report content and whether any themes could be discerned. Of the twenty nine inquiries identified in the data search, twenty inquiry reports were selected for inclusion in the content analysis. The selection was based on the following:

1. Reports that represented different types of inquiries (Ministerial, Inter-Agency, Internal Investigations, and Local Authority Independent Inquiries) were to be included.
2. Reports that were the result of inquiries into social services departments in different types of Local Authorites (London

Boroughs, Metropolitan Boroughs, County Councils) were to be included.

3. At least one report was to be selected for inclusion from each of the years, 1973-1982.

In order to extract report information from each of the twenty reports chosen a set of standard questions was devised and applied to the information in each report. Familiarization with the content of the twenty reports suggested four general categories for preliminary classification of report information.

- Contextual information
- Basic case details
- Organisational focus
- Findings of the inquiry

For each of these categories questions were formulated. The questions had to address the areas set out by the exploratory questions, while also eliciting answers from each report. As questions were formulated they were tested on reports. Developing the questions became an iterative process and checks had to be made throughout this development stage to ensure that the questions remained pertinent to the aims of the analysis. In this way a proforma of fifty-two questions was arrived at.

Representing Data

Each local authority social services department in England and Wales was assigned a number, the numbering followed the order in which departments were set out in the Municipal year book for 1982. (The numbers ran from 1. to 116.). Each inquiry report was assigned a case number. The numbering ran chronologically. Case number 1. was a report produced in

1973, case number 20. was a report produced in 1982. The system of Coding social services departments was to be used for the questionnaire analysis. In this way cross referencing was facilitated between the content analysis of inquiry reports and the analysis of the questionnaire.

The proforma of questions when applied to the reports would yield 1,040 units of data. A coding systems was devised that enabled the data to be computerised. However as the analysis progressed it became clear that the quality of report information varied greatly from report to report. In a number of instances timing of events had to be deduced from report information. For example an answer to the question "What length of time elapsed between the first official notification of abuse/neglect and the social services department being notified?" necessitated the subtraction of two dates which may or may not have been based on approximate answers to two separate questions. It was judged that the information was "too soft" for computerised statistical analysis.

Other ways of presenting data had to be devised. Report information was set out in a matrix which comprised of the proforma of fifty two questions and each report's response to these questions. Abstractions were made from the matrix and represented in the text as a series of tables. Information contained in the tables was extracted in terms of issues. For example, under the category "findings" the following issues, "supervision and staffing", "management and change", "procedures" were represented in table form. Aggregations could be made and the components of the aggregations could be isolated with reference to the tables.

THE DEVELOPMENT OF THE POSTAL QUESTIONNAIRE

The content analysis of inquiry reports provided information on the range and type of inquiries used to investigate NAI deaths, and showed over time how practices and procedures were used in child abuse cases. This analysis informed the focii of the questionnaire.

The questionnaire had two objectives:

(1) To elicit information on how child abuse practices and procedures were used in social services departments between 1979 and 1982.

(2) To elicit the views and opinions of managers on the perceived and actual effects of Ministerial and Formal Local Authority NAI inquiries on:-

(a) Social services departments generally.

(b) The manager's own department, particularly if it had been the subject of a NAI investigation, and whether the investigation was included in the thesis (chapter 5), or if it had been the subject of an internal NAI investigation of which little would be known outside of the authority.

(c) Perceived preferences regarding mode of investigation. With reference to the criticisms of the functions and processes of NAI investigations (chapter 3) was there a preferred form of investigation and what, if any, in their opinion were the alternative approaches to investigating systems failure and improving management efficiency.

The questionnaire was seeking factual and qualitative information on a

sensitive issue. It was difficult to estimate what the response would be. The data search conducted for the content analysis had shown that some departments were sensitive to requests for copies of inquiry reports. Co-operation was an unknown factor. Would departments that had been the subject of NAI investigations co-operate because they had something to state about the process and outcomes? Or, would they refuse to co-operate precisely because they had been subjected to an investigation? Similarly, would departments that had not been the subject of a formal inquiry decide they had no insights to offer to the research?

Because of the degree of uncertainty, sampling of departments was considered inappropriate. Nachmias and Nachmias (1976) point to three basic sampling problems (a) the definition of the population, (b) the determination of sample size, and (c) the selection of a representative sample (Nachmias and Nachmias, 1976; 267-268). Only if probability sampling is used, that is, if the probability of each sampling unit of the population being included in the sample can be specified, is representative sampling possible in the strict sense. In exploratory research, representative sampling of this kind is premature. A questionnaire survey was included as a part of the research strategy because the total population, that is every social services department in England and Wales, was to be addressed. A postal questionnaire was decided upon for another reason. The issues that were raised in questionnaire format necessitated considered responses. The reponses would in all probability require contributions from a number of personnel in departments, and would require longer response lead times than, for example, an interview situation would allow (Moser &

Kalton,1973; 259). The questionnaire was mailed to directors, with the expectation that it would be passed on to appropriate personnel in departments. A completion date was fixed eight weeks from the post date.

Selection of Questions and Question Terminology

A provisional list of eighty sample questions was compiled. The questions were informed in part by the analysis of NAI inquiry reports, (chapter 5) in part by the literature on child abuse procedures (DHSS 1974, 1976 BASW 1978). It was acknowledged at the outset that ambiguity, in terms of question phrasing would be problematic (Oppenheim 1970; 49-78). Advice as to the appropriateness of phrasing and terminology was sought from a range of social services personnel. These included a director, area manager and child care social workers from several departments. The advice gained tended to exacerbate the complexity of the issue under investigation, opinions were divided as to potential response "they're good questions if you can get them answered".

Mindful of the degree of uncertainty surrounding co-operation with the research a sponsor was sought. A synopsis of the research proposal and the rationale for the questionnaire survey was sent to the chairman of the Association of Directors of Social Services (ADSS) Research Committee in the Autumn of 1982. In December of that year the Committee's Research Officer requested a copy of the list of provisional questions for consideration at the committee meeting in January 1983. In

March 1983 a three hour meeting with a member of the committee took place. The feasibility and appropriateness of questions was discussed.

If the Committee was to consider supporting the research (that is by endorsing each questionnaire with a covering letter from the Association) a revised draft of substantially fewer questions would have to be submitted for consideration at the Committee meeting in June 1983.

Advice and guidance from various professionals had enabled questions to be refined. In April 1983 these questions, now numbering forty-two in total, were arranged in questionnaire format.

Five months had elapsed; it was imperative to gain an idea of the extent of the support the questionnaire might receive. At this time there appeared to be two courses of action open. The first was to submit the draft questionnaire to the ADSS Research Committee in June 1983 and await approval that may or may not be forthcoming. At the March meeting certain questions that concerned the development and training of social work staff (in the area of child care) were viewed as 'high risk'. These questions were included in the draft questionnaire. The second course of action was to attempt to gain an informal decision as to whether or not the draft questionnaire was supportable.

The second course of action was pursued, a copy of the draft questionnaire was sent to the chairman of the ADSS and a meeting was arranged for early May 1983. The Chairman (himself a Director of a department that had had a formal inquiry into an NAI death) felt the research to be timely and appropriate. In a personal capacity he would

support the research. However at the end of May 1983, official notification was received to the effect that without the formal approval of the Research Committee, the Association could not support the research.

Attempts to gain sponsorship had taken eight months. In terms of the research time-scale it was decided that further and possibly protracted negotiations with the ADSS could not be entered into. In June 1983 the questionnaire was sent out to each of the one hundred and sixteen (116) social service departments in England and Wales, without the sponsorship of the ADSS. A number of considerations formed the context for this decision.

(1) At no stage in the 'sponsorship process' was any indication given that a substantially revised questionnaire would be approved. Further there was no indication given as to how much control of questionnaire content the committee would require before giving their support.

(2) Should questions be deemed inappropriate because they probed 'sensitive areas' and omitted solely on the assumption that they would not be answered by departments.

(3) Researching into an area from a perspective upon which little is published, the quality of responses and not necessarily the quantity of responses was viewed as a factor of equal importance to considerations of response rates.

The questionnaires were sent out in June 1983, the first completed questionnaire was returned two weeks later. In September 1983 a follow up letter was sent to non respondents; the final completed questionnaire was received in December 1983. The questionnaires that were returned numbered 56, out of a total number of possible responses of 116. This

gave 48% response rate. In 18 cases departments that did not return the questionnaire wrote stating that staff shortages were the reason why they could not co-operate. One department invited a fee of £50 (Bradford) for providing the information requested in the questionnaire, "if the time and work involved in replying to your request is excessive you will be asked to meet the full cost".

Through out this part of the research strategy time factors were of critical importance. Time constraints had to a greater degree influenced a key decision. The length of time it had taken to develop questions, seek sponsorship, organise and mail the questionnaire and analyse responses totalled fifteen months.

THE CASE STUDY

> "If one is to attempt to understand decision making, one has to attempt to understand the complex proclivities in a local ship of state that is subject to the quality of the party hand on the rudder, the squalls of public moods, the gusts of personality, the prevailing wind of professional inputs, the host of counterveiling breezes. . ." (Corina, 1979).

Within the local authority that was the subject of the case study, one NAI death of a child known to the authority's social services department was the subject of seven investigations into the department's involvement in and management of the NAI case. The NAI incident became the issue that brought to the fore a range of organisational relationships that existed within the authority and between the authority and central government. The case study was included as part of the research strategy for the following reasons:

(a) It provided sufficient material to afford a description of how a "Seebohm director" attempted to shape the emphasis of a newly created department.

(b) It provided insights into issues, surrounding and reasons for the setting up of a range of inquiries and investigations into one NAI death.

(c) It brought into focus the relationship that existed between the social services department and other authority departments, between senior management in the social services department and the social services committee, between council members and local members of Parliament.

(d) It afforded unusual access to confidential material and an opportunity to interview the director of the social services department. These diaries recorded the director's impressions of events and causes of events as they occurred within the department and the local authority.

Representing Complexity

It is difficult to present concisely complex sets of interactions that exist within an organisation, more especially, those that exist informally between individuals both in time and over time, in a way that does not over simplify incidents and events and lead to inaccurate statements of causation. "..it took malaria bearing mosquitoes and the spread of Christianity to undo the Roman Empire, the mosquitoes were as necessary as the Christians and neither is paramount to the other." (White 1927).

The case study sought to describe formal and informal relationships within a local authority over a seven year period. Documents that were generated as part of the formal management process of the authority and the social services department are used to locate and set out parallel events chronologically. The events that took place between 1976 and 1981 came about directly and indirectly as a result of the NAI death in 1976. These events represented bureaucratic responses to a failure in the social services child abuse system.

Presenting a complex process in this way does not in itself further an understanding of the context within which events occurred. In the case study the catalogue of events were contextualized with material from the private diaries of and unstructured interviews with the director. This material provided first hand impressions and reflections of a key actor on a complex set of interactions that fuelled and were in turn fuelled by a series of NAI investigations.

The director, on leaving the employment of the authority, was bound by a twelve year ruling, concerning making public any information he produced or had access to as a result of being in the authority's employ. This has affected the way the material is presented in the Case Study. The names of the Local Authority and the key actors in events are not made explicit. Instead, formal role titles and pseudonyms have been used where appropriate. As such this thesis has restricted access.

Public documents (NAI Inquiry Reports) are a tangible proof of accountability, of the individual to the department, the department to

the local authority and the local authority to the public. The material contained in these documents comes about as a result of negotiations which are not made explicit within Reports. In two of the NAI Reports examined in the thesis (chapter 5) negotiations were made explicit (Maria Colwell 1974, Lucy Gates 1982) as they caused dissention amongst panel members. In these two instances the outcome was the production of minority reports putting forward an alternative interpretation of evidence received by the panels of Inquiry.

This raises issues for research into the area of organisational accountability. The examination of documents alone, does not address the area adequately. The thesis sets out to analyse in the first instance, the content of published NAI inquiry reports (chapter 5). The role and function of a decade of ad hoc NAI investigations is then set within the broader context of social services departments in England and Wales. It is within this context that the utility of a range of ANI investigations is assessed (chapter 6). The final component of the research strategy is a case study. This study specifically affords the examination of the functions of and negotiations surrounding a range of NAI investigations concerned with one NAI death within one local authority social services department.

A large amount of data has been generated by the research. This data is contained in appendices 1, and 2 of the thesis.

CHAPTER 5 A Content Analysis of Twenty Two NAI Inquiry Reports Published during the Period 1973 - 1982.

Non-accidental Injury (NAI) inquiries that have published reports, (between 1973 and 1982) identified during the research numbered twenty nine (table 2). From this number twenty two reports were selected for analysis (table 3). The selected reports represent different modes of investigation into social services departments (SSDs) in different types of local authorities between 1973 and 1982. It is acknowledged that due to the absence of common formats and set procedural rules, direct comparision between inquiry reports is difficult (DHSS 1982). However, the aim of the analysis is to set out over time, the range of ad hoc, discretionary investigations used to inquire into NAI deaths and to examine the content of the resulting inquiry reports. The Chapter is divided into two parts. Part one contains a discussion of the data obtained during the analysis of report content. The tables upon which the chapter is based are contained in part two of the chapter.

PART ONE

Organisation of the Analysis

Each local authority social services department in England and Wales was assigned a number, following the order in which departments are set out in the Municipal Year Book 1982, (table 4). This numbering is used also to identify the local authorities who participated in the questionnaire survey (chapter 6). The inquiry reports selected for analysis are arranged chronologically by the month and year in which the NAI death occurred. Report number 1, was the result of an investigation into an

NAI death which occurred in 1972, report number 20 was the result of an investigation into an NAI death that occurred in 1980. In the case of report number 9, the NAI death was the subject of a series of investigations and is presented in the analysis as 9(a), (9b) & 9(c) (table 3).

Each report selected for analysis could be categorized within the general classification set out in table 5. However upon closer examination it was found that the categories were not specific enough to represent concisely the particular modes of investigation that were discovered during the analysis. Nine modes of investigative processes were identified and these are set out in table 6. The analysis is based exclusively upon information contained in each inquiry report and was not supplemented by information from professional journals, or the press. A proforma of 52 questions was devised (Chapter 4) and applied to each report. In this way a matrix of questions and answers was compiled. The tables contained in part two of the chapter are extrapolations from the matrix. The tables are grouped into four sections, each section begins with the appropriate set of questions the answers to which constitute table content.

Section 1. Contextual Information (Questions 1-17)

The questions in this section sought to gain information on the basic details of the inquiry process as set out in each report, for example the mode of inquiry and the number of days an inquiry sat (table 7). In addition the questions sought to discover the explicit trigger factors that influenced the decision to institute an investigation (table 8). Included in the section are questions concerning the form of the accountability of those accused of directly causing or contributing to

the death of the child took (table 9). Due to the sub-judice ruling the length of time taken to conclude criminal proceedings has a direct impact upon the timing of an inquiry. (table 10).

Overall basic information was deduced from the reports, though there were omissions, for example, in three reports the type of NAI incident was not stated, in eight reports the number of days an inquiry sat was absent. In eighteen of the reports examined criminal proceedings had been enacted against the abuser(s): the criminal procedings took on average nine months to conclude. In four cases inquiries were convened during the subjudice period but could not begin their investigations until after criminal proceedings had been brought to an end. Inquiry reports were published an average of nine months after the fate of those accused of abuse was decided. In this way the issue of an NAI death may be kept current for staff and for the department from eight to fifty six months after the death has occurred.

Where information could be deduced it appears that there is a complex interplay of influences upon the decision to hold an NAI inquiry. In six cases the impetus of local authorities to institute an inquiry was related to the comments of the judge during the summing up at the trial of the abusers. In fourteen cases the impetus came from the local authority to institute a formal inquiry.

Section 2. Basic Case Detail (Questions 18-32)

The murder or manslaughter of a child becomes an NAI death if the child or the family is known to a social services department. The questions in this section sought to gain information of the extent of the family

or child's initial involvement with welfare systems for other than normal post natal care (table 11); the subsequent involvement with welfare systems, for example the number of times the child was received into care (table 12) and finally, the child's specific involvement with social services child abuse systems (table 13).

In twelve out of twenty cases children had been received into care on one occasion. In three cases the child had been received into care on more than one occasion. In four of these cases the child was not entered on the at risk register, in one case a child had been received into care on three occasions and was not entered on a register. When an agency was alerted of suspected or actual abuse in eight cases social services departments were notified within twenty four hours. In ten cases the child was entered onto a register after the first recorded incidence of abuse or neglect. It appears that from 1976 onwards children were more likely to be entered onto at risk registers. In only four instances were cases closed by social services departments. What emerges from the analysis is that of care orders, supervision orders and place of safety orders, one or more than one of these was enacted. The enactment of these legislative powers by social workers does not appear to have either informed or influenced decisions to enter a child on an at risk register. There is no information within the reports to explain if this was reluctance upon the part of social workers to place children on at risk registers or if this was departmental policy.

Section 3. Organisational Focii (Questions 33-42)

The questions in this section are concerned primarily with the organisational issues addressed within inquiry reports (table 14). The

level of agency activity in each case is deduced by an analysis of those workers actively involved in the case during the first three months after a child had become known to a department and those involved one month prior to a NAI death (table 15). Components of a child abuse policy, such as the appointment of a key worker, the use of case conferences are examined in table 16. The table also sets out the inquiries views of the factors contributing to failures in the child abuse systems.

Inquiries from 1973 to 1984 consistently highlight failures in inter-agency linkages and intra departmental systems. Decision making in child abuse cases appears to be a specific factor isolated by the later inquiries, (from 1979 to 1982). Social workers and health visitors were the workers most consistently involved in cases both during the first three months and the final month of the NAI case. In three cases no one visited or saw the child one month prior to the NAI death.

In thirteen cases a case conference had been called. In six of these cases it was the view of inquiry panels that the case conferences were called too late. In five cases, the decisions taken at case conferences were not carried out effectively. The lack of experience of staff working with child abuse cases was stated as a factor in thirteen of the twenty reports examined. This appears to be a consistent factor running through the period examined. The term key worker begins to appear in reports from 1978 onwards. The key worker appears to be always appointed from the social services departments.

Section 4. Findings of Inquiries (Questions 43-52)

The questions in this section sought to group the findings of inquiries in terms of three issues, (i) Supervision and staffing levels (table 17) (ii) Management and change (table 18) and (iii) Procedural issues (table 19).

The first five inquiries examined 1973 to 1975, all cited inadequate supervision, understaffing in social services departments and in other agencies involved in the case, as factors leading to the non effective operation of child abuse systems. In only two of the reports were case loads judged to be too heavy, in each of the five inquiry reports local government reorganisation was cited as a contributing factor.

Out of the twenty reports examined it appears that inadequate supervision and understaffing within social services departments are linked in eleven cases. From 1973 to 1980 nine reports cited a lack of senior management support for staff as being an organisational issue, and in terms of direct support for staff in the operation of procedures. Inadequate supervision by senior social workers and team leaders was cited in fifteen cases.

The recommendations of inquiries appear to be the obverse of their findings. In ten cases inquiries recommended that there was a need for clearer administrative guidelines, clarification of criteria for identifying children at risk and the need for a procedural framework common to all agencies. The recommendations run consistently through inquiries from 1973 to 1981.

Analysis of the NAI inquiry process over a period of ten years produces

only a vague and general picture. Inquiries can be convened between 1 and 48 months after an NAI death has occurred. Inquiry panels can sit for between 4 and 50 days. The length of time an inquiry sits does not appear to be directly related to the mode of investigation used. Nine modes of investigation have been identified, there is no indication of a trend towards the use of a specific or preferred mode of investigation for inquiring into NAI deaths. Legal proceedings (sub judice ruling) has a direct bearing upon the length of time elapsing between the NAI death and the production of an Inquiry report. In 18 of the 20 reports examined criminal proceedings were instituted against those accused of abuse with an average period of twelve months elapsing before the commencement of the trial, consequently inquiry reports were published between 1 and 35 months after the conclusion of criminal proceedings. Legal proceedings also have a bearing upon the decision to hold an inquiry. In six of the reports examined in the chapter, the judge presiding over the trial of the abuser(s) in his summing up suggested that the local authority social services department involved in the case should institute a formal investigation.

During the period 1973-1982, the frequency of NAI inquiries has increased. Between 1978 and 1980 nine inquiries took place, as compared with twelve inquiries during the period 1972-1977. In eight of the nine cases the local authority actively sought to institute an inquiry to demonstrate its public accountability. There emerges a complex interplay of influences upon the decision to hold an inquiry. In 13 of the reports examined a mix of judicial comments, media pressure and the local authority's concern to demonstrate accountability were cited as significant factors on the decision to hold an inquiry. The reports do

not however, state the reasons why one mode of investigative process was preferred over another.

The prime objective of an NAI inquiry is stated as "to seek to establish whether or not there are any avoidable failures in any of the services associated with the case and to identify the need for remedial action or to investigate the features which have given rise to serious public disquiet, or both, not to seek to assign blame to individuals" (Select Committee on Violence in the Family 1976-77, para 28).

Not one of the reports examined in the chapter cited the negligence of individual workers as a factor directly contributing to the NAI death. Of the 13 inquiries that produced reports between 1973 and 1978, 8 reports cited the effects of local government re-organisation, re the disruption in procedures as a significant factor contributing to the failure of child abuse systems. However, it is implied in each of the twenty two reports examined that child abuse systems, and systems of communication and co-ordination were not operated efficiently and effectively by individual workers involved in each case. Each inquiry examined in the chapter has as its focii as aspect of co-operation, co-ordination and communication between and within the agencies concerned with the NAI case. If mistaken judgements and individual errors are all inquiry reports highlight, then each report must be treated as a unique presentation of a particular catalogue of events that have taken place within an equally unique confluence of circumstances as such generalisations cannot be usefully made from close examination of micro organisational functioning.

However, reports highlight systems failures that can in management terms

be rectified:

(i) inexperienced staff responsible for NAI cases (cited in 13 out of 22 reports

(ii) inadequate supervision of staff (cited in 15 out of 22 reports

(iii) understaffing in social services departments (cited in 13 out of 22 reports)

(iv) lack of management support for staff (cited in 9 out of 22 reports)

These are specifically management issues. With the exception of one report (9(c)), not one of the inquiries addressed in a substantive way the function of management in social services departments, either in terms of management structure and style or in terms of organisational development approaches. Findings of inquiries become the recommendations of inquiries. For example 10 out of the 20 inquiries examined found that there was inadequate multi-agency co-ordinating systems in relation to child abuse. Their recommendations were that the local authorities should improve multi-agency co-ordinating machinery. This example reflects the nature of NAI inquiries that is that they are reactive and backward looking. This 'characteristic' may account for the absence of a management perspective within the reports examined. Not one report addresses the question, "if organisational performance is found lacking, how can it be improved?"

One report (9(c)) had as one of its terms of reference to inquire into the management relationships in the local authority. In a report of 107 pages in length, an attempt is made to bring out in 14 pages the complexity of management relationships. They concluded by stating that

senior officers should start afresh once the inquiry was over, to create a more productive working relationship. There was no identifiable mangement analysis and no strategy set out for the development of future organisational relationships.

A central concern of inquries is to establish the facts of a case. Facts however only become meaningful when they are contextualised. It is interesting to note that an inquiry producing a report in 1974 (report number 2) contained within it a minority report in which certain panel members voiced their disagreement with the conclusions inferred from the facts of the case. A report published in 1982 (report number 18) similarly produced within the report two interpretations of events. The disagreement was over matters concerning professional interpretation. This brings into question the appropriateness of various modes of investigative processes to examine complex social and organistional relationships. This is one of the issues addressed in the following chapter.

Part Two Tabular representation of Report Information

PUBLICATION

Year of Publication	Name of Child	Publisher of Report
1973	Graham Bagnall	Shropshire (CC)
1973	David Naseby	Staffordshire (CC)
1974	Maria Colwell	H.M.S.O.
1974	Max Piazzani	Essex (CC)
1975	Susan Auckland	H.M.S.O.
1975	Richard Clark	H.M.S.O.
1975	Lisa Godfrey	Lambeth (LB)
1976	Neil Howlett	Birmingham (MB)
1976	Steven Meurs	Norfolk (CC)
1977	Wayne Brewer	Somerset (CC)
1977	"H" Family	Surrey (CC)
1978	Paul Brown	Wirral (MB)
1978	Paul Brown	Wirral (MB)
1978	Simon Peacock	Cambridgeshire (CC)
1978	Karen Spencer	Derbyshire (CC)
1979	Lester Chapman	Berkshire (CC)
1979	Darryn Clark	H.M.S.O.
1979	Stephen Menheniott	H.M.S.O.
1979	Heidi Trott	Humberside (CC)
1980	Claire Haddon	Birmingham (MB)
1980	Paul Brown	H.M.S.O.
1980	Carly Taylor	Leicester (CC)
1981	Maria Delaney	Walsall (MB)
1981	Emma Hughes	Calderdale (MB)
1981	Maria Mehmadagi	South Wark (LB)
1981	Malcolm Page	Essex (CC)
1982	Jason Caesar	Cambridgeshire (CC)
1982	Richard Fraser	Lambeth (LB)
1982	Lucje Gates	Bexley (LB)

TABLE 3

REPORTS SELECTED FOR THE CONTENT ANALYSIS

ARRANGED CHRONOLOGICALLY BY YEAR OF NAI DEATH

Report Number	Local Authority number	Name of Child	Year of NAI death	Year Report produced
1	38	Graham Bagnall	1972	1973
2	16	Maria Colwell	1973	1974
3	17	Max Piazzani	1973	1974
4	72	Susan Auckland	1973	1974
5	49	Neil Howlett	1975	1976
6	31	Steven Meurs	1975	1975
7	16	Stephen Menheniott	1976	1978
8	39	Wayne Brewer	1976	1978
9(a)	82	Paul Brown	1976	1977
9(b)	82	Paul Brown	1976	1978
9(c)	82	Paul Brown	1976	1980
10	05	Simon Peacock	1976	1978
11	11	Karen Spencer	1977	1978
12	105	Richard Fraser	1977	1982
13	61	Darryn Clark	1978	1979
14	03	Lester Chapman	1978	1980
15	28	Carly Taylor	1978	1980
16	111.	Maria Mehmadagi	1978	1981
17	17	Malcolm Page	1979	1981
18	87	Lucie Gates	1979	1982
19	53	Emma Hughes	1980	1981
20	05	Jason Caesar	1980	1982

TABLE 4 LOCAL AUTHORITY SOCIAL SERVICES DEPARTMENTS: ENGLAND AND WALES

COUNTY COUNCILS

1. Avon
2. Bedfordshire
3. Berkshire
4. Buckinghamshire
5. Cambridgeshire
6. Cheshire
7. Cleveland
8. Clwyd
9. Cornwall
10. Cumbria
11. Derbyshire
12. Devon
13. Dorset
14. Durham
15. Dyfed
16. East Sussex
17. Essex
18. Gloucestershire
19. Gwent
20. Gwynedd
21. Hampshire
22. Hereford & Worcester
23. Hertfordshire
24. Humberside
25. Isle of Wight
26. Kent
27. Lancashire
28. Leicestershire
29. Lincolnshire
30. Mid Glamorgan
31. Norfolk
32. Northamptonshire
36. Oxfordshire
37 Powys
38. Shropshire
39. Somerset
40. South Glamorgan
41. Staffordshire
42. Suffolk
43. Surrey
44. Warwickshire
45. West Glamorgan
46. West Sussex
47. Wiltshire

METROPOLITAN BOROUGHS

48. Barnsley
49. Birmingham
50. Bolton
51. Bradford
52. Bury
53. Calderdale
54. Coventry
55. Doncaster
56. Dudley
57. Gateshead
58. Kirklees
59. Knowsley
60. Leeds City
61. Liverpool City
62. Manchester City
63. Newcastle upon Tyne
64. North Tyneside
65. Oldham
66. Rochdale
67. Rotherham
68. St Helens
75. Stockport
76. Sunderland
77. Tameside
78. Trafford
79. Trafford
80. Wakefield
81. Walsall
82. Wigan
83. Wirral
84. Wolverhampton

LONDON BOROUGHS

85. City of London
86. Barking & Dagenham
87. Barnet
88. Bexley
89. Bromley
90. Camden
91. Croydon
92. Ealing
93. Enfield
94. Greenwich
95. Hackney
96. Hammersmith & Fulham
97. Haringey
98. Harrow
99. Havering
100. Hillingdon
101. Hounslow
102. Islington
103. Kensington & Chelsea
104. Kingston Upon Thames
105. Lambeth
106. Lewisham
107. Merton
108. Newham
109. Redbridge
110. Richmond upon Thames
112 Southwark
113. Tower Hamlets
114. Waltham Forest
115. Wandsworth
116. Westminister City.

TABLE 5 GENERAL CLASSIFICATION OF NAI INQUIRIES

	Type of Inquiry	Characteristics	Report Number
1	Ministerial Inquiry	Statutory, ordered by a Minister, under S.7. Local Authority Social Services Act 1972. S.98. The Children Act 1975	2. 4. 13 9(c)
2	Local Authority Formal Inquiry	Non-statutory, not legally constituted, cannot compel the attendance of witnesses or the production of documents. No set format, no procedural rules. Conducted by one or more independent persons, either in private or in public, with a published report.	1. 9(a) 9(b) 7.
3	Interagency Inquiries (Health Service/SSD/ Probation Service)	Set up by different statutory bodies, concerned with a particular incident, which may not meet in public or be conducted by wholly independent persons.	3. 5. 6. 8. 10. 11. 12. 14. 15. 16. 17. 18.
4	Local Authority Internal Investigation	Conducted in private, no formal hearings, results are produced in report form and are submitted to a Committee(s) of a local authority.	19. 20.

Investigation Identified in the Content Analysis

TYPE OF INQUIRY		FORM	Report Number
1(a)	Statutory	Ordered by a Minister and conducted by one or more independent persons, chaired by a Q.C. held in public, possessing powers to compel the attendance of witnesses and the production of documents. Published report.	9(c). 13
1(b)	Ministerial	Set up by a Minister without statutory backing, held in public Published Report	2. 4.
1(c)	DHSS	DHSS independent investigation held in private producing a report	7.
2(a)	Local Authority	Formal independent inquiry, held in private producing a report.	9(a) 9(b)
2(b)	Local Authority	Formal internal inquiry, held in private, producing a report	1
2(c)	Local Authority	Internal investigation held in private, producing a report	19, 20
3(a)	Inter Agency	Independent inquiry held in private, producing a report	11,12,14,15,16,18
3(b)	Inter Agency	Non-Independent inquiry held in private producing a report	3, 5, 6, 10
4	Area Review Committee	Inter-agency non-independent inquiry, held in private, producing a report.	8, 17

Section 1

Contextual Information

This section sets out contextual information in terms of the following:

* Basic details of the inquiry process.

* Influences upon the decision to hold an inquiry.

* Accountability of abuser(s).

* Impact of legal proceedings on the inquiry process.

Questions upon which the Tables are based:

1. Report number
2. Child's initials
3. Local Authority SSD number
4. Type of local authority
5. Type of inquiry.
6. Date of child's death.
7. Date inquiry commenced.
8. Time (in months) between child's death and the convening of an inquiry.
9. Date inquiry report was published.
10. Length of time, (in days) the inquiry sat.

11. Time between child's death and the publication of the report.
12. Were legal proceedings started against abuser(s)?
13. Reasons for holding the inquiry, as given in the report.
14. Reasons given for the time lag between the child's death and the convening of the inquiry.
15. Length of time elapsing between child's death and the trial of the abusers.
16. Type of NAI case, abuse, neglect, ill treatment.
17. Was the abuser(s) convicted.

Table 7
Basic Details of the Inquiry Process

REPORT NUMBER	L.A. TYPE	MODE OF INQUIRY	NAI INCIDENT	YEAR OF NAI DEATH	REPORT PUBLISHED	TIME BETWEEN DEATH AND PUBLICATION	DAYS INQUIRY SAT
1	cc	2(b)	Abuse	1972	1973	8 months	(n)
2	cc	1(b)	Abuse	1973	1974	16 months	41 days
3	cc	3(b)	Neglect	1973	1974	12 months	11 days
4	mb	1(b)	Abuse	1974	1975	14 months	18 days
5	mb	3(b)	Abuse	1975	1976	21 months	(n)
6	cc	3(b)	Neglect	1975	1975	8 months	9 days
7	cc	1(c)	Abuse	1976	1978	32 months	26 days
8	cc	4	Abuse	1976	1977	12 months	22 days
9(a)	mb	2(a)	Neglect	1976	1978	15 months	4 days
9(b)	mb	2(a)	Neglect	1976	1978	20 months	(n)
9(c)	mb	1(a)	Neglect	1976	1980	39 months	50 days
10	cc	3(b)	(n)	1976	1978	12 months	(n)
11	cc	3(a)	Abuse	1977	1978	12 months	11 days
12	lb	3(a)	Abuse	1977	1982	56 months	(n)
13	mb	1(a)	Neglect	1978	1979	22 months	16 days
14	cc	3(a)	(n)	1978	1979	20 months	27 days
15	cc	3(a)	Abuse	1978	1980	14 months	(n)
16	lb	3(a)	Abuse	1978	1981	31 months	(n)
17	cc	4	Neglect	1979	1981	25 months	18 days
18	lb	3(a)	Abuse	1979	1982	41 months	34 days
19	mb	2(c)	(n)	1980	1981	14 months	(n)
20	cc	2(c)	Abuse	1980	1982	14 months	4 days

(n) - information cannot be deduced from report.

Table 6 Influences upon the Decision to hold an Inquiry

Report Number	Suggested by Judge	Decided upon by Local Authority	As an aspect of the L.A.'s Public Accountability	Media Pressure	Number of months after Death Inquiry convened
1	(0)	(1)	(1)	(1)	(n)
2	(n)	* (1)	(1)	(1)	6
3	(0)	(1)	(n)	(n)	11
4	(1)	(0)	(1)	(n)	11
5	(0)	(1)	(n)	(n)	10
6	(1)	(1)	(n)	(n)	4
7	(0)	(1)	(n)	(n)	24
8	(n)	(1)	(n)	(1)	5
9 (a)	(1)	(0)	(n)	(n)	11
10	(1)	(0)	(n)	(n)	(n)
11	(n)	(1)	(1)	(n)	3
12	(n)	(1)	(n)	(n)	48
13	(n)	(1)	(1)	(1)	9
14	(n)	(n)	(1)	(1)	4
15	(1)	#(1)	(n)	(n)	2
16	(n)	(1)	(n)	(n)	1
17	(n)	(1)	(1)	(1)	11
18	(1)	(1)	(1)	(1)	(n)
19	(0)	(1)	(n)	(1)	5
20	(0)	(1)	(n)	(1)	(n)

KEY

(1) - Affirmative
(0) - Negative
(n) - Information cannot be deduced from report
* - Ministerial Inquiry superceded Local Authority Inquiry
\# - Local Authority decided to hold inquiry after the inquest on the child The Judge supported their decision.

Report Number	Legal Proceedings	Abuser(s) Convicted	Type of NAI Incident	Time between NAI Death and Trial in mths	Plea			Grounds of Conviction						Sentence					Appeal		
					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	(1)	(1)	abuse	(n)	n	–	–			(1)				n	–	–	–	–	n	–	–
2	(1)	(1)	abuse	7		(1)					(1)					(1)			(1)		
3	(1)	(1)	neglect	8	(1)				(1)					(1)						(1)	
4	(1)	(1)	abuse	5	(1)					(1)						(1)			(1)		
5	(1)	(1)	abuse	7	n	–	–			(1)							(1)				(1)
6	(1)	(1)	neglect	(n)	(1)					(1)						(1)					(1)
7	(1)	(1)	abuse	23	n	–	–				(1)			n	–	–	–	–	n	–	–
8	(1)	(1)	abuse	5	(1)					(1)						(1)					(1)
9a	(1)	(1)	neglect/ill treatment	11			(1)	n	–	–	–	–	–	n	–	–	–	–	n	–	–
10	(1)	(1)	(n)	8	n	–	–			(1)						(1)					(1)
11	(1)	(1)	abuse	10	(1)					(1)								(1)	(1)		
12	(1)	(1)	abuse	30		(1)		(1)	(1)		(1)					(1)			(1)		
13	(1)	(1)	neglect	5	(n)	–	–		(1)		(1)			(1)		(1)					(1)
14	(0)	(n)	(n)	(n)	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
15	(1)	(1)	abuse	12	n	–	–	(1)		(1)						(1)			n	–	–
16	(1)	(1)	abuse	20		(1)		(1)		(1)		(1)		(1)					(1)		
17	(1)	(1)	neglect	11			(1)		(1)	(1)				(1)					(1)		
18	(1)	(1)	abuse	6	(1)					(1)				n	–	–	–	–			(1)
19	(1)	(1)	(n)	(n)	n	–	–				(1)							(1)	n	–	–
20	(1)	(1)	abuse	12	n	–	–			(1)				n	–	–	–	–	n	–	–

KEY

(1) – Affirmative
(0) – Negative
(n) – Information cannot be deduced from report.

SENTENCE
10 – 0-18 months
11 – 24 months
12 – Over 24 months
13 – Suspended sentence with supervision order
14 – Probation order plus medical treatment

APPEAL
15 – against conviction
16 – against sentence
17 – no appeal made.

PLEA
1 – Guilty
2 – Not Guilty
3 – Accused submitted different pleas.

GROUNDS OF CONVICTION
4 – Wilfull ill-treatment
5 – Wilfull neglect
6 – Manslaughter
7 – Murder
8 – Actual Bodily Harm
9 – Cruelty

Section 2

Basic Case Details

This section sets out details of each NAI case as given in the reports it does so in terms of the following.

* Initial involvement with welfare systems.
* Subsequent involvement with welfare systems.
* Specific involvement with SSD's child abuse systems.

Questions upon which the tables are based:

18. Date of the family's first involvement with a welfare agency for other than routine post natal care.
19. Date that an agency first became aware of the occurrance of actual abuse/neglect.
20. Date that a SSD became aware of the occurance of actual abuse/neglect.
21. Date child was first received into care and/or date of care order.
22. Number of times child received into care.
23. Date of child's final return to family/parent(s).
24. Were other siblings abused or suspected of being abused/neglected.
25. The number of agencies (excluding SSD's) the family was known to.
26. The number of SSDs the abused child was known to.
27. Date of child's first entry onto an 'At Risk' register.
28. Entry onto a register took place:

(1) Prior to the first officially recorded incident of abuse/neglect.

(2) Post the first officially recorded incident of abuse/neglect.

29. Was the case at any time closed by a SSD.

30. Was an application for a care order made for other siblings.

31. Was a supervision order made at any time for the child

32. Was a Place of Safety Order made at any time for the child.

Table 10 Impact of Legal Proceedings on the Inquiry Process

Report Number	Legal Proceedings	Time between death and trial	Time after death Inquiry convened	Time between death and Publication of Report	Time taken between Trial and publication of Report
1	(1)	(n)	(n)	8 months	(n)
2	(1)	7	6 months	16 months	9 months
3	(1)	8	11 months	12 months	4 months
4	(1)	5	11 months	14 months	9 months
5	(1)	7	10 months	21 months	14 months
6	(1)	(n)	4 months	8 months	(n)
7	(1)	23	24 months	32 months	9 months
8	(1)	5	5 months	12 months	7 months
9a	(1)	11	11 months	11 months	same month
10	(1)	8	(n)	12 months	4 months
11	(1)	10	3 months	12 months	2 months
12	(1)	30	48 months	56 months	26 months
13	(1)	5	9 months	22 months	17 months
14	(n)	(n)	4 months	20 months	(n)
15	(1)	12	2 months	14 months	2 months
16	(1)	20	1 month	31 months	11 months
17	(1)	11	11 months	25 months	14 months
18	(1)	6	(n)	41 months	35 months
19	(n)	(n)	5 months	14 months	(n)
20	(1)	12	(n)	14 months	2 months

KEY

(1) - Affirmative
(0) - Negative
(n) - Information cannot be deduced from the report.

TABLE 11 INITIAL INVOLVEMENT WITH WELFARE SYSTEMS

T/R	L.A. TYPE	YEAR OF NAI DEATH	FAMILY'S FIRST INVOLVEMENT WITH A WELFARE AGENCY FOR OTHER THAN NORMAL POST NATAL CARE		TIME BETWEEN FIRST INVOLVEMENT AND AN AGENCY NOTIFIED OF SUSPECTED/ACTUAL ABUSE	TIME BETWEEN AN AGENCYS' NOTIFICATION AND SSD BEING NOTIFIED
	CC	1972	SSD	1971	3 months	3 months
	CC	1973	NSPCC	(n)	73 months	49 months
	CC	1973	H.A.	1970	(n)	(n)
	MB	1974	H.A.	1966	(n)	(n)
	MB	1975	H.A.	1971	6 days	6 days
	CC	1975	H.A.	1974	31 days	31 days
	CC	1976	SSD	1958	(n)	(n)
	CC	1976	SSD	1969	60 months	Same day
	MB	1976	SSD	1973	25 months	Same day
	CC	1976	(n)	1976	3 months	Same day
	CC	1977	H.A.	1974	14 months	Same day
	LB	1977	SSD	1975	Same month	Same month
	MB	1978	(n)	(n)	(n)	Same day
	CC	1978	NSPCC	1970	Same months	1 day
	CC	1978	(n)	1974	9 months	27 months
	LB	1978	H.A.	1978	Same month	Same day
	CC	1979	SSD	1975	10 months	Same day
	LB	1979	(n)	(n)	(n)	(n)
	MB	1980	(n)	1977	(n)	(n)
	CC	1980	SSD	1975	60 months	Same month

information cannot be deduced from the report
Social Services Department
Health Authority
National Society for Prevention of Cruelty to children

TABLE 12 SUBSEQUENT INVOLVEMENT WITH WELFARE SYSTEMS

REPORT NUMBER	CARE ORDER MADE	NUMBER OF TIMES CHILD RECEIVED INTO CARE	OTHER SIBLINGS SUSPECTED/ ACTUALLY ABUSED	NUMBER OF AGENCIES CHILD KNOWN TO EXCLUDING SSD	NUMBER OF SSD'S CHILD KNOWN TO
1	(i)	1	(i)	3	1
2	(i)	1	(i)	3	2
3	N/A	N/A	(i)	3	1
4	(i) •	1	(i)	6	2
5	(n)	(n)	(i)	4	1
6	N/A	N/A	(o)	6	1
7	(i)	2	(i)	2	3
8	(i)	1	(i)	4	1
9(c)	(i)•	2	(i)	3	1
10	N/A	N/A	N/A	4	2
11	(i)	1	(o)	5	1
12	(i)	1	(i)	2	2
13	N/A	N/A	N/A	N/A	1
14	(i)	1	(i)	6	2
15	(i)	1	(i)	5	1
16	(i)	1	(i)	3	1
17	(i)	1	(i)	5	1
18	(i)	1	(i)	10	1
19	(n)	3	(i)	1	1
20	N/A	N/A	(n)	(n)	1

Key

(i) - Affirmative.
(o) - Negative.
(n) - Information cannot be deduced from report.
N/A - Not applicable, child did not enter SSD system at this point.
• - Voluntary care.

TABLE 13 SPECIFIC INVOLVEMENT WITH SSDS CHILD ABUSE SYSTEMS

REPORT NUMBER	WAS CHILD ENTERED ON TO AN 'AT RISK' REGISTER	ENTRY ONTO REGISTER IN RELATION TO FIRST RECORDED INCIDENT OF ABUSE/NEGLECT		WAS CASE AT ANY TIME CLOSED BY AN SSD	WAS APPLICATION FOR CARE ORDER MADE FOR OTHER SIBLINGS	WAS A SUPERVISION ORDER MADE AT ANY TIME FOR THE ABUSED CHILD	WAS A PLACE OF SAFETY ORDER MADE AT ANY TIME FOR CHILD
		PRE	POST				
1	(o)	(o)	(i)	(o)	(o)	(o)	(o)
2	(o)	(n)	(n)	(n)	(i)	(i)	(i)
3	N/A	N/A	N/A	(i)	(o)	(o)	(o)
4	N/A	N/A	N/A	(i)	(o)	(o)	(o)
5	(o)	N/A	N/A	N/A	(i)	(o)	(o)
6	(o)	N/A	N/A	N/A	(o)	(o)	(o)
7	N/A	N/A	N/A	(i)	(i)	(i)	(o)
8	(i)	(o)	(i)	(o)	(o)	(i)	(o)
9	(i)	(o)	(i)	(o)	(o)	(o)	(i)
10	(i)	(o)	(i)	(o)	N/A	(o)	(i)
11	(i)	(o)	(i)	(o)	N/A	(o)	(i)
12	(i)	(i)	(o)	(o)	(o)	(o)	(i)
13	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14	(i)	(o)	(i)	(i)	(i)	(i)	(i)
15	(i)	(o)	(i)	(o)	(i)	(o)	(o)
16	(i)	(o)	(i)	(o)	(o)	(o)	(i)
17	(i)	(o)	(i)	(o)	(i)	(o)	(o)
18	(o)	N/A	N/A	(o)	(i)	(o)	(o)
19	(o)	N/A	(o)	(n)	(o)	(o)	(o)
20	(i)	(o)	(i)	(o)	(o)	(o)	(o)

Key

(i) - Affirmative
(o) - Negative
(n) - Information cannot be deduced from report
N/A - Not applicable

Section 3 Organisational Focii

The section sets out the organisational issues each inquiry is concerned with. It does so in terms of the following:

* Issues of organisation
* The range of agency workers involved in each NAI case
* The use of case conferences in each NAI case
* The involvement of inexperienced staff in each NAI case

Questions upon which the tables are based:

33. Which aspects of organisational functioning does the inquiry focus on:

(1) Inter-agency co-operation
(2) Inter-agency communication
(3) Inter-agency co-ordination
(4) Decision making within the SSD
(5) Intra-agency co-operation
(6) Intra-agency communication
(7) Intra-agency co-ordination

34. Title of agency worker(s) who took a significant role in the first three months of the case.

(1) Social worker
(2) Senior Social Worker
(3) NSPCC worker
(4) Probation officer
(5) Health Visitor
(6) G.P.
(7) Hospital Doctor

35. Title of agency worker(s) most active in the case one month prior to the NAI death.

36. Is the term "key worker" used in the report.

37. Date of the first case conference.

38. The total number of case conferences called.

39. No case conference was called.

40. In the inquiry's view, was a case conference called too late.

41. In the inquiry's view, were decisions taken at the case conference carried out inefficiently.

42. Were inexperienced staff, newly qualified staff or staff new to NAI cases involved in the case.

Table 14 Organisational Focii of Each Inquiry

Report Number	Type of Local Authority	Modes of Inquiry	Date Inquiry Report Published	Organisational Focus of Inquiry						
				1	2	3	4	5	6	7
1	CC	2(b)	1973	(1)	(1)	(1)		(1)		
2	CC	1(b)	1974	(1)	(1)	(1)		(1)		
3	CC	3(b)	1974	(1)	(1)	(1)		(1)	(1)	
4	MB	1(b)	1975	(1)	(1)	(1)	(1)	(1)	(1)	
5	MB	3(b)	1976	(1)	(1)			(1)	(1)	
6	CC	3(b)	1975	(1)	(1)	(1)	(1)	(1)	(1)	
7	CC	1(c)	1978	(1)	(1)	(1)	(1)	(1)	(1)	
8	CC	4	1977		(1)	(1)		(1)	(1)	
9(c)	MB	1(a)	1980	(1)	(1)	(1)	(1)	(1)	(1)	
10	CC	3(b)	1978	(1)	(1)	(1)	(1)	(1)	(1)	
11	CC	3(a)	1978		(1)	(1)		(1)	(1)	
12	LB	3(a)	1982		(1)	(1)		(1)	(1)	(1)
13	MB	1(a)	1979		(1)			(1)		(1)
14	CC	3(a)	1979	(1)	(1)	(1)	(1)	(1)	(1)	
15	CC	3(a)	1980	(1)	(1)	(1)	(1)	(1)		(1)
16	LB	3(a)	1981	(1)	(1)	(1)	(1)	(1)	(1)	(1)
17	CC	4	1981	(1)		(1)		(1)		
18	LB	3(a)	1982	(1)	(1)	(1)		(1)	(1)	(1)
19	MB	2(c)	1981		(1)			(1)		(1)
20	CC	2(c)	1982	(1)	(1)	(1)				(1)

KEY
(1) - Affirmative.

Organisational Focii
1 - inter-agency co-operation
2 - inter-agency communication
3 - inter-agency co-ordination
4 - intra-agency co-operation
5 - intra-agency communication
6 - intra-agency co-ordination
7 - decision making within the SSD

Table 15 Workers Involvement in Each NAI Case.

Report Number	L.A. Type	Agency Workers involved in each case During first three months			Month before NAI Death		
1	CC	3	7	1	3	1	
2	CC	3	1				
3	CC	7	5	1	5		
4	MB	5	1		1	5	
5	MB	5	3	2	1	5	
6	CC	1			1		
7	CC	6	1	3	1		
8	CC	1	2		2	1	6
9(c)	MB	1	7		1	6	
10	CC	7	1	5	1	5	
11	CC	5	1	6	1	5	
12	LB	4	1	5	5		
13	MB	n/a			3		
14	CC	3	1		1	3	
15	CC	1	4	5	2	1	6
16	LB	5	7	1	4	5	
17	CC	1	5		1	5	
18	LB	5	7	1			
19	MB	2	1		1		
20	CC	5	6	2			

KEY

1 - Social Worker
2 - Senior Social Worker
3 - N.S.P.C.C. Worker
4 - Probation Officer
5 - Health Visitor
6 - General Practitioner
7 - HA (Hospital Doctor)

Table 16 The Use of Case Conferences and the Involvement of Inexperienced Staff

Report Number	L.A. Type	Year Report Published	Inexperienced staff involved in NAI case	Use of the term 'Key Worker'	Case Conference Called	Number of Case Conferences (total)	Case Conference called too late	Decisions of Case conference not implemented effectively
1	CC	1973						
2	CC	1974	(1)					
3	CC	1974	(1)					
4	MB	1975	(1)		(1)	1		
5	MB	1976	(1)		(1)	1		(1)
6	CC	1975	(1)					
7	CC	1978	(1)		(1)	2		
8	CC	1977						
9c	MB	1980	(1)		(1)	1	(1)	
10	CC	1978			(1)	2	(1)	(1)
11	CC	1978	(1)	(1)	(1)	3		(1)
12	LB	1982		(1)	(1)	9		(1)
13	MB	1979	(1)	(1)				
14	CC	1979		(1)	(1)	2	(1)	
15	CC	1980	(1)	(1)				
16	LB	1981	(1)	(1)	(1)	6	(1)	
17	CC	1981	(1)		(1)	4	(1)	
18	LB	1982			(1)	4	(1)	(1)
19	MB	1981	(1)		(1)	2		
20	CC	1982		(1)	(1)	3		

(1) - Affirmative

Section 4 Findings of Inquiries

The section sets out the findings of the various modes of investigation, in terms of the following:

- Supervision and staffing levels
- Management and change
- Procedural Issues

Questions upon which the tables are based:

43 Was there inadequate supervision of staff in the SSD?

44 Was understaffing an issue in the SSD?

45 Was understaffing in other agencies cited in the report?

46 In terms of the DHSS recommeded guidelines, did the inquiry judge case loads to be heavy?

47 Was disruption in organisation (SSD) procedures attributed wholly or in part to local government reorganisation?

48 Did the inquiry cite lack of senior management support for lower level staff?

49 Was it the inquiry's view that there was a need for clearer administrative guidelines within the social services department?

50 In the inquiry's view, was there a need for a clarification of the criteria used to identify children at risk?

51 Was it the inquiry's view that child abuse procedures common to all agencies needed to be developed?

52 Was it the inquiry's view that formal co-ordinating machinery for dealing with multi-agency involvement in at risk cases was inadequate?

Table 17

Supervision and Staffing Levels

Report Number	Year of NAI Death	Inadequate Supervision	Understaffing in SSD	Understaffing in other agencies involved in case
1	1972			
2	1973	(1)	(1)	(1)
3	1973	(1)	(1)	(1)
4	1974	(1)	(1)	(1)
5	1975	(1)	(1)	(1)
6	1975	(1)	(1)	(1)
7	1976	(1)	(1)	
8	1976		(1)	
9(c)	1976	(1)	(1)	
10	1976			(1)
11	1977	(1)		
12	1977	(1)	(1)	(1)
13	1978		(1)	
14	1978	(1)		
15	1978	(1)	(1)	
16	1978	(1)	(1)	
17	1979	(1)		
18	1979	(1)		(1)
19	1980	(1)	(1)	
20	1980			

KEY

(1) - Affirmative.

Table 18 Management and Change.

Report Number	Year of NAI Death	Heavy Case Loads	Disruption in Procedures LA Reorganisation	Lack of senior Management Support for staff
1	1972			
2	1973		(1)	
3	1973		(1)	(1)
4	1974	(1)	(1)	(1)
5	1975	(1)	(1)	(1)
6	1975		(1)	(1)
7	1976		(1)	(1)
8	1976			
9(c)	1976	(1)	(1)	(1)
10	1976	(1)		
11	1977			
12	1977	(1)		
13	1978			
14	1978	(1)	(1)	
15	1978	(1)		(1)
16	1978			(1)
17	1979	(1)		
18	1979	(1)		(1)
19	1980			
20	1980			

Table 19 Procedural Issues

Report Number	L.A. Type	Year of NAI death	Year Report published	Need for clear Admin guidelines In SSD's	Need for clarification of criteria for identifying children at risk	Need for a Procedural framework common to all agencies	Need for improved multi-agency co-ordinating machinery
1	CC	1972	1973		(1)	(1)	(1)
2	CC	1973	1974		(1)		(1)
3	CC	1973	1974	(1)	(1)	(1)	
4	MB	1974	1975	(1)	(1)	(1)	(1)
5	MB	1975	1976	(1)	(1)	(1)	(1)
6	CC	1975	1975	(1)	(1)	(1)	(1)
7	CC	1976	1978	(1)	(1)	(1)	
8	CC	1976	1977	(1)			
9c	MB	1986	1980	(1)	(1)	(1)	(1)
10	CC	1976	1978		(1)	(1)	
11	CC	1977	1978	(1)	(1)	(1)	
12	LB	1987	1982	(1)	(1)	(1)	
13	MB	1978	1979	(1)	(1)		
14	CC	1978	1979	(1)	(1)	(1)	
15	CC	1978	1980	(1)	(1)	(1)	(1)
16	LB	1978	1981	(1)	(1)	(1)	(1)
17	CC	1979	1981		(1)	(1)	(1)
18	LB	1979	1982	(1)			(1)
19	MB	1980	1981	(1)			
20	CC	1980	1982				

(1) - Affirmative

CHAPTER 6 Questionnaire Analysis

Enshrined in legislation is the duty of local authorities to "promote the welfare of children". Child abuse procedures and guidelines are one aspect of a social services department's child care policy. Departments are charged with the responsibility of implementing and formulating child abuse guidelines and strategies based on advice, guidance and instructions issued by the DHSS in advisory circulars (Chapter 2). The way in which a child abuse policy is both interpreted and implemented is left to the discretion of each social services department. Due to the degree of local autonomy there are variations in nomenclature and approaches (chapter 2). For example "At Risk" registers may be interpreted as "family at risk" registers or children at risk registers, and criteria for registration and deregistration can vary from department to department. Direct comparability across authorities is problematic.

However, in general social services departments operate primarily along structural functional lines. Brunel (1980) identified five strata of areas of work undertaken by SSDs. These strata are superimposed upon a continuous scale of work of increasing responsibility. The scale runs from the operational end, characterized by para professional activity and autonomy through to the director who has overall responsibility for the functioning of the department. The director in turn is accountable to (i) the social services committee made up of elected members of the local authority and (ii) to the chief executive of the Authority. The five strata are set out here because they provide a general framework into which the variations in nomenclature found in the questionnaire

responses may be placed.

Stratum 1 Located at this level are social work assistants and ancillary staff performing work roles that have a prescribed output.

Stratum 2 Located in this banding are first line management roles. The role holders are qualified social workers with practical experience who allocate work to stratum 1 workers. This role contains an element of supervision.

Stratum 3 In this stratum are located specialist advisors, development officers, area officers who manage local offices, from which operate various members of teams of social workers and ancilliary staff.

Stratum 4 At this stratum there is a move away from direct operational management towards service planning, the banding consists of divisional directors and assistant directors.

Stratum 5 Within this stratum is located the director of the department.

In addition, SSDs may have specialist social workers who work with one client group or generic social workers who work across client groups, they are usually located in strata 2 and 3.

The questionnaire sought (i) to gain information on the ways in which departments managed resources and operationalised procedures in relation to child abuse cases, and, (ii) to ascertain the impact a decade of non accidental injury inquiries have had on SSD's in England and Wales (for example, on departmental resource shifts, typified by the creation of new posts (question 24), the devising of specific operational plans in relation to child abuse as opposed to or in addition to other client areas (questions 9 and 10)). To this end, Section 1 of the questionnaire addresses specifically components of a child abuse policy

(Area Review Committees, multi-disciplinary procedures, case conferences, and the management of the child abuse register, termed in the questionnaire as an 'At Risk' register).

There has been much debate as to the ability and utility of quasi legal devices to investigate and pronounce upon complex social problems (Chapter 3). Section 2 of the questionnaire is concerned primarily with eliciting the evaluations of managers as to the utility and recommendations of NAI inquiries and the impact such inquiries have had (in their view) on management efficiency in relation to child abuse cases (questions 33 and 41).

Organisation of the Chapter

The questionnaire generated a large amount of data. The matrices used to collect the information are set out in appendices 1 and 2. In this way the information upon which this chapter is based is made explicit.

The discussions and inferences set out can be traced back to the types of local authority and the actual SSDs that supplied the information. The chapter is divided into two parts. Part one addresses responses gained from the closed ended questions concentrated in Section 1 of the questionnaire. Part two contains a discussion based on a content analysis of the ended questions found primarily in Section 2 of the questionnaire.

Organisation of the Analysis

The questionnaire was designed to address two objectives:

(i) to elicit information on child abuse practices and procedures in use in SSDs during the period 1980-1983

(ii) to elicit the views and opinions of managers on the perceived and actual effects of formal non-accidental injury inquiries on

(a) social services departments generally;

(b) on the manager's own department irrespective of whether it had been the subject of a non-accidental injury inquiry, and

(c) the manager's perceived preferences regarding modes of investigation.

Each SSD in England and Wales was assigned a number, running from 1-116 (inclusive). The numbering followed the order in which SSD's were listed in the Municipal Year Book (1982).

Fig.1 Questionnaire Response by Type of Local Authority Social Services Departments (SSD).

Type of Authority	Total Number of SSDs	SSD Numbering	Questionnaire Response	%
County Council (CC)	47	1 - 47	22	46
Metropolitan Boroughs (MBC)	36	48 - 83	19	52
London Boroughs (LB)	33	84 - 116	15	45

Out of a total of 116 LASSDs in England and Wales, 56 returned the questionnaire, giving a 48% response rate. Of the 56 SSDs who participated in the survey, 13 had been the subject of a formal NAI investigation (Table 20).

The questionnaire comprised 42 questions grouped into issue areas. Part one of the questionnaire analysis is concerned with the five areas

set out below:

AREA	Question Nos.
1. The Formalization of Management Guidelines	1 - 3
2. Staff accreditation and Development	4 - 8
3. Operational Planning	9 & 10
4. Monitoring and Decision Making	11-20, 26-29
5. Organisation Responses	21, 22-25

Table 20 Participating Authorities in Questionnaire Survey

COUNTY COUNCILS	METROPOLITAN BOROUGHS	LONDON BOROUGHS
1. AVON	49. BIRMINGHAM *	84. CITY OF LONDON
3. BERKSHIRE *	52. BURY	86. BARNET
5. CAMBRIDGESHIRE #	53. CALDERDALE *	87. BEXLEY *
6. CHESHIRE	55. DONCASTER	88. BRENT
7. CLEVELAND	56. DUDLEY	89. BROMLEY
8. CLWYD	58. KIRKLEES	92. EALING
13. DORSET	59. KNOWSLEY	93. ENFIELD
14. DURHAM	60. LEEDS CITY	94. GREENWICH
17. ESSEX #	62. MANCHESTER CITY	97. HARINGEY
18. GLOUCESTERSHIRE	63. NEWCASTLE UPON TYNE	99. HAVERING
20. GWYNEDD	65. OLDHAM	102. ISLINGTON
22. HEREFORD & WORCESTER	68. ST. HELENS	107. MERTON
24. HUMBERSIDE *	71. SEFTON	109. REDBRIDGE
27. LANCASHIRE	72. SHEFFIELD CITY *	110. RICHMOND UPON THAMES
28. LEICESTERSHIRE *	73. SOLIHULL	114. WALTHAM FOREST
33. NORTHUMBERLAND	78. TRAFFORD	
37. POWYS	79. WAKEFIELD	
38. SHROPSHIRE *	80. WALSALL *	
39. SOMERSET *	82. WIRRAL #	
40. SOUTH GLAMORGAN		
44. WARWICKSHIRE		
47. WILTSHIRE		

* Formal NAI Inquiry

\# More than one formal NAI Inquiry

SECTION 1: THE MANAGEMENT OF CHILD ABUSE

1. Has your Department set out guidelines for the notification of Non-Accidental Injury to Children?

YES [ ] (1) NO [ ] (0)

2. Please indicate ways in which the content of the guidelines is communicated to the personnel in your Department?

Committee Reports [ ] (1) In-service training [ ] (3)

Departmental procedures manual [ ] (2) Memoranda [ ] (4)

If other please specify ..... (5)
.....

3. How is the content of the guidelines specifically communicated to

(a) Members of the social services committee?.....
.....

(b) Senior managers?.....
.....

(c) Middle managers?.....
.....

(d) Social workers?.....
.....

4. Has your Department different levels of social workers with differentiated responsibility in the field of Child Care?

YES [ ] (1) NO [ ] (0)

5. Does your Department run an accreditation programme for social workers?

YES [ ] (1) NO [ ] (0)

6. On what grounds is accreditation granted?

Years of experience [ ] (1)

Experience and in-service training [ ] (2)

Proof of professional competence in case work [ ] (3)

If other please briefly specify..... (4)
.....

7. Who validates this competence?

Senior social worker [ ] (1) Area Manager [ ] (2)

If other please briefly specify.....
..... (3)

8. Do only accredited social workers work on N.A.I. cases?

YES [ ] (1) NO [ ] (0)

9. (a) Has your Department an operational plan for dealing with child abuse?

YES [ ] (1) NO [ ] (0)

(b) When was this instituted?

1	9			
		(2)	(3)	

(c) What time span is covered by this plan?

3 yrs [ ] (4) 5 yrs [ ] (5)

If other please briefly specify.....

.....
(6)

10. Has you Department a similar plan for other client groups?

Mental Handicap	[ ] (1)	Single Parents	[ ] (4)
Elderley	[ ] (2)	Homeless	[ ] (5)
Mentally ill	[ ] (3)	Other	[ ] (6)

11. In which year was the 'At Risk' register introduced into your department?

1	9		
		(1)	(2)

12. How many child care cases were dealt with by your Department between April 1982 and April 1983?

(2)	(3)	(4)

13. How many children were on the 'At Risk' register in the period April 1982 and April 1983?

(2)	(3)	(4)

14. Has this number on the register altered over the past 3 years?

Increased [ ] (1) Stayed much the same [ ] (2) Decreased [ ] (3)

15. What factors do you think account for the situation over the past 3 years?

.....

.....

16. Who is responsible for monitoring the 'At Risk' register in your department?

.....

.....

17. What responsibility do Area Managers have for monitoring the 'At Risk' register?

.....
.....

18. Who is responsible for monitoring work with families whose child(ren) are on the 'At Risk' register?

.....

.....

19. How often does the Area Review Committee meet to reassess cases on the 'At Risk' register?

Annually	[ ] (1)	Quartley	[ ] (3)
Biannually	[ ] (2)	Monthly	[ ] (4)

20. How many child abuse case conferences were called by your Department in the time periods specified below?

3 yrs ago [ ][ ][ ] (1)(2)(3) 2 yrs ago [ ][ ][ ] (4)(5)(6) 1 yr ago [ ][ ][ ] (7)(8)(9)

21. (a) Does your Department collaborate with the N.S.P.C.C.?

YES [ ] (1) NO [ ] (0)

(b) Is this collaboration

Formal [ ] (2) Informal [ ] (3)

Please briefly elaborate

.....

.....

(4)

22. How many N.A.I. referrals does your Department receive from the following sources in the time periods specified below?

	3 yrs ago	2 yrs ago	1 yr ago
Voluntary agencies			
Self Referrals			
Health agencies			
Education Department			
Police Department			
Community			

23. Has your Department a Special Child Abuse Team?

YES [ ] (1) NO [ ] (0)

If yes,

(a) Who are its members? (agency and job title)

.....

(b) To whom is the Team accountable?

.....

24. (a) Have you a Specialist Officer for Child Abuse?

YES [ ] (1) NO [ ] (0)

(b) When was this post created

[1][9][ ][ ] (2)(3)

25. Have you a policy of appointing a key worker for Child Abuse cases?

YES [ ] (1) NO [ ] (0)

26. Who is responsible for convening a Child Abuse case conference in your Department?

.....

.....

27. Which agencies normally participate in the initial case conferences?

.....

28. Who usually chairs case conferences in your Department?

.....

29. In a climate of scarce Departmental resources, do you consider the Case Conference format provides the most cost-effective method for decision making in Child Abuse cases?

YES [ ] (1) NO [ ] (0)

Please briefly elaborate.....

.....

.....

.....

PART ONE

The formalization of management guidelines (Area 1)

All responding departments (56) had set out guidelines for the notification of non-accidental injury to children. The most common method used to communicate the content of the guidelines was through the distribution of a departmental procedures manual (52 out of 56 SSD's), with 48 departments using, in addition, some form of in-service training, for example, the organisation of study days 'at six monthly intervals'. In one authority there was emphasis placed on 'personal contact, case conferences and case discussions' as a means of disseminating guidelines. Overall there appeared to be great emphasis on managers operating a formal communication system re child abuse procedures and practices, that is, in distributing manuals. While in 1983 it appears that in-service training was slight, and was not an integral part of formal communication systems.

The question of how the content of the guidelines was specifically communicated to various organisational strata was asked (question 3):

To members of the social services committee. With the social services committee rests an important aspect of a department's public accountability. Overall it was found that departments prepared reports for committees which 'invariably' included a copy of the current child abuse guidelines. There were exceptions. In one SSD the communication of guidelines to members took place on an 'ad hoc' and individual basis. Two SSDs produced an explanatory booklet which was sent to members of the committee. One SSD gave an 'occasional report on activities undertaken by the Area Review Committee' while another SSD organised study days on child abuse for the benefit of committee members. Two SSD's stated that guidelines were not specifically

communicated to the committee.

To Senior Management (stratum 4). In the majority of departments the dissemination of guidelines followed the same route as "to staff in the department in general", that is, through the issuing of a procedures manual. This was the major method of induction. In 5 departments senior managers were directly involved in the compilation of guidelines.

To Middle Management (stratum 3) In 27 departments the major method of induction was through the distribution of copies of guidelines, "(they) have sight of, or own copies of the guidelines". In 5 SSD's middle managers were involved in the compilation of guidelines. In 11 departments in-service training was used as a supplementary method of communication (that is in addition to the distribution of guidelines).

To Social workers (strata 2 and 1) including first line managers and ancillary staff. In 21 departments in-service training in relation to the operation of child abuse guidelines was cited as a specific method of communicating NAI procedures and practices. One SSD held an annual child abuse conference, at which up dated guidelines were distributed. Two SSDs held training seminars and "study periods". There appeared to be a reliance on short training periods of 1 to less than 1 day's duration. Copies of guidelines held by line managers were available to staff in 2 SSDs "if they wish to see it".

What emerges is an ethos of management based upon an "I will guide you" approach. There is no systematic approach to staff training in the area of "using guidelines" but instead reliance upon meetings with team leaders and senior social workers. (Appendix 2).

Staff Accreditation and Development. (Area 2)

Social services departments generally assign social work grades based

upon years of experience; Level 1 is the grade for newly qualified social workers, Level 2 is the grade social workers attain after spending approximately two years as practitioners. Progression to Level 3 is based on a minimum of three years post qualifying experience and an assessment of acquired skill, knowledge and experience. In the Inquiry Reports examined in the thesis, (Chapter 5) 13 out of 20 reports cited inexperienced, newly qualified, or staff new to the area of child care, as factors to be taken into account in their examination of the management of the NAI cases. These factors run through cases examined from 1974 to 1981.

The questions in this Area (2) sought to gain information on the level attained by staff who routinely dealt with child abuse cases and whether or not an SSD ran a specific accreditation programme for those working with child abuse cases.

Of the 56 SSDs who participated in the survey, less than half (21 SSD's) stated that only level 3 and experienced level 2 workers investigated NAI complaints. One SSD specifically stated that "only level 3 staff ever work with children at risk". In terms of a structured training and development programme (accreditation programme) for qualified staff, only 17 SSDs had such a formal programme. One SSD was in the process of negotiating a programme with staff unions, while another stated that they did not have a formal structured programme but work is allocated and sensitive work such as this is given to staff with capacity to deal with it". In 7 SSDs only accredited social workers worked on NAI cases.

Operational Planning (Area 3)

Each of the NAI inquiry reports examined in the thesis had as a focus, aspects of inter and intra organisational co-ordination and

communication. For SSDs in the discharge of their statutory responsibilities in relation to children at risk, there is no publicly acceptable level of failure. However, there have occurred sufficient NAI deaths with resultant inquiries to warrant a systems response to anticipated "failures". Guidelines set out in procedures manuals are a passive and supervisory interpretation of management. Question 9 and 10 sought to establish the extent to which departments were actively engaged in management planning on a client group basis.

An operational plan would typically take into account the provision of service to the client and the system that enables that service to be provided. It would also take into account the existence of the probability of "failure", in this case, a child's death. From the inquiry reports examined, (Chapter 5) it would appear that a manager's attention should be focussed on systems of co-ordination and communication and the development of substantive training programmes. In this way "supply side" errors (services to the client) may be minimised. Of the 56 SSD's participating in the survey, 5 had an operational plan for dealing with child abuse; 16 SSDs stated that they did not have a plan and 35 SSD's interpreted the question to mean process supervision, that is the instituting of "at risk" registers and the setting up of area review committees. One department stated "child abuse is treated as a social work problem and I don't quite see how we can have an operational plan". Another department stated "I would call our guidelines and procedures an operational plan". Perhaps the most disappointing quote comes from an SSD that stated "I really don't understand what you mean by a plan. Do you think that with a plan you

can get rid of it?" Six departments had operational plans for client groups other than children 'at risk'. One stated that "divisional directors have a role in policy, planning strategy for individual client groups and are beginning to develop strategies".

What emerges is a marked absence of active management planning and direction. There appears to be a passive almost fatalist approach to short/medium term planning, summed up by one SSD who stated, "we have philosophies for the development of service to mental handicap and the elderly which gives us a framework for developments if resources become available".

Monitoring and Decision Making (Area 4)

Research conducted in 1977 suggested that where well co-ordinated management procedures were operating, there appeared to be significant reductions in the number of children who were seriously or repeatedly injured (Creighton & Owtram 1977). BASW (1978) in their report found that there was a failure to recognise that responsibility for effective multi-disciplinary co-ordination had to be delegated to an individual and an agency (question 24 and 25). They stressed that child abuse registers were an integral part of total process of management of child abuse and could not be viewed in isolation from other components of the management of child abuse system. The DHSS (1974) in the wake of the Maria Colwell Inquiry (1974) advised the establishment, within existing resources, of Area Review Committees (ARC) made up of representatives from all relevant agencies involved in child abuse cases. The DHSS advised that ARCs should devise standard operating procedures for the

management of child abuse (question 19), and that they should also consider setting up a central register to facilitate multi agency, multi discipline communication between those involved in child abuse cases.

In line with this recommendation, 35 SSDs out of the 56 who participated in the survey introduced registers in 1974/75. Given that registers are one component of department's child care systems, it is interesting to note that only 24 could supply figures for the number of child care cases dealt with by their department over one year (question 12). Whereas 53 out of 56 SSD's could supply figures for the number of children on 'at risk' registers during the same period.

The numbers on registers during the period April 1982-April 1983 vary greatly. Seven SSD's had family at risk registers, and of the 44 SSDs that held registers, the following groupings occurred:

Fig. 2 Number of children on registers April 82-April 83

Numbers on Register	Numbers of SSDs	Alterations 1980-1983		
		increased	stable	decreased
0 - 99	13	4 SSD	6 SSD	1 SSD
100 - 199	14	8	1	5
200 - 299	5	4	1	
300 - 399	3	3		
400 - 499	3		1	2
500 - 599	1			
600 - 699	3	3		
700 - 799	1			1
900 - 999	1			1

Overall the major reason for a decrease in the number of cases on registers was attributed to the tightening up of procedures and revised criteria for registration. One SSD stated "more accurate identification, less nervous registration and the introduction of a deregistration facility" (appendix 2: LASSD 17). Another stated "professional assessment procedures improved, better understanding between agencies of what constitutes child abuse" (appendix 2: LASSD 88). In one SSD a change in the criteria used to identify at risk cases had led to an increase in identification of cases of neglect, "but improved reviewing has lowered overall numbers on registers" (appendix 2, LASSD 44). There were two exceptions; in one SSD a "major review of register undertaken late 1980, and a more specialist approach (adopted) to child abuse . . . the introduction of a special child care team . . . all cases (are now) subject to a case conference . . . review of register (up to 1980) to ensure register was a meaningful tool", and another SSD stated "all professionals concerned have become more experienced and so (are) more prepared to take risks".(appendix 2: LASSD 82 & 86).

In SSDs where numbers on registers had remained approximately stable, it was generally stated that a tightening up of procedures and criteria were directly responsible. The inference being that numbers would have been expected to increase. In terms of NAI inquiries sensitizing the public and agencies to the issue of NAI, twenty-two SSDs (who responded to question 22), stated that over a period of three years, the number of self referrals had increased, as had the number of referrals from the health service, the education service and the police. One SSD stated that a "more considered use of the register and clearer criteria have

tended to offset the increase in referrals which may have been caused by the general increase in stress/unemployment and increased use of procedural guides" (appendix 2: LASSD 78).

Of the twenty-two SSDs who stated that the numbers on registers had increased during the period 1980-1983, 13 attributed the increase to an increased awareness by agencies and the public of child abuse. One authority stated that the increase in numbers was due to "adverse publicity and protection offered by the registration and better liaison with other agencies" (appendix 2: LASSD 37). Three SSD's stated that the increase was due to the fact that they had not had until 1982/83 a policy for deregistration (appendix 2: LASSD 33.59.63). One SSD suspected "that there is a higher rate of throughput and children not remaining on the register for lengthy periods" (appendix 2: LASSD 5). Another stated that the reason for the increase in numbers was "probably linked to the many uncertainties and stresses in society today" (appendix 2: LASSD 53).

The role of the area manager (stratum 3) in monitoring registers varied. Overall their role was a supervisory one, ranging from 'local oversight' (including regular reviews), to "ensure ultimately that the review forms are completed by social workers in their area", in 6 SSDs area managers chaired all child abuse case conferences and in 12 SSDs they had no monitoring role at all. Overall monitoring of work with families whose child(ren) were on 'at risk' registers was part of normal line management duties (senior social worker, Team Leader). In 20 SSDs this was stated to be the case. Nomenclature varies considerably in some instances area managers were also team leaders, in others senior social

workers were team leaders. In two SSDs a key worker had responsibility for monitoring. In one case the key worker was nominated by the initial case conference "usually a level 3 social worker, with line managers reporting to district and area review panels who have responsibility for monitoring on an inter-agency basis". In one authority, the review panel was described as a "local version of the Area Review Committee". Again, nomenclature varies, "divisional review panel", "standing review conferences", "co-ordinating conferences" are variously used for 'review panel'. In 3 SSDs, a principal officer for child abuse had responsibility for monitoring. In one SSD, monitoring was the responsibility of a case work consultant, while in another it was the responsibility of a principal assistant (children). In one SSD an 'Officers Panel' had monitoring responsibilities, while another stated that responsibility for monitoring "varies according to decisions being made. Generally senior social worker but certain issues are decided by the Director".

In 24 SSDs, ARCs had an active involvement in the reassessment of cases. This is a surprisingly low figure given the central role of ARCs in consultation and procedural review (DHSS 1974). In 25 SSDs ARCs were not involved in the reassessment of cases on 'at risk' registers, this was the function of local review panels, and area managers who acted on behalf of ARCs.

The DHSS (1974) recommended that for every case involving suspected non-accidental injury to a child, a case conference should be convened as a means of minimising unilateral agency action. It would provide a forum for information exchange between those agencies involved in a

particular case. Case conferences as a management device for achieving shared understanding of a complex problem space are rational administrative approaches to the minimising of duplication and unco-ordinated interventions. Consequently, they have become an established part of the process of the management of child abuse. Questions 20, 26, 27 and 29, seek to gain information on their usage and overall effectiveness.

Seventeen SSDs did not have information available as to the numbers of child abuse case conferences convened between 1980 and 1983. Of the 38 SSDs who had figures available for the period 1981-1982, the range varied dramatically. At the bottom end of the range under 50 case conferences were called (2 SSDs), while at the top end of the range 2 SSD's called between 500 and 550 case conferences. The majority of departments (20 SSDs) called between 100 and 250 case conferences between 1981 and 1982.

Overall, stratum 3 workers had the responsibility for convening child abuse case conferences and chairing initial conferences. For subsequent case conferences team leaders took the chair. The conferences typically comprised of representatives from the health authority, education department, NSPCC, police, probation and other relevant workers involved "all having some knowledge of the family or likely to be involved in the future".

The rationale for recommending the use of case conferences was to enable all those involved in the case to reach a collective decision (DHSS 1974). The responses to question 29 (appendix 2) shows quite clearly

that several of the SSD's who participated in the survey, did not view case conferences as a forum for decision making. One SSD stated that "case conferences are not convened to make decisions for statutory agencies, but to recommend action, share and collect information" (appendix 2: LASSD 37), "are case conferences decision making bodies? It has been suggested that the case conference is a consultative forum not taking decisions but making recommendations. Success depends on good chairmanship, many are allowed to go on far too long" (appendix 2: LASSD 68). Eight out of 47 SSD's who responded to question 29, were of the opinion that case conferences were not cost effective principally because they "did not make decisions", "were talking shops" and were "not chaired effectively". "Obviously the most cost-effective method is for individual social workers to take decisions in consultation with their team leader" (appendix 2: LASSD 72).

Organisation Reponses (Area 5)

What emerges is that SSDs view themselves as the agency responsible for taking decisions in child abuse cases. The only other agency with statutory powers similar to those of social services departments is the NSPCC. Only 2 SSDs did not collaborate with the NSPCC. The remaining 54 SSDs collaborated at both a formal and informal level. In several local authority areas NSPCC units received financial support from SSD's. In 16 SSDs the NSPCC was represented on the Area Review Committee.

Given the publicity surrounding the issue of NAI deaths and the criticisms made of social services departments' management of child abuse cases in inquiry reports, questions 23 and 24 sought to ascertain if there had been resource shifts, by way of the creation of new posts,

specifically to deal with child abuse cases. Of the 56 SSDs who participated in the survey, 5 SSDs had a specialist child abuse team (three of these departments had been the subject of a formal NAI inquiry). Twenty seven SSDs had appointed a specialist officer for child abuse, seventeen of these posts were created between 1979 and 1983.

Local authority autonomy and DHSS advisory circulars have conspired to produce a fragmented pattern of procedures, practices and approaches to the management of child abuse systems, that have evolved in social services departments in England and Wales over a period of ten years (1973-1983). Systems vary, nomenclature varies, criteria for registration varies, thus direct comparability between departments - even those serving a similar demographic population - is problematic. It appears overall that NAI inquiries have had an indirect impact on the components of child abuse systems within the departments who participated in the survey. Inquiries have however spurred the DHSS on to issuing advisory circulars in relation to children at risk. As a result of these circulars LASSD's have been nudged towards the development of more coherent management structures for administrating and facilitating multi agency co-ordination in respect of NAI cases.

Area Review Committees in line with the formal, structural management approach have accomplished their task. All departments who participated in the survey have standard operating procedures, set out in procedures manuals. However the ways in which the procedures are communicated to decision makers at the operational level is not commensurate with the attention and publicity focussed on this critical client group. In

1983, scant attention appears to be paid to the instituting of specific and substantive training and development programmes for social workers involved with child abuse cases. Management as a term is synonymous with supervision, based on an "I will guide you" ethos. Formal systems are established but are not actively managed.

PART TWO

In Section 2 of the questionnaire, the questions were concerned with eliciting views and opinions of managers as to the utility of various modes of NAI investigative processes. A general fourfold classification of types of inquiries and investigations was set out in the introduction to Section 2 of the questionnaire. The classification was intended as a guide, to focus participants attention on the area of inquiries. Responses to the open ended questions are set out in a series of matrices and reference is made throughout the analysis to the matrices contained in appendices 1 and 2. (Appendix 1 contains responses to closed questions, appendix 2, responses to open ended questions). As in part one, the questions were grouped into issue areas.

AREA		Question No.
6.	The Role of Public NAI Inquiries	30 - 34
7.	Direct Experiences of NAI Investigations	36 - 40
8.	The Utility of various modes of investigation	35 & 41
9.	Alternative Processes for investigating NAI deaths	42

SECTION 2: INQUIRIES INTO CHILD ABUSE

This section deals with the impact that inquiries/investigations into Child Abuse have had on Social Services Departments.

Four types of inquiry/investigation have been listed - these are as follows:-

Public Inquiry	(Statutory, adhoc, ordered by a Minister)
Formal Inquiry	(Non-statutory, adhoc, ordered by a Local Authority)
Inter-Agency Inquiry	(Set up by different statutory bodies)
Internal Investigations	(Less formal internal administration investigation by an authority)

30. What purposes do you consider Public Inquiries serve?

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31. Do you consider that a Public Inquiry is in a position to evaluate realistically the management function in Social Services Departments?

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32. Do you consider that the present method of conducting Public Inquiries into N.A.I. to children is appropriate?

YES ☐ (1) NO ☐ (0)

Please state briefly reasons for your answer.....

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33. (a) In light of the recommendations of Public Inquiry. Reports of the past 15 years, do you consider that these have led to a change in the management of Child Abuse cases across authorities?

YES ☐ (1) NO ☐ (0)

(b) Do you consider management efficiency has:

Increased	☐ (2)
Stayed much the same	☐ (3)
Decreased	☐ (4)

(c) Are there any other factors which you think are responsible for changes in management efficiency?
Please Specify.

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34. In your opinion do the findings of Public Inquiries directly influence future management strategies:

Very influential	☐ (1)
Influential	☐ (2)
Not very influential	☐ (3)

35. In the light of the findings of different types of Inquiry/investigation, please could you rank the following in terms of their practical use to your Department.

Public Inquiry	___	(1)
Formal Inquiry	___	(2)
Inter-Agency Inquiry	___	(3)
Internal Investigation	___	(4)

36. Has your Department been the subject of any of the following:-

Public Inquiry	___ (1)	Inter Agency Inquiries	___ (3)
Formal Inquiry	___ (2)	Internal Investigation	___ (4)

37. What period of time elapsed between the incident and the convening of the inquiry/investigation?

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38. What role, if any, did the Social Work Services Officers play in the period between the incident and convening of the Inquiry/Investigation?

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39. How long did the Inquiry/Investigation take?

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40. What do you identify as the main cost of the Inquiry/Investigation in terms of the Department's resources?

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41. Did the recommendations of the Inquiry/Investigation lead to a change in the management of Child Abuse Cases in your Department?

Substantial change	___	(1)
Minor change	___	(2)
No change	___	(3)

Please elaborate briefly on your answer .....

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42. In you opinion, what are the most cost-effective ways of inquiring into allegations of mismanagement of Child Abuse cases?

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The Role of Public Inquiries into NAI Deaths (Questions 30, 31, 32, 33 & 34 (Area 6)

In the spectrum of NAI inquiries identified in chapter 3 (table 1) a Ministerial Inquiry, that is one set up by a Secretary of State, has greater formal powers than other types of NAI inquiries. Being legally consitituted such inquiries have the power to compel the attendance of witnesses, the production of documents and the taking of evidence under oath. There have occurred during the period the thesis is concerned with (1973-1981) four Ministerial Inquiries exercising full statutory powers, (into the NAI deaths of Susan Aukland (1975) Richard Clark (1975), Darryn Clarke (1979) and Paul Brown (1980).). The inquiries took place an average 25 months after the NAI deaths had occurred, sitting for an average of 28 days, with the approximate cost of one of the inquiries, which took place in 1980, being one million pounds (Gregory and Jones 1981). Public Inquiries are expensive and their powers are far reaching. Questions 30-35 sought to ascertain the impact such inquiries have had on social services departments in England and Wales, from the viewpoint of social services managers.

One of the primary functions of a Public Inquiry is to demonstrate the public accountability of the service and individuals within the service (chapter 3). Of the 51 social services departments (SSDs) who responded to question 30, nine departments viewed the primary purpose of Public Inquiries to be that of demonstrating public accountability. A further 12 SSD's held positive views as to the role that Public Inquiries fulfilled. "The earlier inquiries helped with (the) recognition of child abuse and influenced agency policy and practice"

. . . "to enable legislation to be changed, to indicate the inadequacy of resources and responses" . . . "highlights the need for ongoing review of departmental procedures" . . (they) may be able to offer a more objective scrutiny especially of senior management" (appendix 2: LASSD 8. & 47.). However, swingeing criticisms were made by managers in 10 SSD's of the role of public enquiries. The criticisms concerned a perceived function of inquiries, and centred around the notions of "scapegoating" and "bloodletting". "They meet a ritualistic need for scapegoating as a means of relieving corporate guilt on a psychologicial level. Most of the actual findings could be arrived at by other means" . . . "There is a suggestion that public inquiries re-inforce accountability but at the same time they raise public anxiety and distrust in social workers generally. Culpability is clearly shown to rest with the social worker and senior social worker" (appendix 2: LASSD 13 & 71). One SSD saw the role of Public Inquiries as being "to satisfy media type outrage and seek scapegoats, to produce a report often many, many months after the event" (appendix 2: LASSD 18).

Managers in five departments perceived Public Inquiries as serving a primarily public relations function, that of appeasement. "They allow blame to be attributed without resources being given" . . . "some people may be led to believe something is being done officially" (appendix 2: LASSD 72 & 89). One manager stated "I do feel they neither serve a constructive nor a professionally competent purpose. They apparently serve to satisfy the media rather than the needs of professionals" (appendix 2: LASSD 14). This view was echoed by another manager, who stated "they have served their purpose, are in danger of becoming repetitive. Why should there be enquiries and great debate into child

abuse deaths and not other deaths in the community or hospital. Such inquiries may assist the (social services) Committees to confirm to the rate payers that they are in control" (appendix 2: LASSD 49).

Another equally important function of a Public Inquiry is to establish the facts of a case (chapter 3). Managers in 11 SSDs were of the opinion that this was a primary function of a Public Inquiry. "They highlight common procedural problems, shortfalls in provision of services, training and interagency communication that can be beneficial to other agencies" . . . "an open examination of problems and difficulties" . . . "may influence a change in legislation recommend practice/procedural improvements, through the media, assure that workers are accountable and blame is apportioned" (appendix 2: LASSD 6, 20 & 94).

Managers in departments were then invited to give their opinions as to the ability of Public Inquiries to pronounce upon the management function in SSDs (question 31). Of the 50 SSDs who responded to the question, managers in 33 departments felt that Public Inquiries were not in a position to evaluate realistically the management function in social services departments. One manager stated that this was "because one would have to become aware of managerial attitudes across the board together with formal and informal lines of communication, and every authority appears to vary widely" (appendix 2: LASSD 99). Managers in 12 SSDs were of the opinion that if the composition of the panel, and the terms of reference were appropriate and if Public Inquiries were "conducted properly", they would be able to examine management functioning. One manager stated "usually one member of the Inquiry team

comes from a social services background and the other three (members) are unlikely to appreciate the problems of agency management or, indeed, have any direct experience of agency management" (appendix 2: LASSD 82). Another manager stated "this is dependent on the calibre of the enquiries and their chairman. In theory they are in such a position. In practice several inquiries have been disappointing in the calibre of their inquiry" (appendix 2: LASSD 47). Managers in 4 SSDs held the view that the quasi judicial stance of Public Inquiries (characterised by an adversarial and inquisitorial examination of witnesses) limited the areas that were covered during inquiries. One manager stated that "the quasi juicial approach makes it more difficult but they could get closer by asking the right questions and evaluating evidence from that perspective. No published report yet has got close to this issue". Another manager stated "inquiries have invariably been led by lawyers who themselves have a frightful track record" (appendix 2: LASSD 17 & 62). An interesting observation was made by one manager, concerning inquiry panels' general definition of management as found in inquiry reports. "From reports read it is clear that a number of inquiries indicate lack of supervision by senior officers, breakdown of photo-copiers and staff accommodation as management ineffectiveness" (appendix 2: LASSD 17).

An overwhelming majority (40 SSDs) considered the present method of conducting Public Inquiries in NAI deaths to be inappropriate. The reasons given were associated with the quasi judicial stance of inquiries, and how this orientation resulted in departments adopting defensive postures. Twenty one SSDs cited this as a main reason, "too court like, invariably apportions blame, emotive on the one part and

legalistic on the other. Tends to bring about departmental changes for the wrong reasons, i.e. to keep the heat off" . . . "they are not inquiries so much as inquisitions, the dominance of hindsight is palpable . . . it forces all individuals into defensive postures and therefore examines statements rather than unearthing facts" (appendix 2: LASSD 37, 62 & 93).

Two departments viewed the impact of Public Inquiries as being subject to diminishing utility, "recommendations of earlier inquiries were significant but they can become repetitive" . . . "now they are counter productive. The initial impetus was important but there has been little of positive value since, except to show how little impact they have perhaps" (appendix 2: LASSD 8 & 17). Eight managers in their responses implied that the present method of conducting Public Inquiries into NAI deaths was not cost effective. "The cost in terms of money, stress and low morale is disproportionate to the value of resulting recommendations which are not always implemented as the decision is left to the discretion of the particular local authority" (appendix 2: LASSD 94).

Managers in 36 SSDs stated that the findings of Public Inquiries had influenced management strategies in the area of child abuse (question 34). Managers in 42 SSDs were of the opinion that Public Inquiries had led to changes in management efficiency in relation to child abuse cases (question 33). Though one manager felt their impact to be diminishing "their influence is much less after recent inquiries, most of the changes now having been made" (appendix 2: LASSD 28). Management efficiency was not defined in the questionnaire. Only one respondent gave their interpretation of the components of management efficiency." I

am not sure efficiency is the right word. Watchfulness, awareness, caution, over protectiveness and fear combine to create management efficiency" (appendix 2: LASSD 100). These 'components' were implicit in a range of responses to the question.

Managers of 33 SSDs were of the opinion that management efficiency had increased. Thirteen managers could discern no effects of Public Inquiries on management efficiency and one manager stated that the level of efficiency had decreased. This decrease was attributed to "pressures on Team Leaders and a possible decrease in specialisation" (appendix 2: LASSD 72).

Changes in management efficiency were generally attributed to improvements in systems, improved co-operation and collaboration between agencies, increased awareness of child abuse as a key area for departments and increased experience and training of managers and social workers. Three managers cited the "settling down" of departments as being a factor contributing to management effectiveness. "The period 1971-1974 was fraught with change. Over the last few years there has been more stability leading to more effective planning" (appendix 2: LASSD 79) is an interesting comment from a department that has no operational plan for the management of child abuse cases.

Managers in 13 SSDs viewed increased experience and training of management and social workers as a factor contributing to increased in management efficiency. This view primarily emanated from departments who had accreditation programmes. One manager stated that changes in levels of efficiency were due to "the training and development of

individuals who are managers because they wish to be so, and not merely promoted social workers" (appendix 2: LASSD 71).

Managers in 11 SSDs were of the opinion that systems had improved and in one instance, that the improved operation of systems had led to increases in efficiency. "Social workers have learned that systems set up around child abuse are not only supportive in that responsibility is seen to be shared, but that systems can save time and effort", while another manager was of the view that "there is growing conviction of managers that procedures are reliable and worthwhile and therefore there is an increased commitment to them" (appendix 2: LASSD 65 & 93).

An interesting view was expressed by managers in 4 SSDs, this view concerned 'fear' and 'defensiveness'. That is that caution on the part of departments was responsible for changes in management efficiency . . . "tighten up and keep our fingers crossed that the same does not happen to us" . . . "it has in many cases become more rigid and less flexible in social work terms. Many workers/managements have become frightened of a local situation" . . . "it is not so much Public Inquiries per se, so much as fear of such has driven managers to spend a disproportionate amount of time on the subject" (appendix 2: LASSD 20, 52 & 78). These views echo the findings in Part One of the questionnaire analysis, that is concerning the general interpretation of management effectiveness as the adherence to formal procedures and guidelines. It emerges from the analysis that Public Inquiries into NAI deaths had an impact on the development of child abuse practices and procedures. Their findings directly influencing the formalising of what are now generally regarded as components of a child abuse policy (for

example the instituting of child abuse registers and the holding of case conferences) set out by the DHSS in advisory circulars since 1974. It appears that over time the impact of Public Inquiries has lessened.

The majority of respondents were of the opinion that the quasi judicial orientation of Public Inquiries had forced departments to adopt defensive postures. A view was expressed that the adversarial and inquisitorial methods employed to establish the facts of a case, led to an over concentration, by inquiries, on the examination of statements and cross examination of witnesses. The evidence was taken in some instances several years after the NAI death had occurred. The ability of a Public Inquiry to establish the facts of a case by taking evidence from witnesses who are on oath, has come in for much criticism. The Webbs (1932) thought that "of all recognised sources of information, oral 'evidence' . . . has proved to be the least profitable. Considering the time spent listening to it . . . still more the money spent . . . the yield of fact is abysmally small" (Webb 1932: 142).

One of the findings to emerge from the analysis is that inquiries are not viewed by managers in social services departments as being primarily concerned with 'facts'. Other functions were isolated as being central to their role. These were concerned with the political issue of public accountability: the isolating of 'scapegoats' and 'appeasement'. These views stated in 1983 echo some of the criticisms made of non routinised inquiries as far back as 1937 (chapter 3).

The majority of respondents were of the opinion that inquiries had put child abuse at the top of the list of social services priority areas.

This view sharply contrasts with the analysis of responses to questions contained in section 1 of the questionnaire. The analysis shows that there is a near absence of resource shifts to this area exemplified by the creation of very few specialist posts and in the majority of departments, no substantive training programmes for staff and managers.

It emerges that the utility of the recommendations of Public Inquiries for managers in social services departments is subject to diminishing returns, possibly compounded by the fact that Public Inquiries have not examined in a systematic way the management function in social services departments. The inference from the analysis is that they are not equipped to do so.

A model derived from legal procedure is not necessarily suitable for determining matters of fact and opinion in relation to complex social and moral issues (Bulmer 1983:9). However, Public Inquiries precisely because of their quasi judicial stance are associated with 'justice', 'fairness' and 'objectivity' and thus fulfill their role as forums for a demonstration, to the public, of the accountability of departments and individuals within those departments.

Direct Experiences of NAI Investigations (Q. 36-40)

Of the twenty six social services departments in England and Wales that had been the subject of a formal NAI inquiry (identified in the thesis, chapter 5 table 2) 13 SSDs participated in the survey. a further 17 SSDs stated (in response to question 36) that they had been the subject of an NAI investigation (appendix 1). Nine of these departments had

been the subject of more than one type of investigation. The most frequent mode of inquiry was that of an internal investigation. These investigations either took place within 24 hours of an NAI death occurring or between one and three months after the death had occurred. It would appear that the most frequently used mode of investigating NAI deaths was that of the Internal Inquiry, producing reports for internal consumption only. The internal inquiries were not confined to social services departments but included other agencies 'involved' in the particular NAI case. It can be inferred that if the internal, inter-agency inquiries produced a report that was not acceptable then an appeal would be made for the establishment of a Formal Inquiry. (Some of the influences upon the decision to hold a formal inquiry are discussed in chapter 7 of the thesis).

Question 38 sought to establish the role the Social Work Services Group (SWSG) played in advising departments in the period elapsing between the NAI death and the convening of an inquiry. The SWSG was set up in 1971 (DHSS 1971). Membership of this service comprises of professionally qualified social workers who work within the DHSS and in nine regional offices, alongside administrative staff and other professional advisors. Its role as envisaged by Seebohm (1969) was to advise local authorities and act as a two way channel for information and consultation between central and local government. A circular issued by the DHSS (1979) stated "the general direction of the work of the SWSG in relation to authorities in the field continues to be advisory, promotional and developmental".

Twenty six SSDs who had been the subject of an NAI inquiry responded to

this question. Only one department viewed the SWSG's role as being supportive. In the majority of departments (18 SSDs) the SWSG played no role at all in advising departments in the period between the NAI death occurring and the convening of an inquiry. "One department stated that they were "unhelpful at time of incident. Interfering busy bodies after the trial of the mother and during. Displayed a profound lack of knowledge of post Seebohm SSDs" (appendix 2: LASSD 87).

Given that Public and Formal Inquiries can take place "many many months" after an NAI death has occurred, question 40 sought to establish the basic costs of NAI inquiries as perceived by managers of departments. Managers in 25 SSDs responded to the question. The departments between them had experienced the whole range of inquiries as set out at the beginning of Section 2 of the questionnaire. What is interesting is that the responses to the question were similar. One manager summed up the general response by itemising the human costs. "Staff paralysis caused by anxiety with significant effect upon working capability both in volume and judgement . . . significant diversion of senior management from routine duties . . . time and energy put into restoring normal working practices and relationships" (appendix 2: LASSD 17). It can be inferred that inquiries whether they be Public, Formal or Internal, impact upon organisational behavioural relationships, the longer the period of time elapsing between the NAI death and the inquiry, the greater will be the disruptions in organisational relationships.

The Utility of Modes of Investigation (Q. 35, 41 & 42) (Area 8)

Managers were asked to rank four general types of NAI inquiry in terms of the utility of their findings to their departments (question 35). Forty six departments responded to the question, managers in 16 SSDs ranked the findings of internal inquiries as having the greatest utility for their departments, of these 6 SSDs had been the subject of Public and Formal inquiries into NAI deaths.

Four departments stated that the findings of Public and Formal Inquiries were of greatest utility to their departments. Not one of these SSDs had been the subject of either a Public or a Formal Investigation. Twenty departments ranked the findings of Inter-Agency inquiries as having the greatest utility for their departments. Seven of these departments had been the subject of an NAI Inter-Agency Inquiry bringing out co ordination and co operation.

What emerges is that Internal Investigations and Internal Inter-Agency and Formal Inter-Agency Inquiries produced findings that had the greatest utility for departments. Managers were then asked if the recommendations of NAI inquiries had led to changes in the management of child abuse cases in their department (question 41). Managers from 26 SSDs responded to the question.

In 5 SSDs there had been no change, in 4 SSDs there had been substantial change and in 17 SSDs there had occurred minor changes in the management of child abuse cases. For those departments in which there was no change in the management of child abuse cases, this was principally due

to inquiries not highlighting the need for change. One manager stated "the procedures were well defined and it was their operation that was faulty, so it led to training courses" (appendix 2: LASSD 65). The 4 SSDs who as a result of NAI inquiry recommendations experienced substantial changes in their departments management of child abuse cases, had all been the subject of a Formal Local Authority inquiry. One manager stated that the Formal Inquiry had "led to a major review and formalizing of child abuse procedures" (appendix 2: LASSD 49). In one other department the "report of the inquiry led to departmental procedures manual being amended to accommodate greater involvement by Senior Area and Divisional staff in treatment and care programmes" (appendix 2: LASSD 24). The minor changes referred to by 17 SSDs were concerned with administration such as the writing of case conference notes, preparation of cases for court, recording and message taking in child abuse cases and modifications to inter departmental procedures. One manager stated "It is/was felt that the system adopted locally is efficient but can be 'let down by individual officers' by them failing to comply with procedures, being intimidated by clients or failing to apply professional judgements, i.e. being 'sucked in'. This department has an accreditation programme for social workers and only accredited social workers work on NAI cases." (appendix 2: LASSD 52)

Alternative Processes for Investigating NAI Deaths (Q. 42) (Area 9)

After ten years of Public and Formal Inquiries into NAI deaths, question 42 sought to elicit the views and opinions of managers as to the most cost effective ways of inquiring into allegations of mismanagement of child abuse cases.

Managers in 48 SSD s reponded to the question. A view generally held was that to be cost effective an enquiry should be convened within 24 hours of a NAI death occurring. Managers in 3 SSD s were of the opinion that the Social Work Services Group ought to conduct an investigation if one was required. While managers in 8 SSD s thought that the Area Review Committee ought to be responsible for organising and convening an inquiry if it considered one to be necessary, managers in 3 SSD s expressed the view that a "one person" inquiry was the most cost effective way of investigating an NAI death. "Immediate and thorough examination by an experienced person(s) who have knowledge and understanding of child abuse - who is independent of all concerned agencies, and has sufficient status to present reports to all levels." A rider was added, "generally speaking we doubt whether there can ever be a cost effective approach to the problem especially since inquiries have to serve a political as well as a professional function" (appendix 2: LASSD 20).

Managers in 2 SSD s were of the opinion that to be more cost effective inquiries ought to be approached as other management issues were "by deploying normal regulatory management functions . . . every agency should have a system of ongoing evaluation of work - not only of child abuse work - and special inquiries can be fitted into this framework. There is of course an ongoing cost of a professional service. The cost in terms of anxiety and distress to staff is minimized when the inquiry is part of this normal routine, and when staff are less defensive there is a better prospect of an inquiry being effective in improving practice" (appendix 2: LASSD 17 & 28).

Another manager stated "The most cost effective way must be to avoid the need for them in the first instance. Hence our decision to invest

resources in a special unit and well supported well structured procedures. The one formal inquiry required since the establishment of the special unit proved to be an effective means of review, organised quickly and able to conclude its business in one day's meeting" (appendix 2: LASSD 39).

Several responses referred to a mix of approaches to NAI investigations. For example internal inquiries linked to Social Work Services Group's involvement, internal inquiries linked to inter-agency investigations. An interesting opinion was expressed by one manager who put forward a framework for the centralization and standardization of inquiries, "The DHSS should have a panel of assessors . . . this panel should have access to personnel and documents of all agencies involved. Having assessed the nature of the case the panel could advise the Minister as to whether an inquiry is necessary and if so what form it should take. The DHSS should bear all costs" (appendix 2:LASSD 87).

Part one of the questionnaire sought to examine through the use of specific questions, the development of the components of a child abuse policy in conditions of crisis. The "crisis" focussed on one specific client group and was generated by a succession of publicized NAI deaths and the inquiries into those deaths from 1973 to 1982. The components of the policy examined comprised the following; the instituting of at risk registers, the calling of case conferences, the appointment of key workers and the setting up of Area Review Committees. In addition to seeking information on these formal components, questions concerning staff training and development and the role of area managers re the "components" were also included. The aim was to obtain a picture of the management of child abuse policies between 1980 and 1983.

As far as formal child abuse procedures were concerned, all departments who participated in the survey (56 SSDs) had formal child abuse guidelines set out in procedures manuals. The ways in which the guidelines were communicated to social work staff and elected members varied. Twenty one departments ran in-service training programmes for strata 1 & 2 staff. The programmes were not substantive, comprising mainly of 'study periods' and one-day workshops. For strata 3, 4, & 5 and elected members of the social services committee, the primary method of communicating guidelines was through the distribution of procedures manuals. There was an emphasis on formal communication on an adhoc basis where senior social workers and team leaders would advise and guide staff in the operation of guidelines and when needed (questions 2 & 3 appendix 2). With respect to senior social workers and team leaders, the interpretation of management was based on an "I will guide you ethos," in line with the interpretation of supervisory roles within social work, based on 'one to one' guidance and education of the individual social worker. There appears to be an emphasis on departments "doing the right thing" exemplified by the production and distribution of manuals.

BASW (1977) expressed the view that people seeking help from Social Workers could only be assured of reliability and quality of service by the use of training and maintained and improved practice. An issue running through successive NAI inquiry reports from 1974 to 1982 (Chapter 5) was that inexperienced staff and staff new to the area of child abuse made errors of judgement in their management of cases. In 1983 there appeared to be no noticeable movement towards the use of accreditation programmes for qualified staff working with child abuse

cases. There also appeared to be no consistent policy overall, concerning the allocation of child abuse cases, for example to experienced (level II and level III) Social Workers. Twenty one out of 56 SSDs appeared to have an allocation policy. Seventeen departments had accreditation programmes for qualified staff working with child abuse cases. In seven of these departments only accredited social workers worked on NAI cases.

A point was made in the thesis (chapter 2) that there was "muddled thinking" surrounding management roles within departments. This point is borne out in the analysis, specifically in relation to operational planning. Operational planning on a client group basis is a pro active management activity which can enable area managers (tier four officers) to develop an overall strategy for the unit. It can be inferred that the way operational planning was variously defined by managers denotes a lack of specific management role awareness and points to a possible lack of training for social work managers. Only five departments had an operational plan for child abuse. Managers in thirty five departments interpreted operational planning to mean process supervision, a senior social worker and team leader 'task.'

Managers overall, defined the term operational planning to mean the existence of formal components of a child abuse policy. It was also found that there was a near absence of operational planning for other client groups (question 10, appendix 1).

Fifty five departments had a system of appointing key workers to co-ordinate child abuse cases. Forty four departments held at risk

registers, with wide variations in numbers on registers. Overall between 1980 and 1983 changes in the numbers on registers was attributed primarily to changes in the criteria for registration and deregistration - which had led either to an increase or decrease in the numbers. Area managers played a minor role in monitoring registers and in twelve departments they had no monitoring role at all. In a small minority of departments they chaired all child abuse case conferences. It is suggested in the thesis (chapter 2) that the spectre of NAI inquiries had led to a bureaucratization of child abuse functions within departments. However the findings of the survey suggest that in terms of two components of a child abuse policy, at risk registers and case conferences, team leaders and senior social workers played a more significant role than did area managers. A manager in only one department explicitly stated that decisions concerning specific cases were referred up to senior managers and at times to the director.

Some commentators argue that NAI inquiries have put departments on the defensive (Glastonbury et al 1980). It is difficult to state categorically that this is the case for those departments who participated in the survey. In these departments there appears to be little by way of substantive resource shifts to the area of child abuse. For example, only five departments had specialist child abuse teams and only 50% of departments had appointed a specialist officer for child abuse.

It emerges from an analysis of responses to the first part of the questionnaire, that formal systems for implementing child abuse policies exist, though the ways in which systems are operated vary from

department to department. There is a confusion over role and tasks of managers. A key management task was implied to be supervision, however supervision in social work terms has specific connotations and is associated with the roles of senior social workers and team leaders. There is no clear policy on the allocation of child abuse cases. Management effectiveness is interpreted as adherence to formal procedures and guidelines. The effectiveness of social work staff is not associated with post qualifying training and development programmes, except in the seventeen departments who run accreditation programmes.

The second part of the questionnaire was concerned specifically with examining the perceived role and utility of public (ministerial), formal (local authority and inter agency) and internal (including internal inter-agency) NAI investigations, from the viewpoint of social services managers (tier four and above).

Public Inquiries have a high public profile, the Maria Colwell Inquiry (1974) had a profound impact upon the 'profession' of social work and the management of child abuse across authorities (DHSS 1974, Stevenson 1980, Glastonbury et al 1980). Since 1974 there have occurred four ministerial inquiries exercising full statutory powers, the inquiries have focussed upon aspects of social services management and inter-agency management, particularly co-ordination, co-operation and communication (Chapter 5).

The views expressed as to the purposes of public inquiries were similar for those departments who had been the subject of such an inquiry as for those who had not. Overall managers were of the opinion that public inquiries were not primarily concerned with establishing the facts of a

case, but due to the way they were conducted concentrated instead on examining statements made in evidence. They were viewed as political tools, public relations exercises concerned with appeasement. Their quasi judicial stance gave them a narrow focus and resulted in "bloodletting" with individuals in departments becoming "scapegoats." The obverse to these views consisted of the positive role public inquiries (and this concerned primarily the early inquiries) had as catalysts for changes in and development of child abuse practices and procedures across authorities. Early inquiries had put child abuse at the top of the list of social services priorities. However their impact was diminishing, managers were of the view that this was due to the major changes recommended by the earlier public inquiries having been implemented. The recommendations of successive inquiries were viewed as being "repetitive," the "blunt instrument" referred to by Marre (1978).

Managers in thirty three departments were of the opinion that public inquiries did not and could not analyse the management functions within social services departments. However public inquiries had indirectly led to an increase in management efficiency which came about as a result of more formalised procedures and practices. Though "fear and apprehension" appear to have accompanied the development of formal child abuse systems.

Thirty departments had been the subject of an NAI investigation (13 of these departments were identified in chapter 5 of the thesis) and nine of these had been the subject of more than one type of investigation (question 36, appendix 1). The most frequent mode of investigation was the internal inquiry ("of which little is known about outside of the

authority" (Marre 1978). There emerged a marked similarity of views as to the impact all inquries, from public to internal, had on departments. Inquiries had a negative impact on organisational behavioural relationships.

Managers in sixteen departments, held the view that internal inquiries had had the greatest utility for their departments. This view was shared by those departments that had also been the subject of public and formal local authority investigations. It can be inferred that internal inquiries would take place within approximately 36 hours of an NAI death occurring and would cause the least disruption in organisation relationships. Their utility would not then need to be balanced off against detrimental changes in staff morale.

Managers in twenty departments were of the view that the findings of inter-agency inquiries had the greatest direct utility for their departments as they investigated the specific issues of co-ordination and communication. Only seven of these departments had been the subject of an inter-agency inquiry, illustrating that the problems of co-ordination and communication are clear management concerns. Overall inter-agency investigations produced findings and recommendations that were the most useful for managers. The findings and recommendations of public and formal inquiries were ranked as being least useful to managers. The impact post-Colwell inquiries had specifically upon the management of child abuse was minor. In the majority of departments there had occurred only minor changes. There is a tenuous link between the recommendations for only minor changes and the views as to the utility of various modes of investigations. That is in general those

inquiries that were viewed as having the greatest utility recommended only minor changes.

Public and formal inquiries are costly and take place up to twenty five months after an NAI death has occurred, they affect dramatically organisation relationships and their findings and recommendations have a diminishing utility. Managers were invited to give their views as to alternative methods of investigating social services departments involvement in the management of NAI cases that had resulted in child deaths. Only two managers put forward radical alternatives to inquiries, these consisted of incorporating "inquiries" into normal management functions. This normalising of inquiries was viewed as the most cost effective way of investing alleged mismanagement of child abuse cases.

Overall the views expressed were concerned with alterations to the formal of inquiries and bodies who should have responsibility for instituting and conducting investigations. It was suggested that the DHSS, the Area Review Committees and the Social Work Services group should take responsibility for convening and servicing investigations. There were variations on these suggestions, these concerned internal Departmental inquiries linked to the above bodies. A minority of managers thought that a one person inquiry would be the most effective method of investigation. The majority expressed the opinion that to be effective inquiries ought to take place within 24 hours of an NAI death occurring.

Local authority autonomy, professional autonomy and DHSS advice (without

resource backing) together produce a complex picture of the operation and management of child abuse systems within the social services departments who participated in the survey. Autonomy as a specific issue is not made explicit in the responses to questions, but it runs instead as an implicit thread throughout the analysis. Certainly the exercise of autonomy both at the local authority and professional levels underpins the fragmented picture that emerges from the analysis in Part One of the Chapter.

Autonomy as an issue, is more readily inferred from an analysis of some of the responses set out in Part Two. For instance the Social Work Services Group are termed by one manager as "interfering busy bodies." It is also evident in the area of "organisation learning", that is, a decade after the first formal inquiry published its report, in the opinion of two managers (1983) "social workers have learned that systems set up around child abuse are supportive . . ." and "there is a growing conviction of managers that procedures are reliable and worthwhile and therefore there is an increased commitment to them."

The utility of public and formal NAI inquiries is subject to diminishing returns. A majority of managers expressed a preference for internal investigations. Cost effectiveness was interpreted as concerning almost exclusively human costs and human effectiveness. It appears that which ever mode of investigation is used these costs to the individual worker and to organisational behavioural relationships remain. However, it can be inferred that if an inquiry is convened and takes place as near to the date upon which the NAI death occurred as possible, then these costs are lessened. Public and formal inquiries bound by the subjudice rule cannot take place until the trial of those accused of causing the NAI death is over, in some cases this can take up to 24 months.

CHAPTER 7 Case study: The functions of NAI Investigations in one Local Authority Social Service's Department 1973-1981

INTRODUCTION

The case study sets out a series of events that have taken place within a local authority social services department as a result of an NAI death in 1976. The NAI death was the subject of seven investigations into the department's involvement in, and management of the NAI case. The starting point is 1973, when the director was appointed from outside of the local authority to head the newly formed social services department.

Throughout the study the official record of events in the local authority (council minutes, departmental memoranda) has been supplemented by the perceptions of the Director. His personal comments and views on events and the relationship between events was gained through a series of informal interviews and by access to confidential information about the authority.

The name of the local authority and the key actors in events are not made explicit. Instead formal roles and pseudonyms are used where appropriate. The study contextualises events, in terms of the following:

Organisational and Management issues

- the relationship between the social services department (SSD) and the local authority's servicing departments.
- the relationship between Director (SSD) and chief officers in the

local authority.

- the relationship between the Director (SSD) and members of the Social Services Commitee.
- inter-departmental relationships between staff (SSD) involved in the NAI case.
- the interaction between staff (SSD) and elected members of the local authority.

External Influences

- the involvement of the DHSS.
- the involvement of local members of Parliament.
- the involvement of the British Association of Social Workers (BASW).
- the involvement of local and national media.

The study will seek to draw out the complex set of political circumstances that surround the issue of public and organisational accountability brought to the fore by the occurrence of the NAI death in 1976, and the subsequent inquiries and investigations culminating in 1980 in a public NAI inquiry.

THE CONTEXT

> You argue by results as this world does
> to settle if an act be good or bad,
> you defer to fact for every life and every act.
> Consequences of good and evil can be shown.
> (T.S. Eliot).

In 1973/74 the Public Sector was undergoing wide ranging structural

change. Reorganisation was taking place of both local government and the National Health Service. In 1974 the complex authority of Mixborough was created. The new authority comprised an amalgam of parts of a comparatively wealthy county and two poor county boroughs. The local authority social services department had been in existence since 1971 and comprised of an amalgamation of three separate local authority departments which previously bore responsibility for the major personal social services (the childrens department, welfare department for services to people who are elderly, physically handicapped or homeless and local health departments which were concerned with the care of the mentally ill, mentally handicapped people in the community and with the provision of the home help services). The Social Services Department's headquarters, due to a lack of adequate accommodation at the Council House (the administrative centre of Mixborough) was located in one of the poorer boroughs.

The Local Authority and the Social Services Department. Organisation and Environment, March 1974 - August 1976.

The Director of the Social Services Department took up post in November 1973. One of the first tasks he undertook was to analyse the work of the Department. During the course of data collection several difficulties were encountered due to:

(a) the diversity of systems operating in each borough

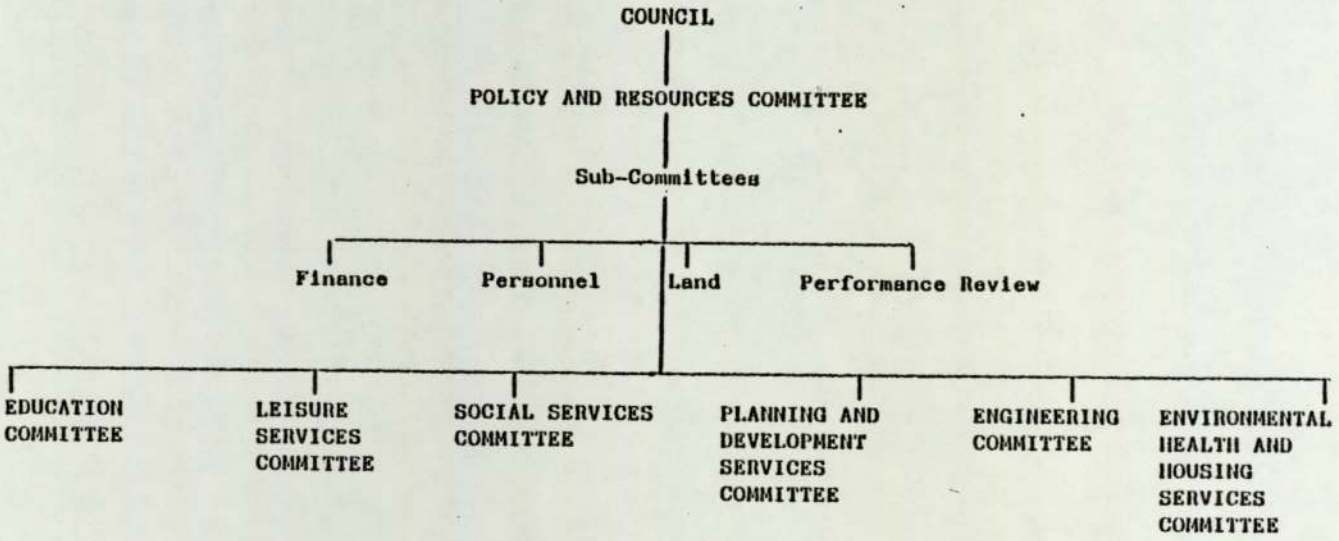
(b) the overall inadequacy of the existing information system

(c) the lack of established systems for the collection of information

The resulting report covered areas of difficulty which included

Fig. 3

COMMITTEE STRUCTURE



* THE CHAIRMEN OF THE COMMITTEES FORMED THE POLICY GROUP

Fig. 4

DEPARTMENTAL STRUCTURE

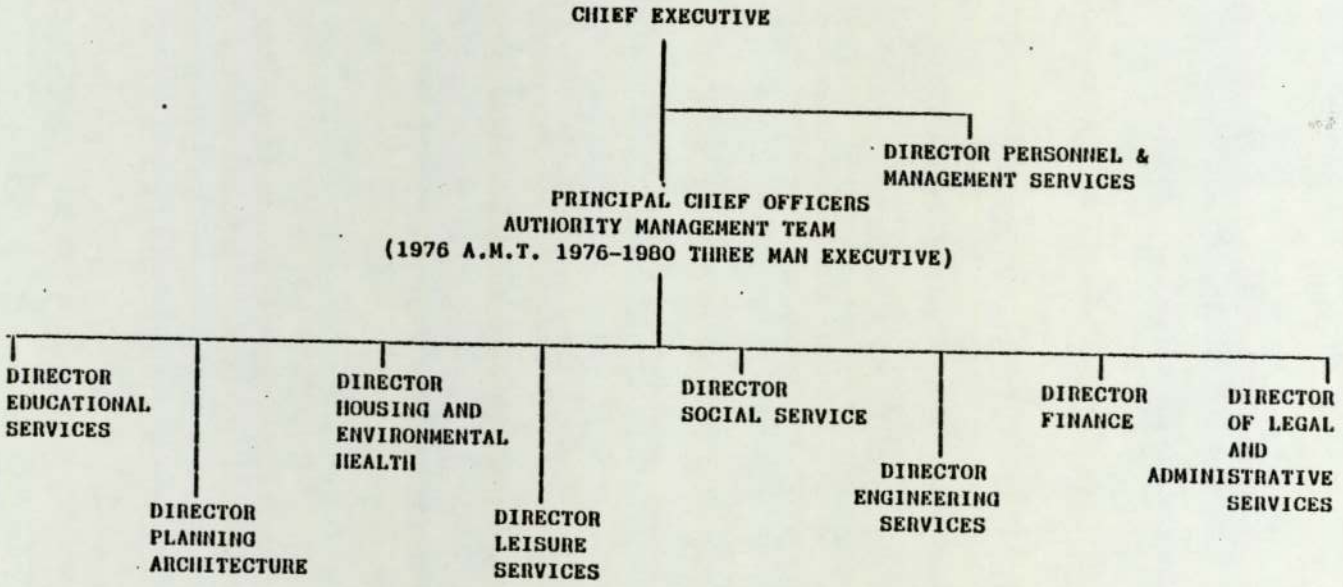
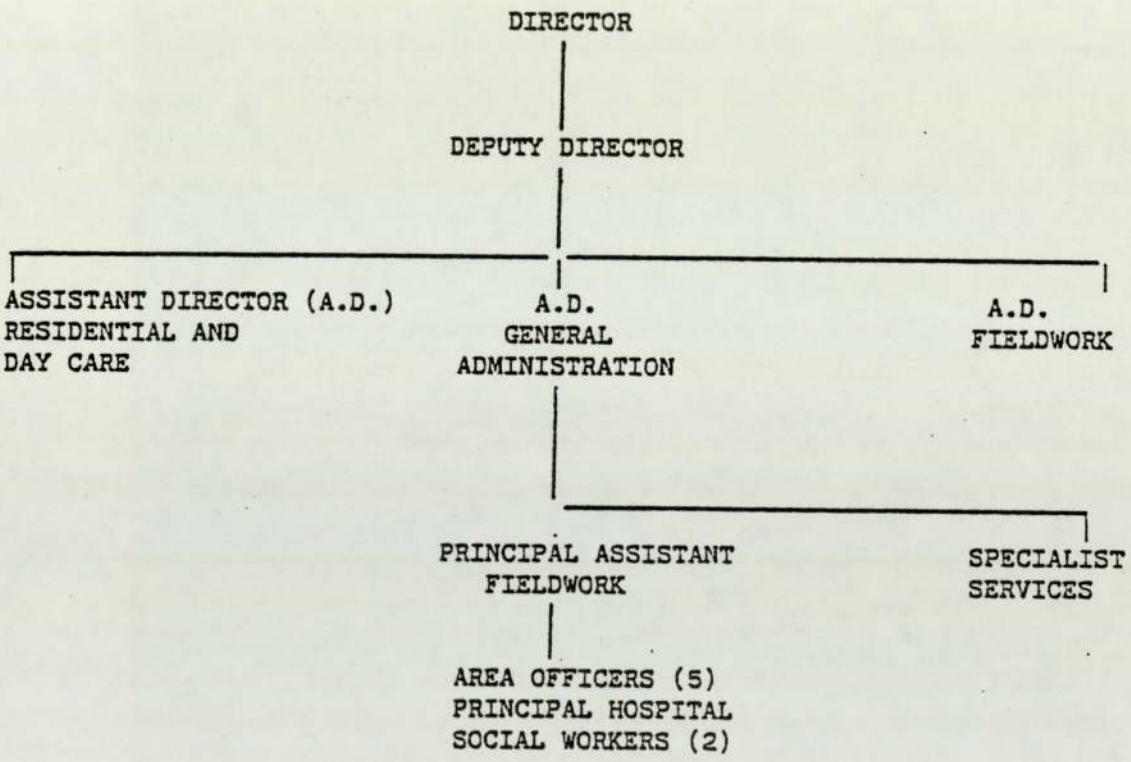


Fig. 5

SOCIAL SERVICES

MANAGEMENT STRUCTURE 1976



departmental problems associated with the lack of equipment, lack of adequate accommodation and the absence of a strong personnel and training section. The Report was submitted to the Social Services Committe in March 1974, and formed the basis for the Department's "Development Plan". The Plan was completed in June 1974, it had several purposes.

(i) to educate the Social Services Committee and the Council as to the nature of the social work services.

(ii) to bring together responsibilities and potential responsibilities of the Social Services Committee.

(iii) to bring together the varied sections of the new complex department and to facilitate a concentration on preventive and rehabilitative social work.

In an extract from the Plan's general statement of priorities the Director stated:

> "During this difficult period of reorganisation our chief aim must be to provide services to meet known existing need. The social work administrative and clerical staff are the ones most affected by reorganisation and their full integration into the new structure will depend partly on their willingness and ability to adopt new ways of working and also on the speed with which they are re-housed in appropriate accommodation. There seems little cause for anxiety on the first point but on the second, considerable progress needs to be made. Until this is done the process of providing anything near a comprehensive service cannot be readily attained. Effective administration can be difficult to attain in buildings which are basically unsuitable and any financial saving made by using such buildings can easily be more than offset in the cost of time wasted by staff and clients in overcoming difficulties of communication."

The Development Plan was circulated to all chief officers and was presented to the Social Services Committee in July 1974. The Director of Finance viewed the plan as pre-emptive of the Council's policy decision in relation to the allocation of resources between services.

This view was supported by other chief officers. At the Social Services Committee meeting (July 1974) it was agreed that accommodation problems would be discussed further at the next meeting of the committee (November 1974). The Development Plan was blocked by the Authority Management Team (AMT). In spite of this it became the accepted philosophy of the SSD.

Within the Social Services Department at this time there was widespread discontent over conditions of service, acute shortages of personnel, very poor accommodation and an absence of appropriate equipment. Two key posts were filled towards the end of 1975, and "Though welcome were little more than a drop in the ocean". A training officer was appointed in October 1975, but could not operate effectively as the council, in the throes of reorganisation had not at that time formed a Personnel and Training Department. The appointment of a Specialist Officer for Child Care in September 1975, afforded the Department an opportunity to assess the standard of child care practice and to seek ways to improve it.

Child Care Practices and Procedures.

It was discovered that many basic grade fieldwork staff and those employed in residential establishments lacked a basic understanding of child care legislation and social work principles. It was not possible at that time to protect or restrict case loads of inexperienced staff due to the pressure of work " . . . staff were required to respond to the complexities of clients' problems at a time when they were far from equipped to do so."

The multi-agency, multi-disciplinary Area Review Committee (ARC) was set up in April 1974. It was responsible for the formulation of local practices and procedures to be followed in the detailed management of cases of ill-treatment to children. In 1975 it was seeking to improve and refine its procedures in the light of local government guidlines and recommendations. The first booklet was issued by the ARC in November 1974 (in response to DHSS circular 1974) and dealt mainly with procedures for referral and case conference arrangements. In December 1975 ARC decided that the procedures should be rewritten. The task was undertaken by a monioring sub-committee, as secretary to the sub-committee, the Specialist Officer was responsible for liaising and advising as and when requested and for collating submissions for the sub-committee and ARC. (The revision took much longer than anticipated, the new procedures were eventually published in April 1977).

The Specialist Officer working outside her job description took on the responsibility of communicating the revised procedures to staff. "By default the Specialist Officer had become the chief communicator with Area Officers on all ARC matters, and with the hospital staff. In addition she became the main focal point for outside agencies".
In a report to the Social Services Committee (January 1976) concerning non-accidental injury to children the Director stated: "Particular attention has been paid to try and provide safeguards for those we work with and also for our own safety . . . at the present time resources we have available are spread thinly across a very wide field and this substantially increases the risk element in our work."

The Appointment of a New Chair to the Social Services Committee.

The Chairman of the Committee was familiar with the problems faced by the Department, in particular staff shortages and "the ease with which very senior officials outside of the committee structure could make decisions to freeze or delete posts at will". In 1976 the Chairman resigned for health reasons. The post was temporarily filled by the vice chairman a Councillor Smith, flamboyant by nature,a toy salesman by profession, the Councillor did not inspire confidence in the Director or the department's staff. He was an ambitious politician and soon "very clear noises were coming forth as to the efforts Councillor Smith was making in trying to influence the Leader of the Council to give him Chairmanship".

At a special meeting of the Social Services Committee (17 February 1976) the Director reiterated his concern over the need to combat NAI and the importance of ensuring that sufficient resources were made available in the area of families considered to be at risk. The Director recomended that in order to maintain effective fieldwork services consideration should be given to increasing the number of training officers and administrative staff. The committee asked for a report on the extent of the need for the appointment of additional training officers to be presented to the next meeting. At a Special Policy and Resources Committee meeting of the Council (23 February 1976) the annual estimates were considered, it was recommended and later approved that the question of filling five vacant social work posts be deferred. Councillor Smith obtained the Chair (March 1976) and informally let his views be known on the way the SSD was managed and his assessment of personalities within the SSD. "There seemed to be very few things he liked . . . he was very

suspicious of certain personnel in the SSD and made it clear he was 'after them'. The Chairman was active in the day to day business of the Department "he seemed to have a lot of free time and I (Director) involved him in many areas of the department's work".

Accommodation and Staffing: Critical Point 1976.

For two years an Area Team of social workers had been working on trestle tables, with no filing cabinets, no filing clerk and almost no clerical and administrative assistance. In addition there was a problem with the filing system. Due to reorganisation two systems should have been rationalised into one, "files were left on the floor and retrieval was open to all area staff".

The conditions under which the Specialist Officer for Child Care worked were little better. She had no clerical support, and since her appointment in September 1975, the Officer had accrued many additional tasks because "there was no one else there to do them". The organisation of the Child Abuse Register had demanded much of the Officer's time. At the same time the Officer had become involved in covering case conferences for children at risk of neglect or abuse in addition to the normal duties of dealing with statutory reviews. The Officer's workload continued to increase, particularly her role in designing and delivering training programmes for a wide variety of staff dealing with child welfare. Changes in legislation, the introduction of the Childrens Act 1975, led to an increase in this aspect of her role. In July 1976 the situation became critical, the Officer wrote to the Assistant Director of fieldwork.

"I would be grateful if you would give consideration to the difficulties I am faced with in maintaining the above register without adequate assistance . . . as you are aware one of the recommendations (ARC) is that each case should be reviewed twice a year. I have recently requested about 50 and I am completely overwhelmed by the extra work involved . . . Previously it was only just possible to cope with the work when concerned with referrals. However experience has shown it is impossible for me to organise reviews under these circumstances."

Managing in a Political Dimension.

Mixborough in line with other local authorities in the wake of reorganisation was moving towards the formulation of a corporate plan. To facilitate corporate planning the Chief Executive asked each department to produce a list of areas worthy of in-depth study. The stated intention was to discover areas where economies could be made in order to finance current levels of provision or improvements in other areas. Arrangements were made for Directors to meet with the Chief Executive and Director of Finance to discuss their selected key areas.

At the meeting between the Chief Executive, the Director of Finance and the Director of Social Services, the two officers presented to the Director (SSD) a list of areas they felt he should include in his department's study of "savings". Administration was isolated as one of the areas in which savings could be made. A heated argument ensued, later the Director told the Chairman (Social Services) what had happened, "he smiled pointing out that he was not at all happy with our administration nor most of the senior staff".

In addition to the officer's group who were examining key areas, there were also working parties of politicians "doing something similar". At one of the politician's working parties (June 1976) the Social Services Department had been discussed. The following day the Chief Executive telephoned the Director (SSD) "to tell me that he had approached the DHSS and had asked them to come in and examine our administration"..."the Chairman (Councillor Smith) had told him I was not to know, but that he (the Chief Executive) felt that I should."

From 1973 to mid 1976 the Director (SSD) had argued constantly for more resources for the department. In particular the 'unfreezing' of posts and an increase in administrative staff. The Director however had acted out of step by producing a "pre-emptive" Development plan. Though this plan became the accepted philosophy of the Department, it was effectively stymied by the other chief officers in the Authority's Management Team. The Social Services Committee had a new chairman who was making it known within the Authority that he was going to "sort out" the management of the Social Services Department. The one Special Officer in the Social Services Department was greatly over loaded and was becoming ineffective. The one Training Officer in the department was isolated for there was in 1976 no Training Department within the Authority. Staff shortages were acute and morale within the Department was low. In addition the department without the agreement of, or formal notification to the Director, was about to be subjected to a DHSS investigation.

The terms of reference for the DHSS investigation were set by the Chief Executive and the Director of Finance, they were:

"to inquire into the top level organisation of the SSD and to advise upon its effectiveness in deploying the resources allocated to that department to carry out its functions."

In 1976 the Authority's management structure was coming in for criticism, for failing to manage the Authority. In the Directors opinion there were attempts to divert attention into other areas. "Our new Chairman provided fertile ground for manipulation, for he had made it known to all that he was going to sort us out. The attacks and personal vendettas against a number of senior personnel continued. In this the Chairman was supported by another Conservative Councillor. This was the atmosphere which led up to the Chief Executive calling in the DHSS. No satisfactory reasons or any facts were provided to justify this but the ground was well prepared by the Chief Executive and the Director of Finance to ensure that support for this action would come from appropriate quarters."

Within this organisational context the management of the NAI case was being carried out.

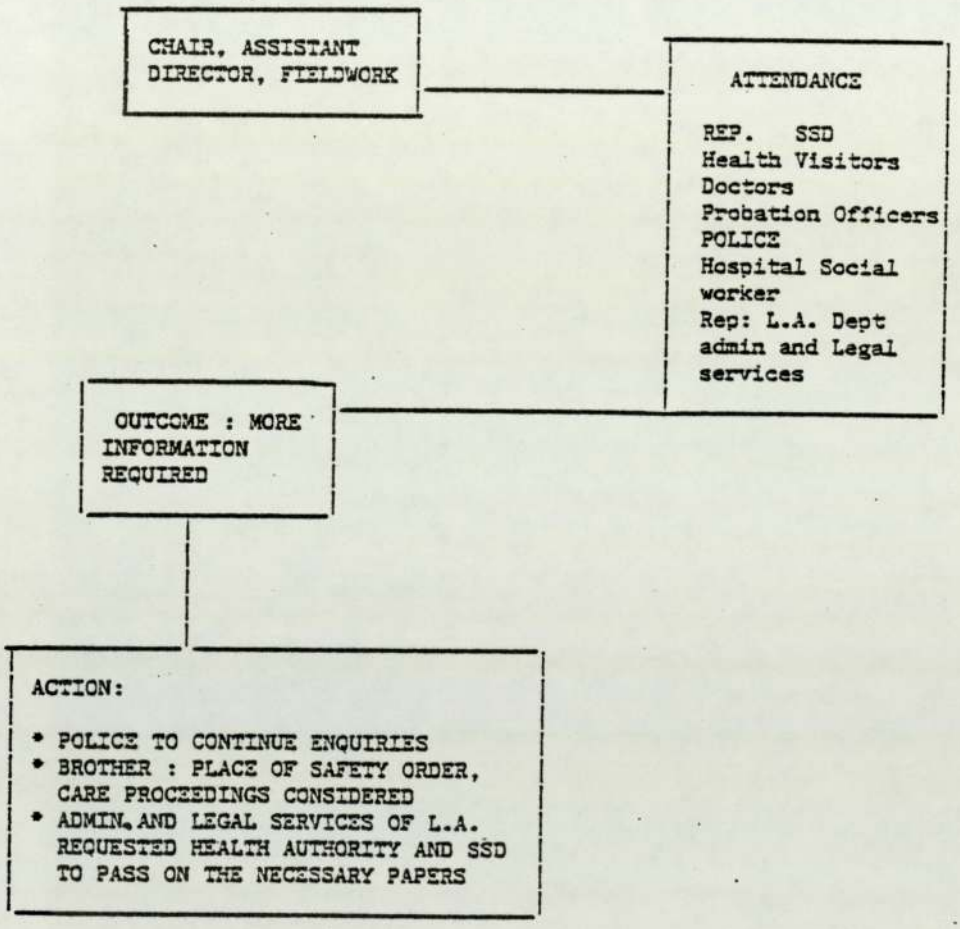
The NAI Incident and Organisational Responses

August 1976 - June 1977.

The child was admitted to a local childrens hospital on the night of 11th August 1976, after his step-grandmother had called the doctor. The child's brother was also admitted on the 12th August for investigation. The Director was notified on the evening of the 12th August, 1976. A case conference was arranged for 17th August to which everyone who was known to have some knowledge of the children and relatives were invited.

Fig. 6

CASE CONFERENCE 17 AUGUST : ATTENDANCE AND OUTCOME



A case conference was arranged for the 17th August to which everyone who was known to have some knowledge of the children and relatives were invited. By the 20th August 1976 the Specialist Officer (Child Care) produced an initial report (Dark Report). This was not a complete account as key staff were on vacation and the case files had not been brought up to date. The report however highlighted five failures in the SSD's operation of child care systems:

(a) Boarding-Out regulations had not been carried out whilst the children were with foster parents.

(b) Health visitor claimed she could not obtain the childrens address from the SSD Area Office.

(c) When Social Worker eventually obtained the case file from Area Office 'X', it was put away unread.

(d) Communication between the Paediatrician, the Doctor (GP), Health Visitor, Hospital Social Worker and the Area Office 'Y' (The office currently responsible for the case) was inadequate.

(e) There was no proper transfer of the case file from Area Office 'X' to Area Office 'Y'.

The Report concluded that there appeared to be serious faults in the communication system, "we must recognise the difficulties Area staff labour under, which will affect the quality of recording and it may not be surprising that messages or reports are not recorded. However the transmission of information and quality of recording appear to have fallen below what one would expect".

On receipt of the Report the Assistant Director, Fieldwork Services, immediately made arrangements for a meeting with representatives from

the then Area Health Authority (A.H.A.), Education Department, Social Services Department including all five Area Officers and the Principal Solicitor from the LA's Department of Administration and Legal Services, to consider communication and co-operation in connection with NAI to children - this meeting was held on 8th September, 1976.

A fortnight prior to the meeting the step grandparents had been charged with assault (25th August, 1976) and were remanded on bail until 20th September. The child died in hospital on 29th November 1976.

In spite of the various internal investigations carried out by SSD, AHA, the Police, a comprehensive picture of the situation did not emerge. The Director (SSD) was becoming concerned:

> "It was expecting a lot to anticipate that all of the various strands should be co-ordinated by the Specialist Officer . . . from what the Officer had deduced it did seem there was room for criticism and further the Chair of Social Services Committee who was also a member of the Regional Health Authority, had told me of the criticisms some members of that body had been making . . . there was a clear need to ensure that every possible avenue was considered."

There was no obvious person available to co-ordinate the investigations, a problem acknowledged by the Director, "I had to confess to myself that there was no-one who could combine the expertise with the time that would be necessary to carry this out, but before making any decision on this or even discussing the matter, I decided to call a meeting of all those who might have some involvement".

First Meeting to Consider Departmental Involvment in NAI Case.

9 December 1976.

The Area Officer, (Area Office 'Y') was on leave and the meeting had to be viewed as a preliminary one. As the meeting progressed " . . . it very quickly emerged that other members of staff would have to be called in because there were wide gaps in the information coming through and there was no documented record of contact with the children and the family up to the time the child was admitted to hospital from either of the two Area Offices involved."

It became clear to the Director that this was the first opportunity for the staff who had had some contact with the family to state what that involvement was. In the Director's view this was because "almost all of the hierarchy of the SSD down to sixth tier (team leaders) were heavily involved in the Key Areas Studies and at the same time were also co-operating with the DHSS investigation currently taking place."

On the 9th December 1976 the Deputy Director (Legal and Administrative Services) wrote to the Director (SSD) re the date for the adjournment meeting (to be obtained from the Coroners Office). A provisional date (13 Jan. 1977) had been given "but this was subject to alteration as the papers had been placed before the DPP and it was considered unlikely that he would give instruction before 13 January". On the 5th January 1977, the Deputy Director (A & L Services) wrote again to the Director (SSD), the Inquest had been cancelled and would not be held on 13th January.

DHSS Investigation.

The DHSS Team concluded their investigation into the administration of the Department in December 1976. Their report in the form of a letter was submitted to the Chief Executive on 7th January 1977. In addition to examining the senior management function within the department, the Team drew conclusions as to the role of servicing departments. These conclusions included some critical comments about the Finance Department's lack of policy and the Personnel and Management Services Department's training function was criticised. "Deprivation of training personnel and resources has had a profound effect upon the development of the Social Services Department."

The investigation uncovered no new information and in terms of its remit did not apportion blame to any individual with the SSD. The Chief Executive on receiving the report requested the "interview notes" the team had made. Copies of the Report were circulated prior to the Social Services Committee having considered it. Because of this action the Chief Executive was accused of attempting to drive a wedge between the Director (SSD) and NALGO. He was severely criticised by the Committee.

Second Meeting to Consider Departmental Involvement in NAI Case

17th January 1977.

Between the two meetings more information had been assembled. The Director himself recalled having some knowledge of the family - a Councillor's wife, a play group supervisor, was extremely worried that two children were in real danger following a conversation she had had with the children's maternal grandmother. "There were references to the gas being cut off, no food in the house plus the fact that it looked as

if the department had not followed something through". On investigation by the Director it transpired that action by the SSD had been taken on 17th March, 1975.

At the 17th January meeting a more comprehensive picture of the Department's involvement was emerging but a number of dates and times were still to be clarified (due to lack of documentation). There was still considerable confusion surrounding the transfer of the NAI case file from Area Office 'X' to Area Office 'Y'. This also had to be clarified.

At this meeting a difference of opinion had shown itself between the Senior Social Worker (SSW) and the Social Worker (SW) Area Office 'Y' and the Senior Hospital Social Worker (SHSW). This matter it was agreed would be resolved by Area Officers. The meeting concluded with an information update:

* Police were continuing with their investigations to see if the charges against the step grandparents were to be changed.
* Neighbours had made a claim that they had seen the children tethered together to a kennel in the backyard. The suggestion had been disputed after a police investigation. It was widely known that there was considerable rivalry between the accused and the neighbours making this allegation.

Shortly after the meeting ended the Area Officer (Area Office 'Y') with SSW visited the Director to discuss a comment the SHSW had read from her

file during the meeting. As they had been instructed at the meeting to resolve the situation the Director felt there was nothing to discuss. It was not until a week later when the Director heard that the situation had not been resolved that he arranged a meeting with the parties concerned on 1st February 1977. The offending remark recorded by the SHSW was:

> ". . . the SSW then in confidence to this file expressed regret concerning the childs present state, and that due to difficulties at the local office, supervision of her team had been virtually impossible. She had complained about this to her Area Officer. The SSW clearly indicated that she felt this incident might be a slur on her personal career."

The Director thought this was "Unprofessional" but the SHSW was insistent that it be kept on file. Later the Director heard that she had removed the comment but was keeping a copy, which in his view was, "fine, I did not pursue this matter any further then." There was at this point still no indication as to what charges, if any, were to be brought against the accused. On 31st March 1977 the administration and Legal Services Department contacted the Director (SSD) they were unable to establish a firm date for the trial. But they had asked the Police which members of the SSD would be required to give evidence for the prosecution, and thought it appropriate for all relevant information relating to the SSD's contact with the child and his relatives to be passed on to the Department's Principal Solicitor.

Copies of this memo were sent to the Assistant Director Fieldwork Services and to the Specialist Officer (Child Care). The Officer immediately suggested that she made available a copy of her Report on the case to the Principal Solicitor, she also arranged for the SSW and

SW from the Area Office 'Y' to see a solicitor the following week.

In a memo to the Assistant Director Fieldwork (27th April 1977) the Director wrote:

> "I understand there is to be a further hearing on the 12th May regarding the NAI case. I have also heard that the Legal Department are having discussions with members of our staff. I assume we are keeping in close touch with what these discussions are all about and the advice being offered to our staff members - presumably a Senior Officer from this Department is in attendance when these discussions take place."

In his reply (28th April 1977) the Assistant Director Fieldwork wrote:

> "The hearing taking place on 12th May is the committal ... if the decision is yes, . . . then no-one can say at this stage in which month of the Crown Court Calendar the hearing will commence."
>
> "The Legal Department are in effect rehearsing with the staff the part each should play in assisting in the use of terminology. There is no member of Senior Staff overseeing the business."
>
> "The Legal Officers will I am sure, alert you should there be anything about which the interests of the Department should be safeguarded. I spoke to the Principal Solicitor on this issue, when he stated that it was his intention and advice to 'Maintain a low profile'".

The Director on advice from the Legal Department did not attend the commital proceedings in the Magistrates Court. At the Committal on 12th May the Chairman of the Social Services Committee "turned up." The Director (SSD) had gathered that the Legal Department who had had detailed discussions with the key staff members involved in all the meetings and discussions included the Case Conference of 17th August, 1976, were satisfied that no-one was at fault. "Hence their extreme annoyance to find Councillor Smith parading himself in the Court Room, which would automatically attract the attention of some who might be looking for something sinister."

Several days after the proceedings the Director heard that a radio reporter had been making a number of inquiries in and around the housing estate where the child lived. The reporter requested an interview with the Director, "I could see no reason for refusing to see him for I was sure he was aware that the matter was sub-judice." The reporter was referred to the Principal Solicitor, "nothing more was heard from him and all went quiet up to the Crown Court Hearing of 11th October, 1977".

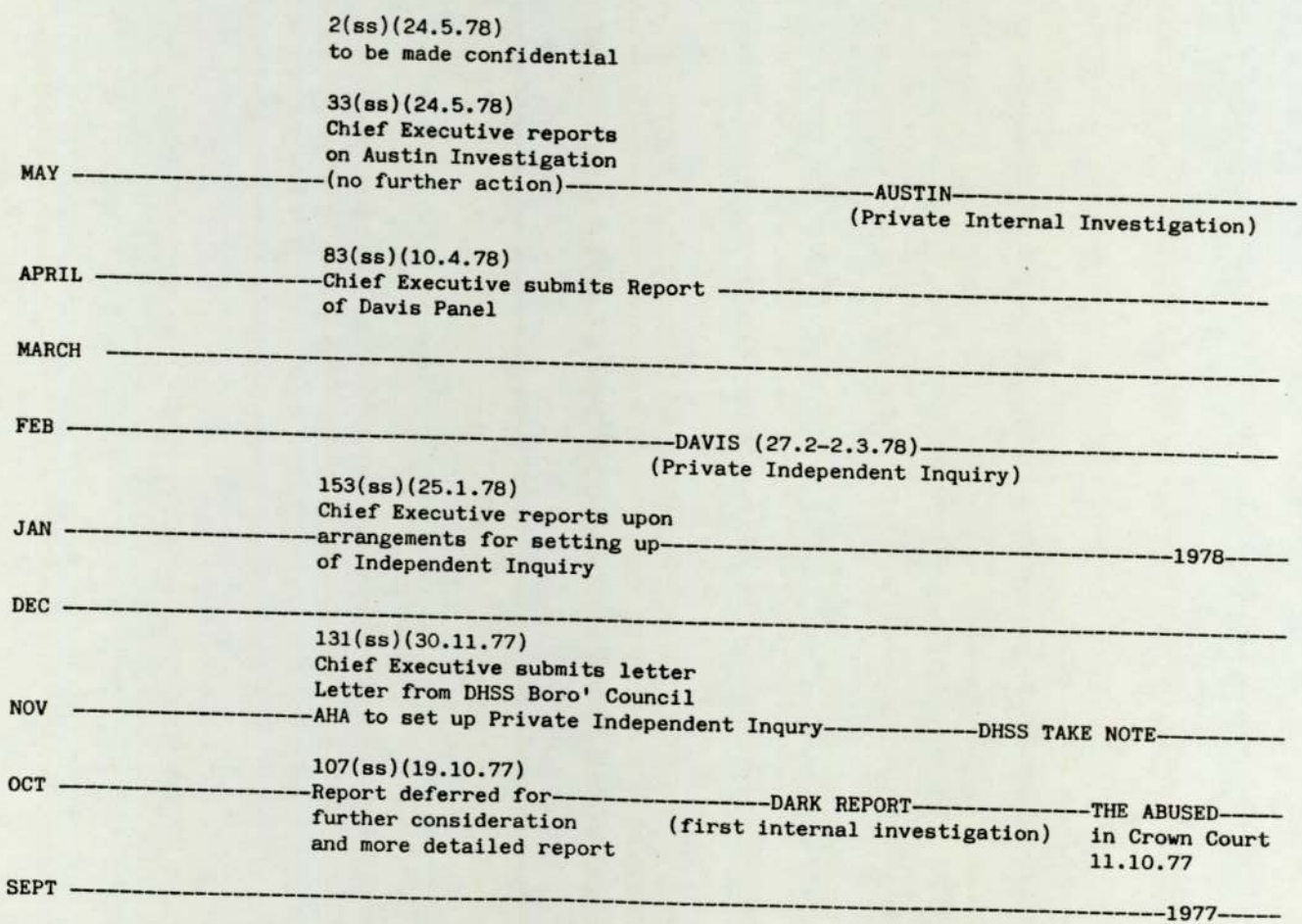
The Crown Court Hearing and Social Services Committee Meeting October 1977

The Crown Court Hearing was held on the 11th October 1977, the accused (the step-grandparents) were found guilty of ill-treatment and neglect and received prison sentences of 15 months and 9 months. The following day 12th October 1977, the Chairman of the Social Services Committee (Councillor Smith) asked the Director to provide a report for the next Committee meeting due to take place on the 19th October 1977.

Fig. 7

SOCIAL SERVICES RESPONSE OCT 1977–MAY 1978

(SOCIAL SERVICES COMMITTEE)



The Social Work Services Group (DHSS).

In September 1977 the DHSS Social Work Services Officer from the Regional Office, in discussion with the Director had mentioned that she was shortly to attend a meeting of other Social Work Services Officers in London to look at some seven or eight NAI cases that had taken place nationally. She believed they intended to select two of these for their investigation, and that she did not anticipate that the NAI death currently under investigation in Mixborough would be one of them.

However on 17th October 1977 before the Social Services Committee meeting (19th October 1977) the Social Work Services Officer contacted the Director to inform him that a letter was to be sent from the DHSS London to the Chair of the Area Review Committee to ask if "in view of the peculiar circumstances in which the child died" they would arrange for an inquiry to be held. Subject to the ARC agreement they would approach the then Area Health Authority and the Local Authority for the arrangements to be made. "I (Director SSD) informed the Chairman of the Social Services Committee of this on the same day and told the chair of the ARC that the letter was coming and we agreed to discuss it as soon as it arrived." At a meeting of ARC on 27th October agreement was given for the DHSS Social Work Services Group to approach the Local Authority and Area Health Authority.

The Social Services Committee Meeting 19th October 1977.

The Director asked for two points to be included in the Report to the Committee;

(i) the delay in transferring the file, which was a failure in communication.

(ii) the general problems of communication of which the Social Services Committee were already aware.

At the Committee meeting (19th October) the Social Services Management Team and the Special Officer (Child Care) were present. The Director recollected that:

"When we came to the report (of the Specialist Officer) which was the final item for discussion almost every Member (of the Committee) and most staff took part. Suddenly the Chairman, supported by the Deputy Director of Administration and Legal Services said he was recommending that the Council bring in their own barrister to examine the case. One other Conservative member (Councillor Mrs Williams) supported this but everyone else asked why. The Chairman said something along the lines that he felt it needed to be investigated very deeply. I leaned over and reminded him about the DHSS asking the ARC to set up an Inquiry, but he either didn't hear or ignored it and deferred to the Deputy Director (Administration & Legal Services). Some heated exchanges began to take place with the Chair threatening to resign unless the Committee accepted his decision. The Chair threatened to resign for a second time, but members said there was no need for this and could not see why it was necessary to bring in a barrister to investigate this matter. I of course could not tell them that the DHSS had been in touch with me - if the Chair didn't want to mention it I thought it would be unwise for me to do so. In any case it was for the ARC to inform the Local Authority and they had not yet received the letter. I had only been told as a matter of courtesy."

The formally recorded Council minute read, "the Committee considered the

Report of the Director of Social Services . . . and resolved that this matter be deferred for further consideration by this committee on a date to be arranged, and that the Director of Social Services be requested to submit at that time a more detailed report on this case."

At the ARC 27th October meeting, the letter from the DHSS Social Work Services Group was responded to positively. In a letter to the Chief Executive (of Mixborough) and the then Area Health Authority's Administrator, the DHSS wrote that the Minister "considers it would be desirable that an independent inquiry should be held in order to draw from it any lessons relevant to the future handling of cases both in your area, and more generally in the country as a whole . . . In the interests of thoroughness and objectivity the Department would favour the Inquiry being held in private; this should also avoid the undesirable impact that press reports and comment on isolated items of evidence during the currency of an enquiry sometimes have on public confidence in services, and on staff morale and efficiency."

In responding to the proposed inquiry the Chair of the Social Services Committee (in an interview with Community Care Magazine 30th October 1977) stated that there "were some aspects of the case that an inquiry could clear up." The child was admitted to hospital on the 11th August 1976, a case conference was called on the 17th August and the Specialist Officer produced on internal report for the 20th August. The Report was highly critical of the "serious faults in the communication system." On receipt of the Report the Assistant Director Fieldwork made arrangements for a multi-agency meeting on communication and co-operation in connection with NAI to children, this took place in September 1976.

These events represent the internal administrative responses to malfunctions in child abuse systems and took place within 4 weeks of the child entering hospital. At this time there were three "routine" administrative investigations taking place, within the SSD, within the Health Authority and by the Police.

When the child died (29th November 1976) the Director took on the responsibility (due to severe staff shortages) of calling two meetings to consider departmental involvement in the NAI case (9th December 1976 and 17th January 1977). The local press were interested in the case but no interviews or comments could be made by the SSD due to the sub judice ruling. The DHSS Social Work Services Group wished to undertake an investigation of a number of NAI deaths. Their aim was to produce a report that would be disseminated to all Social Services Departments re lessons to be learned. They chose Mixborough for one of their investigations. Their expressed intent was that it would be a private independent investigation. The abusers were convicted on the 11th October 1977, fourteen months after the child had been admitted to hospital. The ARC granted permission for the DHSS to proceed ahead with their investigation at the end of October 1977. At a Social Services Committee meeting during the same month Councillor Smith was calling for a formal independent local authority inquiry, even though he was aware of the impending DHSS investigation, and had before him a copy of the internal NAI investigation conducted by the Specialist Officer. The Chairman's wish was granted.

The Davis Inquiry: The First Local Authority

Formal Inquiry 27 February 1978

In January 1978 the Department was asked to submit copies of all casework records to the solicitor who was acting as Secretary to the forthcoming Davis Inquiry. Copies were sent off with the exception of those held by the Senior Hospital Social worker (SHSW) who was "off sick" at the time. The Specialist Officer (Child Care) had managed to locate the file, it was in the SHSW's possession. When it was eventually made available, the SHSW stated that it was incomplete as she had removed a certain document. The document comprised a personal handwritten note concerning a private conversation she had had with a Senior Social Worker (SSW) involved with the case. There was a history of ill feeling between the two women, the SSW had objected to its inclusion in the file. The Specialist Officer had suggested the SHSW remove the note. This she had done, but had then made a further note on file to the effect that she had been "asked to remove it."

The Private Independent Inquiry sat to receive evidence from 27 February to 2nd March 1978. The Chairman - a Barrister - called a total of 21 persons to give evidence. The Chairman of the ARC attended each day but was not called on to give evidence. The Director made a request to be allowed to give evidence during the last day, his request was granted. His evidence was concerned with organisational matters and referred to the economic difficulties faced by the Authority and the impact these had had on his department. In particular he drew attention to the unsatisfactory conditions under which staff in his department operated. He made reference to the note on the Senior Hospital Social Worker's (SHSW) file. While the removed note was not germane to the case the

Inquiry panel thought her remarks "most strange". The Chief Executive insisted on addressing the panel after the Director had given his evidence. He did so on the theme of the amount of resources the Authority had made available to the Social Services Department.

The Report of the Davis Panel was submitted to the Social Services Committee on the 10th April 1978. While the Director and staff were dissatisfied with the large number of factual inaccuracies in the Report, the conclusions it drew were in line with the Director's expectations, "nowhere do we detect dereliction of duty." Blame was not apportioned to any one individual or to the Department. The Report reiterated to a greater degree the findings of the Specialist Officers report (October 1977), twenty months previously.

In Mid-March 1978 the Director discovered amongst papers on his desk a letter to the Principal Hospital Social Worker from the Senior Hospital Worker (SHWS) in connection with the NAI case. The letter referred to two reports the Director had requested re the case, "one is a copy from my (SHSW) own file, whilst the other has been taken from the social history submitted to (the child's) medical notes" she went on "I had hoped they would be given to the Director to demonstrate to him both my loyalty and my wish to support my colleagues. Nevertheless I would be grateful if you could discuss the whole situation with the Director on my behalf."

"As my (the Director's) secretary was unaware as to who or how the letter had arrived I thought it best to keep it with the other information I had on the case and that maybe in due course someone would

contact me, to explain what it was all about." (The information she had referred to were records that were well known in the reports on the case).

The Austin Investigation: The Missing Memo

The Davis Inquiry on 1st March (its penultimate day) had sat in one of the Council's Committee Rooms. That evening the room was used by Conservative Councillors, two of whom sat on the Social Services Committee. One of these Councillors noticed a bundle of papers relating to the Davis Inquiry which had been left in the Committee Room. Amongst these papers it was alleged was a memo from the social worker involved in the NAI case (to whom it was addressed was not remembered). According to the Councillor the memo included recommendations that the step-grandparents of the children were not fit persons to have charge of them. He passed on the alleged memo to Councillor Mrs Williams who also sat on the Social Services Committee. The bundle of papers that same evening were passed to the Leader of the Council for safe keeping (he did not read the papers). The following day (2 March 1978) the bundle was taken by the Chief Executive's Assistant to the Social Services Department.

At a Special Meeting of the Social Services Committee (10th April 1978) the Chief Executive submitted the Report of the Davis Panel. A member of the Committee referred to the document which he had seen and of which no reference was made in the Report. The existence of this document was corroborated by Councillor Mrs Williams.

A meeting of the Policy Group was called on the 2nd May 1978 at which

the Chief Executive, the Director of Administration and Legal Services and the Director of Finance (the three officers who formed the Executive which replaced the Authority Management Team in 1976) were asked to attend. The meeting was called to:

> "Consider the growing dissatisfaction at the way in which the Director of Social Services is failing to carry out efficiently the duties of his office."

As a result of the meeting the Chief Executive was instructed to write to the Director on 5 May 1978. The final letter of the paragraph stated.

> "A period up to the end of this year is being allowed, during which the members will expect a substantial improvement in the discharge of your duties as Director. If there is no such improvement ... I must warn you that your continued employment with this authority will not be countenanced."

(This threat of dismissal was not withdrawn until 16 July 1980, two days before the conclusion of the Public Inquiry.)

The Chief Executive instigated an investigation into the "missing memo," conducted by Mr Austin, the Deputy Director of Administration and Legal Services. His report was submitted to the Social Services Committee on 24 May 1978.

The SSD personnel who were involved in the case denied knowledge of the existence of a memo, as did the Social Worker who was alleged to have written it. Both Councillors who had claimed to have read the memo on the evening of 1 March signed statements to the effect that a memo existed and contained information that was not made available to the Davis Inquiry.

The Final paragraph of the Austin Report (a private internal,

Fig.8

COUNCIL AND DEPARTMENTAL RESPONSES MAY 1978-AUG. 1978

AUG ——A.R.C.——

Council Meeting	Policy and Resources Committee	Social Services Committee
(C)(26.7.78) that 41(ss)(5.7.78) be amended addition of special meeting to consider report		58(ss)(5.7.78) D.L.A.S. gives progress report from A.R.C. 41(ss)(5.7.78) B.A.S.W. seeks inquiry approved JARVIS (25.7.78)
	70(P.R.)(13.7.78) D.L.A.S. reports on (C) (21.6.78)	38(ss)(5.7.78) amended 33(ss)(24.5.78) received

JULY——————————members of special committee selected——————————————————————

(C)(21.6.78)
that 33(ss)(24.5.78):
1. Independent lawyer: terms of reference: report back to Council.
2. Special Committee to be drawn up - carried.
3. Full public inquiry called for - lost.

7(EX-ORD.C)(14.6.78)
concern and lack of confidence in the manner the Report was originated and determined.

Key
D.L.A.S. - Director Legal and Administrative Services
B.A.S.W. - British Association of Social Workers
EX-ORD - Extra ordinary Council Meeting

JUNE ——

motion for independent inquiry lost.

(E)(25.5.78)
Mayor asks for aspects of the case to be investigated by members of the Council.

2(ss)(24.5.78)

MAY ——————————————————————————————————————AUSTIN ——————1978

(unable to reach a decision)

33(ss)(24.5.78)

investigation) concluded " . . . this fundamental conflict of evidence cannot be satisfactorily resolved in the absence of other more conclusive evidence. On the basis of the available evidence one must conclude that the existence of the alleged memorandum cannot be proved. The Committee is, therefore, to consider what further action, if any, they wish to take."

The chain of events that took place in Mixborough up to May 1978 are not entirely explained by the impact of local authority reorganisation nor the organisational responses to the NAI death in 1976. The Directors Diaries for the period 1974 to 1978 give some indication of the underlying political manoeuvering that was one continuous thread contributing to the backcloth against which events may be placed.

The Director and the Social Services Committee

Tension existed between the Director and Councillor Mrs Williams, a member of the Social Services Committee from April 1974 to May 1978. There follows extracts from the Director's record of his professional relationship with Mrs Williams.

1974/1975	"A very supportive Committee. Mrs Williams always seemed to be around the Department, it became a joke amongst staff, re- affair with the Director." "She made very regular phone calls to me personally, though the content of them centred around work. I felt some embarrassment at Civic Functions, I was always singled out as her dancing partner. I was always invited for drinks with her after Social Services Committee meetings. As she had no car I often took her home. Any expected response from me was not forthcoming."
Mid 1975	There was a noticeable change in attitude. Criticisms of the Department and individual managers began to flow. "One day in my office when Mrs Williams was visiting the question of conferences came up."

	"I was asked when the next one was (Institute of Home Help Organisers) and would it be possible for us to attend together. The response she required was not forthcoming."
January/ February 76	"The (then) Chair of the Social Services Committee resigned. Chairmanship or Vice-Chairmanship was required or else she was 'Getting off" the Committee. It was as if I was required to ensure this promotion. Her bid - if one was made was unsuccessful."
	"First real signs of anti-Director feeling showing through this was felt at Committee and within the Department."
1976 - 1978	"Our relationship on the surface appeared reasonable. Staff however regarded her very suspiciously. No opportunity was missed to attack and criticize the Department and individuals within it.
April 10 1978	"At the Social Services Committee the Davis Report was presented. Mrs Williams insisted despite lack of evidence that a document ('missing memo') existed. Onus of proof should have been on them (Mrs Williams and her colleague), the Department knew it was a frame-up."

A Deputy Area Officer (SSD), a neighbour and constituent of Mrs Williams, on the 21st April 1978 telephoned the Councillor asking if she would see her as she had "things to get off her mind." It transpired that she was concerned about a move in the Department towards putting resources into community work as opposed to case work. Mrs Williams invited the Vice-Chair of the Social Services Committee along to this meeting, and took a record of what was said (this record was later disputed by the Deputy Area Officer during the Public Inquiry). The record formed the basis for the Policy Group Meeting of the 2nd May 1978, at which it was agreed that the Director should be put under threat of dismissal.

Mrs Williams had recorded that 'Top Management' in the Department were repressive and that at Area Office Level the Director, Deputy Director and Assistant Director were hated. During the Public Inquiry, when pressed the Councillor admitted that she had not taken a verbatim record and that the words used described her impressions of the meeting but she could not "really remember."

The Ministers Request, 14 June 1978

The then Minister of Health wrote to the Chairman of the Social Services Committee on 14 June 1978, having studied the recommendations of the Davis Report he expressed concern ". . . that as a result of the committee of Inquiry . . . suitable arrangements are made to prevent such an incident from happening again." The Minister raised four points to which he requested a reply. The Chairman passed the letter to the Director (SSD) and asked for a reply to be drawn up. (Councillor Smith had vacated the Chairmanship, his place was taken by a Councillor Nesbitt).

The Chief Executive on receiving a copy of the letter felt that it was his (or the Director of Administration and Legal Services) responsibility to reply. The Chairman disagreed, he believed that the Director was the most appropriate person to reply. In the ensuing discussion it emerged that if the Director responded to this request it would be breaking with tradition as it had always been the right and duty of the Chief Executive to draw up letters for Chairman to sign.

"It was finally agreed that the Director (Administration and Legal Services) would draw up the draft and that I (Director SSD) could add appropriate points." This first draft was amended and expanded upon by the Director (SSD) the Chairman approved the SSD input, the draft was then passed back to the Director (Administration) where it was amended and deletions made. "This version was passed back to the Chairman to sign - the letter finally being sent to the Minister on 28 June 1978."

The Director had been summoned to attend an Extra-ordinary Meeting of

the Council on 14 June 1978, the meeting was called in response to a requisition signed by five councillors to consider the following motion:

> "That in the light of the report submitted to the Social Services Committee (24.5.78), the Council records its concern and lack of confidence in the manner in which this report was originated and determined."

This motion referred to the Chief Executive's report following his investigation, into the "missing memo." On the 21 June 1978 the Council passed a motion for an Independent Inquiry to be set up to investigate the matter further and to inquire:

> "into a claim that the material document which was not put in evidence before the panel of inquiry investigating the conduct of the NAI case existed at the time of the inquiry."

This became the basis of the remit for the second Local Authority Formal Inquiry, the Jarvis Inquiry (25th July 1978).

In July 1978, the British Association of Social workers (BASW) gained permission from the Social Services Committee to hold their own investigation into the conduct of the Davis Inquiry.

Social Services Department, Organisation and Environment April - October 1978

From the 10th April, when the first allegations of a suppression of evidence and a "cover-up" were made, through to October 1978 when the Jarvis Inquiry reported, staff morale within the Department was very low. Staff shortages and inadequate accommodation were crippling the Department. Though the situation was easing due to some posts being unfrozen (as a result of the recommendations of the Davis Inquiry).

The relationship between the Director (SSD) and the three-man Management Executive of Mixborough was worsening. The Minister's request (June 1978) for a report on the present procedures and practices re children at risk, had caused heated discussion as to the rights and duties of officers. The Director was under threat of dismissal, and the two Councillors who had allegedly read the 'missing memo' continued to be vociferous in their claims of a "cover up". Within political circles two camps were forming, those who supported the SSD and those who supported the Councillors. At the same time as the Jarvis Inquiry was announced, BASW were granted permission to perform an Inquiry into the conduct of the Davis Inquiry.

The Second Local Authority Formal Inquiry 27th June 1978

The staff of the Council on the advice of NALGO did not give evidence. In spite of this the inquiry proceded, concluding that

(i) The "memo" was in existence in March 1976; and that this document was not shown to the Davis Inquiry.

(ii) The running record had been "skillfully" changed (reference to the SHSW's notes of her personal conversation with the SSW).

The Jarvis Inquiry recommended that a Public Inquiry be considered under Section 98 (i) (a) of the Children Act 1975. When the Report was leaked to the press in the words of the Director (SSD) "all hell was let loose."

Not one of the employees of the Council gave evidence, as they were following NALGO's instructions not to co-operate with the Inquiry. Following this instruction the Director a member of NALGO sought advice from the Chief Executive (also a member of NALGO) as to what he should

do. Following the Chief Executive's advice, the Director asked permission (from a special committee of the Council) to be excused from attending the Inquiry. This was granted.

> "I (Director) was surprised and very disappointed when it emerged that the Chief Executive had after all appeared before Mr Jarvis. The Chief Executive and I were the only chief Officers invited to attend and it was my understanding that both of us would be seeking the special Committees' permission to be excused."

Extract from The Guardian headlined "Call for an Inquiry."

> "The Director of Social Services is maintaining his call for a Police Investigation or full Ministerial Inquiry into an alleged deception in his department... Mr Jarvis Q.C. accepts that there was such a memo... the director said he had no comment on the Report as he had not seen it yet. He added "in commenting on this two months ago," I said it appears to be being suggested that there has been a suppression of evidence in this department and if that is what is being suggested, I regard such allegations as extremely serious and amounting to a criminal offence. Therefore it is a matter for the police and I would hope that they would be brought in immediately or that a full Ministerial inquiry should be held. This is something we are going to insist upon! I still feel that way."

On that same day, the Chief Executive on the Council's instructions, wrote to the Minister of State (Health) requesting on inquiry as suggested by the Jarvis Report under Section 98 (i) (a) of the Children Act 1975. There was no response from the Minister until 19 March 1979, when he wrote to the Leader of the Council suggesting a meeting to discuss the "view I have reached."

Very shortly after this it was announced that a General Election was to be held in May - thus all business that might have implications for a new administration was deferred.

In April 1979 BASW published their Report "An Inquiry into an Inquiry." It examined the way the Davis Inquiry was organised, its quasi judicial stance, and was critical of the fact that no medical witnesses were called, nor elected members of the Council, nor the Chairman of ARC. Perhaps its most swingeing criticism was of the level of resourcing of the Social Services Department.

As the Director put it "the DHSS would know that almost all the posts now authorized as a result of the Davis Inquiry including the Specialist Child Abuse Team, had been approved by the Social Services Committee as far back as 1974 when they were put forward in The Development Plan." (This Plan was 'frozen' by the Chief Officers Group).

The BASW report filled in some of the graphic descriptions the Davis Inquiry referred to but did not reproduce it in detail, such as the "grossly inadequate" staffing and accommodation of the Area Office. BASW listed "supervision sessions" conducted on park benches to "get a bit of quiet and privacy", area office teams with not a single qualified main-grade social worker and piles of unsorted files still in cardboard boxes. In the office referred to as the 'barn' staff had to work on trestle tables and files were laid on the floor.

As New Society reported it (1 May 1979)

> "Under such circumstances, it is hardly surprising that the file was lost between offices and that the case was unallocated for six months."

The BASW Inquiry produced sufficient evidence to show that the conduct of the Independent Inquiry was enough in doubt to warrant a full, comprehensive and open investigation.

Policy and Resources Committee
101(P.R.)(17.7.79)
Letter from Sec. of State (10..7.79)
1. No Inquiry
2. Report requested
   (i) decisions noted
   (ii) Social Services Committee to be informed.

JULY

JUNE

Social Services Committee
2(ss)(23.5.79)
Chief Executive reads letter from Sec. of State. Change of Govt.

MAY — Early request for Inquiry further to 41(ss)(5.7.78)

B.A.S.W. 'An Inquiry into an Inquiry' (30/31.8.78)

B.A.S.W. Present report - Report received

416(P.R.)(2.4.79)

APRIL — Letter received from Sec. of State inviting Chairmen of P.R. & Social Services Committees to London

MARCH

FEB

JAN — 1979

DEC

(P.R.)(6.11.78)
Chief Executive submits letter

NOV — from Sec. of State - Inquiry being considered. Noted.

1(P.R.)(55)(12.10.78)
* Decision not in exclude public
OCT — * JARVIS Report read out
- request for Ministerial Inquiry

90(ss)(18.10.78)
further to 58(ss)(5.7.78)
Report of A.R.C. received
1. Approved
2. File completion recommendation
Director to put to O&M
64(ss)(13.9.78)
Delay in Jarvis Report
63(ss)(13.9.78)
Amended 41(ss)(5.7.78) be received

SEPT — 1978

	Extra-Ordinary Council Meeting	Council Meeting	Policy and Resources Committee	Social Services Committee
			344(P.R.)(7.2.80) D.A.L.S. Reported on decision to hold Inquiry	
FEB			P.R. Committee to have delegated in making arrangements	PUBLIC INQUIRY CONWAY INQUIRY
JAN				1980
	5(E)(3.12.79) Response to Sec. of State stating an Inquiry would take place? - unable to reach unanimous decision			Sec. of State Announces Inquiry (20.12.79)
DEC				
		75(C)(19.11.79) Mayor's objection to 52(ss) (12.9.79) withdrawn - minute confirmed		105(ss)(28.11.79) Progress on issues raised in Davis Report
		66(C)(14.11.79) Two objections to 233(P.R.)(5.11.79) (4) to be deleted Police to be involved - Objections lost.	233(P.R.)(5.11.79) D.A.L.S.Reports 52(ss)(12.9.79) 59(C)(3.10.79)(E)(9.1.0.79) * no further investigations * any information must go to JARVIS * No NAI documents to be made available to Councillor.	
NOV				ADJOURNMENT DEBATE
	(E)(9.10.79) 59(C)(3.10.79) considered - unable to reach decision	59(C)(3.10.79) Objections to 52(ss)(12.9.79) Mayor amends by:- 'examination of records' - referred to S.0.29 Committee		
OCT				
				52(ss)(12.9.79) D.A.L.S. Reports 101(P.R.)(17.7.79) Noted.
SEPT				1979

Discussions at Ministerial Level

With the change of Government in May 1979 a new Minister (Health) was considering the request for an inquiry into the 'Missing Memo'. He invited the Leader of the Council and the Chairman of Social Services Committee to see him on 12 June 1979 to discuss the matter and to explain why the felt it was necessary to hold a further inquiry.

On the 10 July 1979 the Minister wrote to the Leader of the Council stating that "such an inquiry would not be appropriate . . . There may be other matters which individuals and the Council may wish to see pursued further. I am advised that they do not relate to the functions of the Social Services Committee in so far as those functions relate to children, and that it would not be appropriate to use Section 98." (of the Children Act 1975). The Council decided to drop the matter. "Efforts were once again made to shut-up the agitators which on the one hand were the two councillors on the other me (Director of Social Services)."

"The Chair of the Social Services Committee asked me as a favour to him, to quieten down the feelings in the Department, particularly those who were shouting - with good reason - to have their names cleared. I was assured the Leadership were now taking a strong line with the two councillors and that they had 'now shut up.' I wanted to co-operate if only to get the distasteful business out of the way and thus enable the department to settle down. I was reminded that the Social Services Committee had at their meeting on 23 May 1979 given, 'Full support and a vote of confidence' in the department and all its staff which followed the presentation of the BASW report. Whilst agreeing that this was much

appreciated I had to say it had somehow not been recorded in the official minute of the meeting." (At this time the Director was still under threat of dismissal).

"As a means of responding to the Chairman I wrote to him saying that we didn't really want any further inquiries but that we all felt strongly that where staff had been unjustly criticized in the Davis Report and in the Jarvis Report something should be said to clear them. My hope was that something would be recorded in the minutes with, if necessary, individuals being named, rather than just a blanket clearance.

However Councillor Mrs Williams and her colleague remained vociferous in their allegations and in their demand for an inquiry. The Labour Group began to call for an investigation and asked a local Labour Member of Parliament to make such a request to the Minister. During November 1979 the request was refused on several occasions. During this month also a former Liberal Leader of the Borough who sat in the House of Lords had his call for an inquiry rejected.

Escalating Political Involvement

Councillor Mrs Williams in 1977 became the Vice-Chair of the Education Committee, her Chairman shortly after this time became Member of Parliament. The Chairman (a solicitor) before leaving for Westminster had in the Director's view "taken more than a passing interest in the allegations about a cover up".

The insinuations and allegations of a 'cover up' continued throughout 1979. The Mayor Councillor Smith (Former Chair of The Social Services

Committee) demanded that Councillors should see the files of the NAI case. "Press interest greatly increased and staff involved in the NAI case were harrassed by reporters, considerable tension was generated within the department." The chairman Councillor Nesbitt attempted to alleviate the situation by inviting another local female M.P. (Conservative) to "discuss the matter with us to see what she could do."

"During the meeting she mentioned that the husband of one of the key witnesses had tried to contact her on the telephone. There had been no conversation but she gained the impression that the key witness (SHSW) did not want a further inquiry. It was known that the SHSW had felt a sense of guilt about the child's death - she felt and indeed had told the Specialist Officer that she "knew blame was being attached to her at HQ."

In November 1979 the local Mixborough paper ran an article headlined "Key Witness Was Got At." Councillor Mrs Williams was reported as saying "at the time of the Inquiry I had a personal visit from the husband of a Senior Social Worker involved (SHSW). His wife had been approached and asked to change her evidence. I could not use it in any part of my evidence because she was close to breakdown and she was not prepared to go on a stand and swear to it."

On Friday 30 November 1979 the local paper ran another feature on "NAI Death, with reference to the SHSW it read:

> ". . . She has asked MP and Local Solicitor (The former Chair of the Education Committee) for advice over the affair."
>
> "The MP would not release any names but confirmed that a consitutent had been to see him regarding the death of the little boy."
>
> "I was approached by someone who has evidence very pertinent to the

case. This person was intimately involved and I have advised that they put the evidence before the Leader of the Council. I have no doubt that if the evidence can be substantiated the Council would take some further action" he said."

The Adjournment Debate

On the afternoon of the 28 November 1979, the local MP (who had been approached by the Labour Group) telephoned the Director. The MP stated that he had persuaded the Minister to hold an adjournment debate on the 30 November.

"He was obviously pleased with his success but was more than a little concerned that he has so little information upon which to base his case. He asked 'have you (Director SSD) any information to give me for the debate as the Mayor, Councillor Smith has given me nothing other than to suggest a cover-up. I have not seen the Davis Report, could you let me have a copy.' I agreed to send him a copy right away and suggested it might be best to send a copy of the BASW Report as well."

It was several days before the Director (SSD) learned what had been said in the House during the Adjournment Debate. The local press published a copy of the MP's speech. "Staff were highly indignant at what had been said. I felt sure the MP would be in touch with me to explain why he had found it necessary to distort the facts so disgracefully. Alas he did not come forth."

The Davis Inquiry (reporting April 1978) had not uncovered new facts nor apportioned blame to any individual or to the Department. It had

however made recommendations which enabled more resources to be made available to the Social Services Department. The stance of the Inquiry and the factual inaccuracies in its report, coupled with the absence of evidence from key people and agencies involved in the NAI case cast a shadow over its legitimacy. These points were brought out by BASW in their report. The charges made by two Councillors concerning suppression of evidence by the Director (SSD) further cast doubt on the legitimacy of the Davis Inquiry. Investigations into a "missing memo" led eventually to a call for a second formal Local Authority Inquiry (Jarvis Inquiry convened July 1978).

The outcome of the Jarvis Inquiry supported the Councillors allegations. But the Report also stated that the production of the document to the Davis Panel would not have affected the recommendations and findings of that Inquiry. The Jarvis Inquiry itself could not take evidence from those staff directly involved in the NAI case because NALGO had advised its members not to co-operate with further inquiries. Thus the Jarvis Inquiry took evidence primarily from Councillor Mrs Williams and the Chief Executive.

The call for a Public Inquiry had come from elected members of the Authority and from the Director of Social Services. This call had been several times rejected by the Minister as it did not come under the relevant sections of the Children Act 1975. The local M.P. who put forward the case for an Inquiry during the Adjournment Debate had emphasised in his speech the supression of evidence and requested that a Public Inquiry be set up to look "into the behaviour of certain officers long after the child had died." The reasons why a Public Inquiry was

granted were in the Director's view based upon the protection afforded by Parliamentary privilege. This enabled the MP to distort information and present a false picture to the House of the "facts" surrounding the NAI death and events that had taken place in Mixborough since 1976.

The Minister in his response (during the adjournment debate) stated "no one who has read the details of this case can be happy about the episode of the missing document . . . there is the clearest indication from the Jarvis Report that some evidence that should have been made available to the Davis Inquiry was not available at best, and might even have been witheld. No one with a concern for the Welfare of children can be anything but concerned at the implications of such behaviour. The Minister decided that there should be a Public Inquiry into the case as put forward by the local MP. As the Director viewed it "the inquiry had been brought about by dirty means and none of us wanted to be associated with these."

The Senior Hospital Social Worker and The Media

The SHSW on 3 December 1979 was interviewed for a television programme at her home. In response to questions put to her she said.

> "My prime concern is not to have a witch hunt of the social workers concerned . . . the things that happened against my conscience was that I was asked to delete or to change my files. As a Social Worker I felt that this was against my ethics . . . It was put to me by a high ranking official in the Social Services Department that I should change files or delete them or have them retyped."
>
> "There are two purposes it would have served - it would have protected the interests of another Social Worker involved, the

second purpose was that it would have protected the department in that the department could then have regarded the case as not being a non-accidental injury case.

'I am prepared to name the person concerned at any further legal Inquiry."

The comments she had been asked to delete were the reference to a personal conversation she had had with the Senior Social Worker, and to which the Director had referred during his submission to the Davis Panel. The comments were:

> "The Senior Social Worker then in confidence to this file expressed regrets concerning the child's present state, stating that due to difficulties at the Area Office Supervision of her Team had been virtually impossible. She had complained about this to the Area Officer. She clearly indicated that she felt this incident might be a slur on her personal career."

(The original file, complete with the above comment and a written and verbal statement from the Senior Hospital Social Worker were presented to the Davis Panel).

Two points remained unclear the first, was what the comments had to do with shielding the Department and, the second, why the comments were included on the case file in the first place. The Senior Hospital Social Worker had also kept the file at her home before the Davis Inquiry and for several months afterwards eventually depositing with her Solicitor, where it remained until the Public Inquiry. She was under a lot of pressure and in the words of Councillor Mrs Williams was near to a nervous breakdown. The incident served only to add an additional layer of intrigue to the SSDs involvement in the NAI case. The point was picked up and misinterpreted by the MP who during the Adjournment

Debate had stated.

> ". . . People as they say are beginning to hum at the present time and on one of the television programmes, we will again receive more evidence not just of forging documents in this case but of another instance as well."

Preparation for the Public Inquiry

The Director had been told that he would not be represented by the Counsel representing the Local Authority, neither would the Chief Executive nor Mr Austin. On day two of the Inquiry (12th May 1980) the Counsel representing the Authority applied to represent a further six people. "It was quite a shock to hear that the Chief Executive and Mr Austinwere to be included. Both had a direct involvement in the case, if the Authority's Chief Officer was to be placed in this favoured and sheltered position, I and my department would have no chance."

By being represented by the Local Authority's counsel evidence that the Chief Executive would give, would be associated with the Council's view. Whereas if evidence given by the Director and his colleagues differed in any way from that given by those represented by the Authority's counsel, it would be deemed as being against Council Policy. It transpired that at a Policy and Resources Committee Meeting, the Chief Executive had requested that he and Mr Austin should be represented by the Local Authority's Counsel. The reason put forward was that it would be difficult for either of them to afford the cost of providing their own legal representation.

> "The whole situation was now just a dirty game, for in addition to all this, I and my Department had provided the instructing Solicitor and Counsel representing the Authority with information."

On the 21 December 1979 the Mayor in the local paper claimed that, "the public inquiry is a vindication of the stand I took, I hope we will finally get at the truth." The paper also stated, "intense pressure to re-open the case has been brought on the Government. This followed the accusation by the MP in the House that an unnamed person had been bribed to withold vital evidence from a previous inquiry."

The Chairman of the Social Services Committee and the Director had discussed in detail preparations for the Inquiry, "both of us were aware of the implications arising from the Panel's fourth term of reference, which was to inquire into:

> "The working relationships of the Social Services Committee within the Metropolitan Borough Council in so far as they are relevant to the discharge of functions of that committee in relation to children."

The Chairman had experienced the interference by the Executive (the three-man Management Team of the Authority) in the affairs of the Social Services Department, a case in point being the heated discussion over who should reply to the Minister following the Davis Inquiry Report. "He also recognised that it would inevitably mean the 'Authority's dirty washing' would be hung out for all to see, something neither of us were very keen on." According to the Director;

> "The chairman said it was important for me to deal positively with this matter for there had been unnecessary interference which needed to be illustrated - he hoped however that I would not be too critical of the Authority."
> "I said there were two factors that would have to be taken into account - firstly, the threatening letter of 5 May 1978 was still hanging over me even though points made in it had not been substantiated. I would therefore have to raise

this matter because it was so directly linked with the Panel's interpretation of the fourth term of reference. The second point was that I understood the Treasury Solicitor would be indicating the main areas to be covered by all those drawing up their statements."

The Chairman agreed to take the first point up with the Leader of the Council, to see if the letter could be removed from the file, thus obviating the need to air the matter in public. "He did raise this matter with the Leader, who after consultation, felt he could not do this at the time. In the light of this it was agreed that questions relating to each of the points made in the letter would be raised at the Inquiry whereby the Leader and the Chief Executive would be asked to substantiate the validity of the criticisms made."

"Sometime in April, possibly towards the end of the month I met the Treasury Solicitor. He felt the alleged 'missing memo' was a very serious matter. A week later the NALGO solicitor and I met the Treasury solicitor to discuss the form and main contents of the statement I was to make. When we came to the fourth term of reference, the Treasury Solicitor said that he was very surprised to find that only two criticisms had been made which came under the fourth term of reference and which might be said to be 'criticisms of you and your senior management Team and in fact, only one of them could be said to be directly made and even this is not likely to be taken any further'."

The Solicitor also informed the Director that the Chief Executive had passed on to him a private and confidential note which contained criticisms of the senior managers in the Department made by the Deputy Area Officer. (This note had been made available to the solicitor without the knowledge or consent of the Officer or Councillor Mrs Williams). "He then went on to advise the NALGO solicitor and myself

how he felt I should draw up my statement and what should be included."

The Committee of Inquiry convened on the 14th March in London. The Directors statement was finalised and signed on the 6th May. The Inquiry was held at Mixborough Civic Hall and sat on the 12th May for 50 days concluding on the 18th July. The Report was published in December.

Conclusions

The Director was attempting to perform a role which according to Seebohm (1968) was impossible to perform without coherent integrated management and planning throughout an Authority. The Director's attempts to put forward a Development Plan for the Social Services Department was stymied by Chief Officer resistance and the Plan was shelved. The Director's pro-active management style had resulted in the formation of hostilities between him and the other local authority chief officers. The hostilities were based primarily on two factors: an ambitious and unpredictable chairman of the Social Services Committee, who wished to "sort out" the management of the Department and had let it be known (within the Authority and the Department) that this was his mission. Secondly the sexual politics surrounding the relationship between the Director and a female elected member of the Social Services Committee. Councillor Smith (first as Chairman of the Committee then as Mayor of Mixborough) and Councillor Mrs Williams, were two chief protagonists in escalating events from 1976 onwards.

Staffing and accommodation are themes running through the case study from 1973 until 1978. The senior Hospital Social Worker was approaching

a nervous breakdown. Her fears led her to include an inappropriate comment on the NAI case file. This comment (and her strange behaviour for example placing the NAI file with her solicitor for two years) assumed disproportionate importance and was picked up by Councillors and the local media. The move in the Department (along Seebohm lines) towards a more community based approach to social work, had pushed a Deputy Area Officer to contact her local Councillor (Mrs Williams). The Deputy Area Officer's comments were falsely recorded by the Councillor (Retraction taking place during the Public Inquiry) and served to fuel hostilities towards the Director. The Chief Executive had played an active role in the Social Services Department's business and had taken significant unilateral decisions on a number of occasions (the freezing of posts, leaking reports to the press, setting up the DHSS investigation into the management of the SSD).

Inquiries and investigations became a regular feature in the Department. From the Case Study it emerges that these inquiries and investigations were used as political tools, to provide leverage on the Senior Management of the Social Services Department. The alleged existence of the "missing memo" was an issue that formed the basis for an internal investigation (Austin 1978) a second formal Local Authority Inquiry (July 1978) and a Public Inquiry in 1980. The "missing memo" became translated into an allegation of a "suppression of evidence," the accused were the Director and senior managers within the social services department.

The Public Inquiry into the NAI death (at an estimated cost of £1 million) was called to resolve a stalemate situation. The DHSS investigation, the internal NAI investigation carried out by the

Specialist Officer (1977) and the DHSS Social Work Services Group's inquiry, in their Reports supported the Director's demands for more resources for the Department particularly for an increase in qualified staff and appropriate accommodation. It is interesting to note that in eight of the Inquiry Reports examined in the thesis, local authority reorganisation and its impact on procedures was a major factor contributing to the mismanagement of NAI cases. In a further nine cases case loads that were too heavy, had led to a dramatic decrease in efficiency and non operation of established procedures (Chapter 5).

The first Formal Local Authority Inquiry (April 1978), the Davis Inquiry, was criticized by BASW (1979). These criticisms coupled with the issue of the "missing memo" served to bring the legitimacy of the Inquiry into question. But this formal investigation did result in more resources being made available to the SSD. The second Formal Local Authority Inquiry was a farce. It was boycotted successfully by NALGO members. The result was that only two key people from the Authority gave evidence, Councillor Mrs Williams and the Chief Executive. In establishing the facts of the NAI case the Public Inquiry did not unearth any new fact or facts different to those included in the Specialist Officer's internal report of October 1977. From the transcripts of the inquiry it emerges that witnesses' ability to recall the minutae of their involvement in the case was impaired by the length of time elapsing between the NAI death and the Public Inquiry.

The Public Inquiry focussed on co-operation, co-ordination and communication (each inquiry report examined in the thesis addressed these organisational issues, chapter 5), and made what are now standard recommendations. That is, "the clarification of criteria for

identifying children at risk" (already carried out by the Area Review Committee in 1977), "the development of a common procedural framework for all agencies" who may be involved in NAI cases (addressed in a multi-agency meeting held in August 1976 before the death of the child), "improved multi-agency co-ordinating machinery" (addressed by the Davis Inquiry April 1978, and made possible by the recommendations of that inquiry to increase the number of staff posts in particular the formation of a Specialist Child Abuse Team).

The Public NAI Inquiry differed from the twenty two inquiries examined in the thesis, in that one of its terms of reference was to examine specifically "The working relationships of the Social Services Committee within Mixborough in so far as they are relevant to the discharge of the functions of that Committee in relation to children." In a report 107 pages long, it is only in the final 14 pages of the Report that management relationships are addressed. Relying solely upon the evidence contained in the Report it is impossible to determine the management style of the Director, or the management ethos of the authority. There is no formal description of the Director's role, the report states that "ample material" was amassed "upon which to assess him as a man and a Director of Social Services." His pro-active style of management is variously described as "pugnacious" (he was an amateur boxer in his youth - a fact included in the report) "determined" and "imaginative." The Report went on to state that "he has a genuine concern for those in need. His vision of social work is expansionist and experimental."

In terms of effective management within an organisation, the

implications of the value judgements remain unclear. The Report's analysis of the relationship between the Director and the Chief Executive is equally unclear. The cause of conflict between the officers was attributed to "personal incompatibility and differing backgrounds." In the concluding paragraph on management relationships, the Report stated "At the end of our Inquiry the Chief Executive (on orders from the Leader of the Authority) offered the Director an olive branch, an offer to start afresh once the inquiry was over and to create a more productive working relationship."

The case study has set out some of the political negotiations surrounding the instituting of a series of investigations and inquiries into Mixborough's Social Services Department's management of one NAI case. The factors influencing the level of efficiency within the SSD are similar to those found in other inquiry reports (Chapter 5) namely, the impact of local authority reorganisation, and shortages of qualified staff. When the child was admitted to hospital (August 1976) the appropriate procedures were enacted and an internal investigation (Dark Report) established where failures to operate existing systems had occurred. The Davis Inquiry (April 1978) fulfilled an important function, not to establish the facts of the case, but instead, the Report enabled the department to accrue additional resources to ease staff shortages.

The path that led to the establishment of a Public Inquiry was a complicated and convoluted route strewn with accusations and misinformation. With regard to the "missing memo" the Public Inquiry came to the firm conclusion that the memorandum did not exist. An

interesting inference can be drawn from the case study, that is that both the SSD and the Council continued to believe in the efficacy of inquiries, the former to exonerate the innocent, the latter to damn the guilty. If an hierarchy of inquiries can be established then it would appear that a Public Inquiry, with full statutory powers holds supreme position. The quasi judicial orientation of such an Inquiry (often replicated in Formal Local Authority Investigation chapter 3), its independent stance, enhances public credibility. But Public and Formal Inquiries precisely because of this quasi judicial orientation have been criticised as inappropriate devices for examining complex organisational functions (BASW 1982). The Public Inquiry examined in the Case Study was unable to address in a substantive way management and organisational issues. In general, a committee of Inquiry is formed to investigate a matter which causes great public concern (Bulmer 1983;2). It is difficult to quantify what "great public concern" is. It emerges from the study that "great public concern" is equatable to media attention, which was informed and shaped by the elected members and officers of Mixborough.

The Aftermath of the Public Inquiry

Given the absence of a coherent organisational recovery strategy, there was a failure of the Public Inquiry to translate the "olive branch" into a management strategy. Organisational relationships within Mixborough did not improve. Both the Senior Hospital Social Worker and the Deputy Area Officer had nervous breakdowns. Their ill health was a fact not brought out in the Public Inquiry because the chairman of the Social Services Committee and the Director had a "gentleman's agreement that no reference was to be made to this during the Inquiry."

The estimated cost of the Public Inquiry was £1 million. Its Report was published in December 1980. Six months later in June 1981 Mixborough Council passed a vote of no confidence in the Director of Social Services and called for his resignation. The recommendations of an expensive central government inquiry were disregarded by local politicians. The Leader of the Council was quoted in the local press as stating "dissatisfaction with the style of management stems from happenings from 1974, which is before the NAI issue."

CHAPTER 8 Conclusions

The thesis is concerned with an examination of one aspect of one part of one function of social services departments. The focus of the thesis is specifically on NAI inquiries, their form, their impact and their utility. According to Bulmer (1982) there is in British public life a strong bias towards knowledge derived from the experience of the practitioner 'he who does knows'. While this may hold true for the established professions of medicine and the law, it does not hold true for social work. No other public welfare service has consistently come in for such thorough public scrutiny as has the functioning of social services departments and social workers, in relation to management of child abuse cases that have resulted in NAI deaths.

Using inquiries as an 'entry point' the thesis has examined several of the issues that confront social services departments as sub organisations of a wider local authority structure. The issues are professionalism, accountability and management. Within social services departments these three issues are inextricably linked. Professional discretion brings with it a dual accountability to the department (and through the department to the local authority and elected members) and to the client, the recipient of the service. Professionals, that is professionally qualified social workers, dominate management positions within departments. While BASW (1975) is quite clear as to what consistutes social work, there is much less clarity as to what constitutes management. Management appears from the research to be closely associated with supervision which has specific and particular connotations in social work comprising as it does of an uneasy

combination of educational and administrative functions. For social services departments in the discharge of their responsibilities to promote the welfare of children, there is no publicly acceptable level of failure. Formal NAI inquiries can be viewed as an acknowledgement by authorities of public concern. Such inquiries when they occur, are ad hoc, discretionary and expensive. There is no set format and no procedural rules to govern their conduct. Thirteen years on from the first NAI inquiry report examined in the thesis, inquiries are still taking place, they are still ad hoc, their format and quality of their published material is still variable. Though there have been two reports on child abuse inquiries (BASW 1982, DHSS 1982) the "lessons to be learned" from investigations remains unclear. Commonsense notions about the 'fairness' and 'objectivity' (words associated with the enactment of justice) of inquiries perpetuates their usage as a means of investigating a highly emotive and complex social problem. There is thus a dichotomy, what does 'fairness' and 'objectivity' actually mean in relation to emotive and social problems. Given the criticisms made of the quasi judicial inquiry process as a method of investigating complex social reality, in particular social workers assessments of a particular social reality (BASW 1982), it emerges from the thesis that there continues to be a belief in the efficacy of inquiries, whether is be to 'damn the guilty' or to 'absolve the innocent'.

Published inquiry reports are tangible proof of a department's accountability to the public and individual social worker's responsibility to the client. In the aftermath of a tragedy, if a formal inquiry is held, its primary function is to investigate an aspect of the service to the client. While the public are informed of the

facts of a case through the press reporting of legal proceedings, it is not clear how many of the general public (that is those who are not associated with welfare activities or academic research) actually read inquiry reports. It is assumed that the audience for reports comprises mainly those who are engaged in welfare activities. Criticisms of reports emanate primarily from this audience.

Unless inquiry reports identify specifically their intended audience then nothing of significance will emerge. Their findings will remain synonymous with their recommendations, made in some cases several years after an NAI death has occurred. If inquiries are to become a yardstick for what is 'good social work practice' or even 'good management', then clearly they will be addressing social services and health services staff, and they will have to focus specifically on these issues. Inquiries may then become part of the system of welfare, routinised. By implication there will be an acknowledgement that NAI deaths are not abberrations but are identified due to state activity in highly complex situations. It is only because a social services department is involved in a child abuse case, that the murder or manslaughter of a child is termed an NAI death.

This is one scenario of the possible future of NAI investigations. In the present it is found that after a decade of ad hoc formal NAI investigations, inquiries focus on child abuse systems, a policy in practice. If the systems do not operate effectively then they need to be altered. If systems exist and do not need to be altered then individuals responsible for accessing them are found wanting. "Blame" is a by product of this process.

The Griffiths Report (1984) stated that if Florence Nightingale were alive today she would be walking the corridors of the NHS searching in vain for a manager. Just as NAI inquiries have not focussed specifically on social work methods, they have equally not focussed upon management within departments. The research has shown that there is role confusion over what constitutes management methods. Though a number of inquiries have noted that there was within some departments inadequate supervision and a lack of senior management support for staff, noting these organisational factors is all that they have done. The spectre of inquiries has been held responsible for forcing departments on to the defensive (chapter 6). While the fifty six departments who participated in the survey all have formal child abuse guidelines and procedures manuals, there appears to be little else to denote defensiveness. In the departments examined there were no substantial resource shifts to the area of child abuse, typified by the absence of training programmes and specialist staff posts. There was also little evidence to demonstrate the over bureaucratization of procedures, the extreme example picked up by Glastonbury et al (1980) of decisions being taken higher up the organisation than they, on the surface, appeared to warrant, was not in evidence in the results of the survey. In only a small minority of departments were area officers and above involved in case decisions.

In 1985 the wheel has apparently come full circle. In 1973, two events occurred which were to alter the public and professional perception of child abuse, the death of Maria Colwell and the conference at Tunbridge Wells. In 1985, the inquiry into the death of Jasmine Beckford brought child abuse and social services departments once more to the forefront

of public consciousness. When BASW published in 1985 its code of practice on the management of child abuse, coincidentally the DHSS produced a consultative document on a Review of Child Care Law, and announced new procedures for investigating child abuse cases.

BASW's code of practice are the first national guidelines aimed specifically at three strata of social services departments' staff: social workers, supervisors and managers. The code was the result of revisions and reviews of existing codes and was not based on systematic research. (The DHSS do not centrally hold child abuse statistics and there are no national records of the number of children on abuse registers). The code however is not mandatory, and as with the DHSS guidelines on child abuse, the extent of implementation will be left to the discretion of local authorities.

The research supports the recommendations made by BASW, in so far as the organisational issues that have emerged in the thesis centre around the need for:

(i) training (post qualifying) for social workers involved in child abuse cases.

(ii) management training for those in management positions.

(iii) development of clear operational management policies concerning for example the allocation of child abuse cases.

The Beckford inquiry (not examined in the thesis) recommended that there should be more specialised training in dealing with child abuse. The inquiry panel expressed surprise that responsible officers were not

acquainted with the literature on child abuse. This highlights a central point, organisational learning is a slow and incremental process. Organisation literature appears to have had only a marginal impact upon social services organisational reality. There has been a consistent incidence of non routinised NAI inquiries (approximately two per year) during the period examined in the thesis. The format and procedures of early inquiries do not appear to have influenced later inquiries. In 1981 a formal inquiry into the death of Maria Mehmadagi (1981, chapter 5) published its report, during the Lucie Gates Inquiry (1981). Yet one mode of investigation did not inform the other even though the Gates inquiry was beset by panel dissension from the outset concerning format and procedures. The Gates Inquiry did not signal the end of the era of formal NAI inquiries.

Ultimately formal inquiries are political tools. Chapter seven of the thesis examined the reasons for instituting NAI investigations in one local authority. The study demonstrates the belief held in formal investigations irrespective of their outcomes. At a time of crisis and turmoil for departments and local authorities it can be inferred from the study that an appeal is made to an independent arbitrator to simplify the chaos and 'put the issue to bed'.

Formal NAI inquiries perform a clear function, they demonstrate the accountability of individuals and departments to the public. The expectation that each inquiry should produce meaningful recommendations which will feed into a child abuse policy scenario has been greatly exaggerated. There is no reason why they should. Formal inquiries investigate the operation of systems, they do this in a limited rational

quasi legal way. If the facts of a case are open to various interpretations (for example the Maria Colwell Inquiry 1974 and the Lucie Gates Inquiry 1982) this appears to matter less than the indisputable fact that a child has died and that social services departments should have prevented the death.

The case study (Chapter 7) addressed specifically the management and local authority context within which the series of NAI and NAI related investigations took place. While it is not appropriate to generalize from one case study, the study did point out the uncertain relationship between management facts, and reality as represented in inquiry reports. There was a belief in the authority in the efficacy of NAI investigations to resolve problematic organisational situations, a belief that remained irrespective of the views and experiences of those directly involved in the investigations. NAI investigations may be used in part to resolve organisational conflict, but they were not in the case study or elsewhere in the thesis found to be an integral part of the process of management learning.

Where legislation extends substantially the field of public responsibililty its consequences can rarely be predicted with certainty. If social workers are not be be tried in a court of law for contributory negligence it is a matter of public importance that their actions and responsibilities and those of their departments is examined. It is too soon to estimate the role and impact the new procedures (announced 1985) for investigating child abuse cases will have on the management of child abuse across authorities. One authority has taken a decision to obviate the need for time wasting multi disciplinary consultation in cases of

child sexual assault and non-accidental injury, from October 1986 onwards "all cases will be passed on to the police immediately". (Perera 1986).

APPENDIX 1 Questionnaire Analysis: Matrices of closed questions, Sections 1 and Sections 2.

Key to Symbols:

1 - YES
0 - NO
x - NOT ANSWERED
n - QUESTION NOT APPLICABLE
f - INFORMATION UNAVAILABLE (STATED IN QUESTION RESPONSE)
B - ADDITIONAL INFORMATION
- FAMILY AT RISK REGISTER

SECTION 1: THE MANAGEMENT OF CHILD ABUSE

1. Has your Department set out guidelines for the notification of Non-Accidental Injury to Children?

YES [ ] (1) NO [ ] (0)

2. Please indicate ways in which the content of the guidelines is communicated to the personnel in your Department?

Committee Reports [ ] (1) In-service training [ ] (3)

Departmental procedures manual [ ] (2) Memoranda [ ] (4)

If other please specify ..... (5)

.....

3. How is the content of the guidelines specifically communicated to

(a) Members of the social services committee?.....

.....

(b) Senior managers?.....

.....

(c) Middle managers?.....

.....

(d) Social workers?.....

.....

4. Has your Department different levels of social workers with differentiated responsibility in the field of Child Care?

YES [ ] (1) NO [ ] (0)

5. Does your Department run an accreditation programme for social workers?

YES ☐ (1) NO ☐ (0)

6. On what grounds is accreditation granted?

Years of experience ☐ (1)

Experience and in-service training ☐ (2)

Proof of professional competence in case work ☐ (3)

If other please briefly specify..... (4)

.....

7. Who validates this competence?

Senior social worker ☐ (1) Area Manager ☐ (2)

If other please briefly specify.....

..... (3)

8. Do only accredited social workers work on N.A.I. cases?

YES ☐ (1) NO ☐ (0)

9. (a) Has your Department an operational plan for dealing with child abuse?

YES ☐ (1) NO ☐ (0)

(b) When was this instituted?

1	9		
		(2)	(3)

(c) What time span is covered by this plan?

3 yrs [ ] (4) 5 yrs [ ] (5)

If other please briefly specify.....

.....

(6)

10. Has you Department a similar plan for other client groups?

Mental Handicap	[ ] (1)	Single Parents	[ ] (4)
Elderley	[ ] (2)	Homeless	[ ] (5)
Mentally ill	[ ] (3)	Other	[ ] (6)

11. In which year was the 'At Risk' register introduced into your department?

1	9		
		(1)	(2)

12. How many child care cases were dealt with by your Department between April 1982 and April 1983?

(2)	(3)	(4)

L.A. SSD	Q C	1	2 1 2 3 4 5	4	5	6 1 2 3 4	7 1 2 3	8	9 1 2 3 4 5 6	10 1 2 3 4 5 6	11 1 2	12 1 2 3 4
1		1	0 1 1 1 B	0	0	n - - -	n - -	n	0 n - - - -	n - - - - -	7 5	x - - -
3		1	0 1 1 1 B	1	0	n - - -	n - -	n	0 n - - - -	n - - - - -	7 5	1 0 0 0
5		1	0 1 1 0 -	0	0	n - - -	n - -	n	x - - - - -	x - - - - -	7 5	4 2 5 1
6		1	1 1 1 1 -	1	1	0 1 1 -	1 1 B	0	0 - - - - -	1 1 1 1 1 1	7 7	1 4 3 2
7		1	1 1 1 1 -	1	0	n - - -	n - -	n	0 - - - - -	0 - - - - -	7 4	3 2 4 5
8		1	0 1 1 1 -	1	0	n - - -	n - -	n	0 - - - - -	1 1 1 0 0 0	7 4	x - - -
13		1	0 1 1 1 -	1	1	1 1 1 -	1 1 B	0	B - - - - -	B - - - - -	7 4	f - - -
14		1	0 1 1 1 B	1	1	1 0 1 -	0 1 -	1	B - - - - -	B B B 0 0 0	7 4	0 1 0 9
17		1	0 1 0 1 B	1	0	n - - B	B - -	B	0 - - - - -	- - - - - -	7 4	f - - -
18		1	0 1 1 1 B	1	0	n - - -	n - -	n	B - - - - -	B B B - - B	7 4	0 1 1 1
20		1	0 1 1 0 B	0	1	1 1 1 B	n - B	0	B - - - - -	B B B - - -	7 5	x - - -
22		1	0 1 0 0 0	1	1	1 0 1 -	n - B	1	0 - - - - -	0 - - - - -	7 6	f - - -
24		1	0 1 1 1 -	1	1	0 1 1 -	0 1 B	1	B - - - - -	B B B - - B	7 4	x - - -
27		1	0 1 1 0 -	1	1	1 0 1 -	0 1 -	1	1 0 0 B B B	1 1 1 - - -	8 3	f - - -

L.A. SSD	Q C	1	2 1 2 3 4 5	4	5	6 1 2 3 4	7 1 2 3	8	9 1 2 3 4 5 6	10 1 2 3 4 5 6	11 1 2	12 1 2 3 4
28		1	0 1 1 0 –	0	0	n – – –	n – –	n	0 – – – – –	0 – – – – B	7 5	2 4 8 0
33		1	1 1 1 0 B	1	0	n – – –	n – –	n	0 – – – – –	n – – – – –	7 6	f – – –
37		1	0 1 1 0 –	1	0	n – – –	n – –	n	B – – – – –	x – – – – –	7 5	x – – –
38		1	0 1 1 1 B	1	1	1 1 1 –	0 1 B	1	B – – – – –	B – – – – –	7 2	0 3 3 9
39		1	0 1 1 1 B	1	0	n – – –	n – –	n	B – – – – –	B – – – – –	7 5	f – – –
40		1	0 1 1 0 B	1	0	n – – –	n – –	n	B – – – – –	B – – – – –	7 5	0 3 0 9
44		1	x – – – B	0	0	n – – –	n – –	n	x – – – – –	B – – – – –	7 6	f – – –
47		1	0 1 1 1 B	0	0	n – – –	n – –	n	0 – – – – –	0 – – – – –	7 3	f – – –
METROPOLITAN BOROUGHS												
49		1	0 1 1 0 B	1	1	0 1 1 –	0 1 0	1	1 7 8 1 0 0	1 1 1 0 0 0	7 8	0 2 5 1
52		1	0 1 1 1 –	1	1	1 1 1 –	1 1 B	1	0 – – – – –	1 0 1 0 0 0	7 5	f – – –
53		1	1 1 1 1 –	1	0	n – – –	n – –	n	x – – – – –	x – – – – –	7 3	f – – –
55		1	0 1 1 1 B	1	0	n – – –	n – –	n	1 8 1 – – –	x – – – – –	7 3	f – – –
56		1	0 0 1 1 B	1	0	n – – –	n – –	n	1 x – – – –	x – – – – –	7 6	0 8 5 4
58		1	0 1 0 0 B	1	0	n – – –	n – –	n	1 x – – – –	x – – – – –	7 4	f – – –

L.A. SSD	Q C	1	2 1 2 3 4 5	4	5	6 1 2 3 4	7 1 2 3	8	9 1 2 3 4 5 6	10 1 2 3 4 5 6	11 1 2	12 1 2 3 4
59		1	0 0 1 1 –	1	0	n – – –	n – –	n	x – – – – –	x – – – – –	7 4	f – – –
60		1	0 1 1 1 0	1	0	n – – –	n – –	n	x – – – – –	x – – – – –	7 4	f – – –
62		1	0 – – – B	0	0	n – – –	n – –	n	B – – – – –	B – – – – –	n	n – – –
63		1	0 1 1 0 B	1	x	x – – –	x – –	x	x – – – – –	x – – – – –	7 4	x – – –
65		1	0 1 1 1 –	0	1	1 0 1 –	n – B	0	x – – – – –	x – – – – –	7 4	0 0 4 4
68		1	0 1 1 0 –	1	0	n – – –	n – –	n	x – – – – –	x – – – – –	7 5	f – – –
71		1	1 1 1 1 –	0	0	n – – –	n – –	n	1 – – – – B	0 – – – – –	7 4	1 7 4 0
72		1	1 1 1 1 –	x	0	n – – –	n – –	n	– – – – – B	x – – – – –	7 0	2 1 1 5
73		1	1 1 1 1 –	0	0	n – – –	n – –	n	x – – – – –	x – – – – –	7 4	f – – –
78		1	0 1 1 0 B	1	0	n – – –	n – –	n	x – – – – –	x – – – – –	7 4	3 5 0 0
79		1	1 1 1 0 –	1	0	n – – –	n – –	n	x – – – – –	x – – – – –	7 4	1 6 5 8
80		1	0 1 1 0 –	0	0	n – – –	n – –	n	0 – – – – –	o – – – – –	7 5	1 2 0 0
82		1	0 1 1 1 B	1	1	0 0 1 0	0 1 B	0	B – – – – –	n – – – – –	7 4	f – – –
LONDON BOROUGHS												
84		1	0 1 1 0 –	0	0	n – – –	n – –	n	0 – – – – –	0 – – – – –	7 7	0 0 2 0

L.A. SSD	Q C	1	2 1 2 3 4 5	4	5	6 1 2 3 4	7 1 2 3	8	9 1 2 3 4 5 6	10 1 2 3 4 5 6	11 1 2	12 1 2 3 4
86		1	1 1 1 1 –	1	0	n – – –	n – –	n	0 – – – – –	0 – – – – –	7 8	0 1 0 0
87		1	0 1 1 0 –	1	0	n – – –	n – –	n	0 – – – – –	0 – – – – –	8 1	x – – –
88		1	1 1 1 1 –	0	1	x – – –	x – –	x	x – – – – –	x – – – – –	7 3	0 1 3 9
89		1	0 1 1 1 –	0	0	n – – –	n – –	n	0 – – – – –	0 – – – – –	7 4	f – – –
92		1	0 1 1 1 –	0	0	n – – –	n – –	n	0 – – – – –	0 – – – – –	7 6	0 2 2 5
93		1	0 1 0 1 –	0	1	0 0 1 0	0 1 B	0	0 – – – – –	0 – – – – –	7 5	x – – –
94		1	0 1 0 0 –	0	0	0 – – –	0 – –	0	0 – – – – –	0 – – – – –	8 1	f – – –
97		1	0 1 1 1 –	0	0	0 – – –	0 – –	0	0 – – – – –	0 – – – – –	7 3	f – – –
99		1	0 1 1 1 –	1	1	0 1 1 0	0 1 B	0	0 – – – – –	0 – – – – –	7 4	1 9 3 3
102		1	0 1 1 1 –	0	0	0 – – –	0 – –	0	0 – – – – –	0 – – – – –	7 5	x – – –
107		1	0 1 1 0 –	1	1	0 0 1 0	0 1 0	0	0 – – – – –	0 – – – – –	7 3	x – – –
109		1	1 1 0 1 –	1	0	0 – – –	0 – –	0	0 – – – – –	0 – – – – –	7 4	0 9 3 1
110		1	1 1 1 0 –	1	0	0 – – –	0 – –	0	0 – – – – –	0 – – – – –	7 5	0 0 1 5
114		1	0 1 1 1 –	0	0	0 – – –	0 – –	0	0 – – – – –	0 – – – – –	8 1	0 0 6 8

13. How many children were on the 'At Risk' register in the period April 1982 and April 1983?

(2) (3) (4)

14. Has this number on the register altered over the past 3 years?

Increased (1) Stayed much the same (2) Decreased (3)

15. What factors do you think account for the situation over the past 3 years?

.....

.....

16. Who is responsible for monitoring the 'At Risk' register in your department?

.....

.....

17. What responsibility do Area Managers have for monitoring the 'At Risk' register?

.....
.....

18. Who is responsible for monitoring work with families whose child(ren) are on the 'At Risk' register?

.....

.....

19. How often does the Area Review Committee meet to reassess cases on the 'At Risk' register?

Annually (1) Quartley (3)

Biannually (2) Monthly (4)

20. How many child abuse case conferences were called by your Department in the time periods specified below?

3 yrs ago [ ][ ][ ] (1) (2) (3) 2 yrs ago [ ][ ][ ] (4) (5) (6) 1 yr ago [ ][ ][ ] (7) (8) (9)

21. (a) Does your Department collaborate with the N.S.P.C.C.?

YES [ ] (1) NO [ ] (0)

(b) Is this collaboration

Formal [ ] (2) Informal [ ] (3)

Please briefly elaborate

.....

.....

(4)

22. How many N.A.I. referrals does your Department receive from the following sources in the time periods specified below?

	3 yrs ago	2 yrs ago	1 yr ago
Voluntary agencies	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]
Self Referrals	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]
Health agencies	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]
Education Department	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]
Police Department	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]
Community	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]

23. Has your Department a Special Child Abuse Team?

YES [ ] (1) NO [ ] (0)

If yes,

(a) Who are its members? (agency and job title)

.....

(b) To whom is the Team accountable?

.....

24. (a) Have you a Specialist Officer for Child Abuse?

YES [ ] (1) NO [ ] (0)

(b) When was this post created

[1][9][ ][ ] (2) (3)

25. Have you a policy of appointing a key worker for Child Abuse cases?

YES [ ] (1) NO [ ] (0)

26. Who is responsible for convening a Child Abuse case conference in your Department?

.....

.....

27. Which agencies normally participate in the initial case conferences?

.....

28. Who usually chairs case conferences in your Department?

.....

29. In a climate of scarce Departmental resources, do you consider the Case Conference format provides the most cost-effective method for decision making in Child Abuse cases?

YES ☐ (1) NO ☐ (0)

Please briefly elaborate.....

.....

.....

.....

L.A. SSD	Q C	13 1 2 3 4	14 1 2 3	19 1 2 3 4	20 1 2 3 4 5 6 7 8 9	21 1 2 3 4	23	24 1 2 3	25	29
1		B#- - -	B - -	B - - -	x - - - - - - - - -	1 1 0 B	0	1 8 3	1	1
3		0 2 3 0	1 0 0	0 0 1 0	3 4 0 3 9 0 4 6 0	1 1 1 B	0	0 - -	1	1
5		0 2 7 6	1 0 0	0 1 0 0	x - - 4 0 1 4 7 5	1 1 1 B	0	0 - -	1	x
6		0 4 9 3	0 0 1	n - - -	f - - - - - - - - -	1 0 1 B	0	0 - -	1	1
7		0 2 6 1	1 0 0	0 0 1 0	f - - - - - - - - -	0 - - -	0	0 - -	1	1
8		0 3 4 8	1 0 0	0 0 1 0	0 8 9 0 9 7 1 0 8	1 1 1 B	0	1 8 2	1	1
13		0 6 0 5	1 0 0	0 1 0 0	1 2 7 1 3 2 1 4 4	1 1 1 B	0	1 8 2	1	1
14		0 3 5 3	1 0 0	0 0 1 0	1 6 1 1 5 7 1 1 3	1 1 1 B	0	0 - -	1	1
17		0 9 0 0	0 0 1	n - - -	f - - - - - - - - -	1 1 0 B	0	0 - -	1	0
18		0 1 3 3	0 0 1	n - - -	f - - - - - - - - -	1 1 1 B	0	0 - -	1	1
20		0 0 4 6	0 1 0	0 0 0 1	f - - - - - - - - -	1 1 0 B	0	1 7 5	1	1
22		0 4 8 1	0 1 0	0 1 0 0	f - - - - - - - - -	1 1 1 B	0	0 - -	1	x
24		0 5 5 4	0 1 0	n - - -	1 6 5 1 9 3 1 6 3	1 1 0 B	0	1 7 9	0	1
27		0 7 0 0	0 0 1	0 0 1 0	2 9 8 3 2 4 3 0 5	1 1 1 -	0	1 8 2	1	1

L.A. SSD	Q C	13 1 2 3 4	14 1 2 3	19 1 2 3 4	20 1 2 3 4 5 6 7 8 9	21 1 2 3 4	23	24 1 2 3	25	29
28		B# - - -	B - -	n - - -	5 4 2 4 7 8 4 4 7	1 1 1 B	0	1 8 1	1	1
33		0 1 6 3	1 0 0	n - - -	1 2 0 1 3 0 1 5 0	1 1 0 B	0	1 8 0	1	1
37		0 6 5 2	1 0 0	0 0 1 0	0 3 0 0 4 5 0 8 0	1 1 0 B	0	0 - -	1	1
38		B# - - -	B - -	n - - -	2 0 3 2 7 8 2 7 0	1 1 1 B	1	1 7 4	1	1
39		0 0 4 0	1 0 0	n - - -	0 3 9 0 4 9 0 5 8	1 1 1 B	0	1 7 6	1	1
40		B# - - -	B - -	n - - -	2 3 3 3 1 4 3 8 2	1 1 0 B	0	1 7 4	1	1
44		0 1 0 5	0 0 1	n - - -	0 6 6 0 9 1 1 0 5	0 - - -	0	0 - -	1	1
47		0 6 1 1	1 0 0	0 1 0 0	f - - f - - 5 3 4	1 1 - B	0	1 7 1	1	1
METROPOLITAN BOROUGHS										
49		0 6 2 4	1 0 0	n - - -	3 0 0 4 0 0 5 0 0	1 1 0 B	0	0 - -	1	1
52		0 1 2 2	1 0 0	n - - -	2 9 8 3 1 2 3 6 5	1 1 1 B	0	1 8 0	1	x
53		0 1 2 4	1 0 0	0 0 0 1	0 5 8 0 6 5 1 0 9	1 1 0 0	0	0 - -	1	x
55		0 2 5 0	1 0 0	n - - -	f - - 3 5 1 2 0 4	1 1 1 B	1	1 8 1	1	1
56		B# - - -	B - -	n - - -	1 6 8 1 7 8 1 8 8	1 1 0 B	0	0 - -	1	0
58		0 1 7 0	0 0 1	n - - -	f - - - - - - - -	1 1 1 0	0	0 - -	1	x

L.A. SSD	Q C	13 1 2 3 4	14 1 2 3	19 1 2 3 4	20 1 2 3 4 5 6 7 8 9	21 1 2 3 4	23	24 1 2 3	25	29
59		B#- - -	B - -	n - - -	x - - - - - - - -	1 0 0 0	0	0 - -	1	x
60		0 3 7 6	1 0 0	0 0 1 0	1 0 7 1 5 9 1 9 4	1 1 1 B	0	1 8 1	1	0
62		f - - -	x - -	n - - -	x - - - - - - - -	1 1 0 B	0	0 - -	1	x
63		x - - -	1 0 0	0 0 0 1	f - - - - - - - -	1 1 0 B	0	0 - -	1	1
65		- - 4 4	0 1 0	n - - -	0 6 0 0 6 0 0 6 0	1 0 1 B	0	0 - -	1	1
68		B#- - -	B - -	n - - -	1 3 7 1 9 8 2 2 3	1 0 1 B	0	1 8 2	1	1
71		0 0 4 2	0 1 0	0 1 0 0	f - - - - - - - -	1 1 0 B	0	0 - -	1	1
72		0 4 7 4	0 0 1	0 0 1 0	1 9 2 2 0 4 2 1 6	1 0 1 B	0	1 7 2	1	0
73		0 0 8 0	0 1 0	n - - -	x - - - - - - - -	1 0 1 -	0	1 7 9	1	1
78		0 0 9 4	0 1 0	n - - -	0 5 0 0 5 5 0 7 6	1 1 0 B	0	1 8 0	1	0
79		0 2 8 2	0 1 0	n - - -	f - - - - - - - -	1 1 1 B	0	0 - -	1	1
80		0 0 8 2	1 0 0	0 0 1 0	0 1 6 0 1 7 0 3 3	1 1 1 B	0	0 - -	1	1
82		0 1 9 0	0 0 1	n - - -	f - - - - - - - -	1 0 0 B	1	1 7 9	1	1
LONDON BOROUGHS										
84		0 0 0 1	0 1 0	0 0 1 0	f - - - - - 0 0 6	1 1 1 B	0	0 - -	1	x

L.A. SSD	Q C	13 1 2 3 4	14 1 2 3	19 1 2 3 4	20 1 2 3 4 5 6 7 8 9	21 1 2 3 4	23	24 1 2 3	25	29
86		0 0 9 6	0 0 1	0 0 0 1	f - - - - - 0 0 6	1 1 0 B	0	1 7 8	1	x
87		0 1 6 2	1 0 0	0 0 1 0	f - - 0 8 2 0 8 1	1 1 0 -	1	1 8 1	1	1
88		0 1 6 3	0 0 1	n - - -	f - - - - - 1 6 8	1 1 0 B	0	1 8 0	1	1
89		f - - -	0 1 0	0 0 1 0	f - - - - - - - - -	1 1 1 B	0	0 - -	1	1
92		0 1 8 2	1 0 0	0 1 0 0	1 7 0 1 9 3 2 0 1	1 1 0 B	0	0 - -	1	1
93		x - - -	x - -	n - - -	0 6 3 1 8 2 2 1 8	1 0 1 -	0	0 - -	1	0
94		0 0 9 5	f - -	n - - -	f - - - - - - - - -	1 1 1 B	0	1 8 3	1	1
97		0 1 2 8	1 0 0	0 0 1 0	0 7 0 1 7 0 1 5 8	1 1 1 B	1	1 7 7	1	1
99		0 0 6 1	0 1 0	n - - -	f - - - - - - - - -	1 1 0 B	0	0 - -	1	1
102		0 1 3 0	0 1 0	n - - -	1 5 0 1 5 0 1 5 0	1 0 1 0	0	1 7 4	1	x
107		0 0 9 5	0 1 0	n - - -	0 4 6 0 5 3 0 7 0	1 1 1 B	0	0 - -	1	1
109		0 1 2 5	1 0 0	n - - -	1 2 4 1 5 4 1 5 9	1 1 1 B	0	1 x -	1	0
110		0 0 3 9	1 0 0	0 1 0 0	f - - 0 9 6 1 2 4	1 0 1 B	0	0 - -	1	1
114		0 1 3 2	0 0 1	n - - -	0 3 3 0 2 0 0 5 2	1 1 1 -	0	0 - -	1	0

SECTION 2: INQUIRIES INTO CHILD ABUSE

This section deals with the impact that inquiries/investigations into Child Abuse have had on Social Services Departments.

Four types of inquiry/investigation have been listed - these are as follows:-

Public Inquiry	(Statutory, adhoc, ordered by a Minister)
Formal Inquiry	(Non-statutory, adhoc, ordered by a Local Authority)
Inter-Agency Inquiry	(Set up by different statutory bodies)
Internal Investigations	(Less formal internal administration investigation by an authority)

30. What purposes do you consider Public Inquiries serve?

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31. Do you consider that a Public Inquiry is in a position to evaluate realistically the management function in Social Services Departments?

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32. Do you consider that the present method of conducting Public Inquiries into N.A.I. to children is appropriate?

YES ☐ (1) NO ☐ (0)

Please state briefly reasons for your answer.....

.....

.....

.....

3. (a) In light of the recommendations of Public Inquiry. Reports of the past 15 years, do you consider that these have led to a change in the management of Child Abuse cases across authorities?

YES ☐ (1) NO ☐ (0)

(b) Do you consider management efficiency has:

Increased ☐ (2)

Stayed much the same ☐ (3)

Decreased ☐ (4)

(c) Are there any other factors which you think are responsible for changes in management efficiency?
Please Specify.

.....

.....

.....

.....

4. In your opinion do the findings of Public Inquiries directly influence future management strategies:

Very influential ☐ (1)

Influential ☐ (2)

Not very influential ☐ (3)

In the light of the findings of different types of Inquiry/investigation, please could you rank the following in terms of their practical use to your Department.

Public Inquiry	___	(1)
Formal Inquiry	___	(2)
Inter-Agency Inquiry	___	(3)
Internal Investigation	___	(4)

Has your Department been the subject of any of the following:-

Public Inquiry	___ (1)	Inter Agency Inquiries	___ (3)
Formal Inquiry	___ (2)	Internal Investigation	___ (4)

What period of time elapsed between the incident and the convening of the inquiry/investigation?

.....

.....

What role, if any, did the Social Work Services Officers play in the period between the incident and convening of the Inquiry/Investigation?

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How long did the Inquiry/Investigation take?

.....

40. What do you identify as the main cost of the Inquiry/Investigation in terms of the Department's resources?

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41. Did the recommendations of the Inquiry/Investigation lead to a change in the management of Child Abuse Cases in your Department?

Substantial change	☐	(1)
Minor change	☐	(2)
No change	☐	(3)

Please elaborate briefly on your answer .....

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42. In you opinion, what are the most cost-effective ways of inquiring into allegations of mismanagement of Child Abuse cases?

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L.A. SSD	Q C	32	33	34	35	36	37	39 (in months)	41 (in days)
			1 2 3 4	1 2 3	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3
1		x	x - - -	x - -	x - - -	x - - -	x - - -	x - - -	x - -
3		x	1 0 1 0	0 0 1	4 3 2 1	0 1 0 0	0 0 0 4	0 0 2 7	0 1 0
5		x	1 1 0 0	0 1 0	4 3 1 2	0 1 1 0	0 0 1 5	0 0 0 5	1 0 0
6		x	1 0 1 0	0 1 0	4 3 1 2	0 0 1 1	0 0 0 3	0 0 0 6	0 1 0
7		0	0 0 1 0	0 0 1	0 1 0 2	0 0 0 1	0 0 0 2	0 0 4 0	0 1 0
8		0	1 1 0 0	0 1 0	4 3 1 2	n - - -	n - - -	n - - -	n - -
13.		0	1 1 0 0	0 1 0	4 3 1 2	0 0 1 0	0 0 0 1	0 0 1 0	0 1 0
14		0	1 1 0 0	0 1 0	4 3 2 1	n - - -	n - - -	n - - -	n - -
17		0	0 0 1 0	0 0 1	0 0 0 1	0 0 1 1	x - - -	x - - -	0 1 0
18		0	1 1 0 0	0 1 0	4 3 1 2	n - - -	n - - -	n - - -	n - -
20		0	1 0 1 0	0 1 0	0 1 0 0	n - - -	n - - -	n - - -	n - -
22		0	1 - - B	0 1 0	4 3 2 1	n - - -	n - - -	n - - -	n - -
24		0	1 1 0 0	0 1 0	4 3 1 2	0 0 0 1	0 0 0 4	0 2 2 0	1 0 0
27		x	x - - -	x - -	x - - -	x - - -	x - - -	x - - -	x - -

L.A. SSD	Q C	32	33 1 2 3 4	34 1 2 3	35 1 2 3 4	36 1 2 3 4	37 1 2 3 4	39 (in months) 1 2 3 4	41 (in days) 1 2 3
28		0	0 0 1 0	0 1 0	4 3 2 1	0 1 1 1	x - - -	x - - -	0 1 0
33		0	1 1 0 0	0 1 0	3 2 1 4	n - - -	n - - -	n - - -	n - -
37		0	1 1 0 0	0 1 0	4 3 1 2	n - - -	n - - -	n - - -	n - -
38		x	1 1 0 0	0 1 0	4 3 2 1	0 1 1 1	x - - -	x - - -	x - -
39		0	1 1 0 0	0 1 0	4 3 1 2	0 0 1 0	0 0 0 5	0 0 8 0	1 0 0
40		0	1 1 0 0	0 1 0	x - - -	0 1 0 1	x - - -	x - - -	0 1 0
44		0	1 1 0 0	0 1 0	4 2 1 3	n - - -	n - - -	n - - -	n - -
47		0	1 1 0 0	0 1 0	4 3 1 2	0 0 0 1	0 0 0 1	0 0 2 0	0 1 0
METROPOLITAN BOROUGHS									
49		1	1 1 0 0	0 0 1	4 3 2 1	0 1 0 0	0 0 1 2	0 0 3 0	1 0 0
52		0	1 1 0 0	1 0 0	4 3 2 1	0 0 1 1	0 0 0 3	0 0 0 2	0 1 0
53		x	0 1 0 0	0 1 0	0 0 1 0	0 1 0 0	x - - -	x - - -	0 0 1
55		x	1 1 0 0	0 1 0	4 3 2 1	0 0 1 1	x - - -	x - - -	0 1 0
56		x	1 1 0 0	0 1 0	x - - -	0 - - -	n - - -	n - - -	n - -
58		x	1 1 0 0	0 1 0	x - - -	0 0 0 1	x - - -	x - - -	x - -

L.A. SSD	Q C	32	33 1 2 3 4	34 1 2 3	35 1 2 3 4	36 1 2 3 4	37 1 2 3 4	39 (in months) 1 2 3 4	41 (in days) 1 2 3
59		x	x - - -	x - -	x - - -	x - - -	x - - -	x - - -	x - -
60		0	1 1 0 0	0 1 0	3 4 2 1	0 - - -	n - - -	n - - -	n - -
62		0	x - - -	0 0 1	x - - -	x - - -	x - - -	x - - -	x - -
63		0	1 1 0 0	x - -	x - - -	0 0 0 1	x - - -	0 0 0 7	0 1 0
65		0	1 1 0 0	0 0 1	0 0 1 0	0 0 0 1	f - - -	0 0 0 7	0 0 1
68		0	1 1 0 0	0 1 0	3 2 1 4	0 - - -	n - - -	n 0 0 0	n - -
71		1	x 0 1 0	0 0 1	4 2 3 1	0 - - -	n - - -	n - - -	n - -
72		0	1 0 0 1	0 0 1	4 1 3 2	1 0 0 0	x - - -	x - - -	x - -
73		0	0 x - -	0 0 1	4 1 2 3	0 0 1 1	0 0 0 3	0 0 1 4	0 0 1
78		0	1 1 0 0	0 1 0	1 2 3 4	0 0 0 1	immediate	0 0 9 0	0 1 0
79		0	1 1 0 0	0 1 0	4 2 3 1	0 0 0 1	0 0 0 1	0 0 6 0	0 1 0
80		0	0 0 1 0	0 0 1	3 1 2 4	0 - - -	n - - -	n - - -	n - -
82		0	1 1 0 0	0 0 1	0 0 0 1	1 0 0 1	0 0 3 6	0 0 9 0	0 1 0
LONDON BOROUGHS									
84		x	x - - -	x - -	x - - -	x - - -	x - - -	x - - -	x - -

L.A. SSD	Q C	32	33	34	35	36	37	39 (in months)	41 (in days)
			1 2 3 4	1 2 3	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3
86		1	1 x - -	1 0 0	1 0 0 0	0 - - -	n - - -	n - - -	n - -
87		0	0 0 1 0	0 0 1	4 3 1 2	0 1 0 0	0 0 2 4	0 0 3 4	0 1 0
88		0	1 1 0 0	0 1 0	0 0 1 0	0 1 0 0	0 0 0 2	0 1 5 0	0 0 1
89		0	1 1 0 0	0 1 0	x - - -	0 - - -	n - - -	n - - -	n - -
92		0	1 1 0 0	0 1 0	4 3 1 2	0 - - -	n - - -	n - - -	n - -
93		0	1 1 0 0	0 1 0	2 1 3 4	0 - - -	n - - -	n - - -	n - -
94		0	1 0 1 0	0 1 0	4 3 1 2	0 - - -	n - - -	n - - -	n - -
97		0	1 0 1 0	0 1 0	4 2 1 3	0 0 1 0	0 0 0 2	0 2 4 0	0 1 0
99		0	1 1 0 0	0 0 1	4 3 2 1	x - - -	x - - -	x - - -	x - -
102		x	1 0 1 0	0 0 1	0 0 1 0	0 0 0 1	0 0 0 3	0 0 0 3	0 0 1
107		0	1 0 1 0	0 1 0	4 3 2 1	0 - - -	n - - -	n - - -	n - -
109		0	x - - -	0 1 0	2 1 4 3	0 - - -	n - - -	n - - -	n - -
110		0	1 1 0 0	0 1 0	4 1 2 3	0 - - -	n - - -	n - - -	n - -
114		0	1 1 0 0	0 0 1	3 4 2 1	0 0 1 0	immediate	0 0 0 7	0 1 0

APPENDIX 2 Questionnaire Analysis: Content Analysis of Open Ended Questions.

Section 1 and Section 2

Abbreviations

ARC	Area Review Committee
ARCG	Area Review Committee Guidelines
ACCRED.	Accreditation
CA	Child Abuse
CC	Case Conference
CTT CTTEE	Committee
Comm phys.	Community Physician
DD	Demand
DHA	District Health Authority
DM	Decision Making
Ed	Education
EWO	Education Welfare Officer
FSU	Family Service Unit
G's	Guidelines (Child Abuse)
GP	General Practitioner
H	Health Authority
HV	Health Visitor
HQ	Headquarters (Social Services)
LA	Local Authority
LB	London Borough
Mgt	Management
NSPCC	National Society Prevention of Cruelty to Children
NO	Nursing Officer

SECTION 1: THE MANAGEMENT OF CHILD ABUSE

1. Has your Department set out guidelines for the notification of Non-Accidental Injury to Children?

YES ☐ (1) NO ☐ (0)

2. Please indicate ways in which the content of the guidelines is communicated to the personnel in your Department?

Committee Reports ☐ (1) In-service training ☐ (3)

Departmental procedures manual ☐ (2) Memoranda ☐ (4)

If other please specify ..... (5)

.....

3. How is the content of the guidelines specifically communicated to

(a) Members of the social services committee?.....

.....

(b) Senior managers?.....

.....

(c) Middle managers?.....

.....

(d) Social workers?.....

.....

4. Has your Department different levels of social workers with differentiated responsibility in the field of Child Care?

YES ☐ (1) NO ☐ (0)

5. Does your Department run an accreditation programme for social workers?

YES ☐ (1) NO ☐ (0)

6. On what grounds is accreditation granted?

Years of experience ☐ (1)

Experience and in-service training ☐ (2)

Proof of professional competence in case work ☐ (3)

If other please briefly specify..... (4)

.....

7. Who validates this competence?

Senior social worker ☐ (1) Area Manager ☐ (2)

If other please briefly specify.....

..... (3)

8. Do only accredited social workers work on N.A.I. cases?

YES ☐ (1) NO ☐ (0)

9. (a) Has your Department an operational plan for dealing with child abuse?

YES ☐ (1) NO ☐ (0)

[1][9][ ][ ] (2) (3)

(c) What time span is covered by this plan?

3 yrs [ ] (4) 5 yrs [ ] (5)

If other please briefly specify.....

.....

(6)

10. Has you Department a similar plan for other client groups?

Mental Handicap [ ] (1) Single Parents [ ] (4)

Elderley [ ] (2) Homeless [ ] (5)

Mentally ill [ ] (3) Other [ ] (6)

11. In which year was the 'At Risk' register introduced into your department?

[1][9][ ][ ] (1) (2)

12. How many child care cases were dealt with by your Department between April 1982 and April 1983?

[ ][ ][ ] (2) (3) (4)

13. How many children were on the 'At Risk' register in the period April 1982 and April 1983?

[ ][ ][ ] (2) (3) (4)

14. Has this number on the register altered over the past 3 years?

Increased [ ] (1) Stayed much the same [ ] (2) Decreased [ ] (3)

15. What factors do you think account for the situation over the past 3 years?

.....

.....

16. Who is responsible for monitoring the 'At Risk' register in your department?

.....

.....

17. What responsibility do Area Managers have for monitoring the 'At Risk' register?

.....

.....

18. Who is responsible for monitoring work with families whose child(ren) are on the 'At Risk' register?

.....

.....

19. How often does the Area Review Committee meet to reassess cases on the 'At Risk' register?

Annually [ ] (1) Quartley [ ] (3)

Biannually [ ] (2) Monthly [ ] (4)

20. How many child abuse case conferences were called by your Department in the time periods specified below?

3 yrs ago [ ][ ][ ] (1)(2)(3) 2 yrs ago [ ][ ][ ] (4)(5)(6) 1 yr ago [ ][ ][ ] (7)(8)(9)

21. (a) Does your Department collaborate with the N.S.P.C.C.?

YES [ ] (1) NO [ ] (0)

(b) Is this collaboration

Formal [ ] (2) Informal [ ] (3)

Please briefly elaborate

.....

..... (4)

22. How many N.A.I. referrals does your Department receive from the following sources in the time periods specified below?

	3 yrs ago	2 yrs ago	1 yr ago
Voluntary agencies	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]
Self Referrals	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]
Health agencies	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]
Education Department	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]
Police Department	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]
Community	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]

23. Has your Department a Special Child Abuse Team?

YES [ ] (1) NO [ ] (0)

If yes,

(a) Who are its members? (agency and job title)

.....

(b) To whom is the Team accountable?

.....

24. (a) Have you a Specialist Officer for Child Abuse?

YES [ ] (1) NO [ ] (0)

(b) When was this post created

[1][9][ ][ ] (2)(3)

25. Have you a policy of appointing a key worker for Child Abuse cases?

YES [ ] (1) NO [ ] (0)

26. Who is responsible for convening a Child Abuse case conference in your Department?

.....

.....

27. Which agencies normally participate in the initial case conferences?

.....

28. Who usually chairs case conferences in your Department?

.....

29. In a climate of scarce Departmental resources, do you consider the Case Conference format provides the most cost-effective method for decision making in Child Abuse cases?

YES ☐ (1) NO ☐ (0)

Please briefly elaborate.....

.....

.....

.....

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21(c)	23	26	27	28	29
1.	Guidelines on inter agency basis by ARC formally revised x 2 and issued since 1975.	(a) Report on revised issues (b) Involvement in prep. personal copies and training seminars. (c) as in (b) (d) as in (b)				Stringent review of families on register. Revised criteria for retention on register.	Area Social services officers.	Line Managers with service provision responsibility. Chairman of area review panels.	District Principal SW Managerial resp. Area review panel on behalf of ARC	NSPCC member agency of ARC		District Principal S.W.	Selectively CORE agencies S.S Community nursing G.P. comm. medicine police.	District prin. SW but may be a manager from any agency.	Provided the are convened with discretion and other effective methods of inter A COM are used.
3.	Regular meetings of divisional co-ordinators	(a) Reports (b) Div co-ord ARC training Div review. (c) Div co-ordinators and training Div review cttee (d) as (c) above.				Increased awareness staff training	Div. Review cttees.	Divisional directors. Allocate senior staff as members of Div. review cttee + provide clerical support.	Supervisors + line managers.	NSPCC represented on all 6 review cttees with NSPCC member being present Chairman of ARC		Divisional co-ordinators.	All thought to have info	Div. co-ordinator or nominated deputy.	Have not bee able to devise any better alternative
5.		(a) procedures bklet and up-dates. (b) as above for HQ staff as appropriate (c) As above for all Div. officers. (d) In service training days + team leaders procedures manual.				Suspected that there is a higher rate of throughput + children not remaining on reg. for lengthy periods.	Child abuse coordinator.	Div. officers are members of District review cttee which is local version of ARC	The line manager of the KEY worker.	RSPCC invited to custom represented on ARC + DRC New referrals (informal SSD reception team).		Child abuse coordinator.	SSD. NHS. Police ED Probation housing. NSPCC. Any other agency having knowledge of family.	Initially - C.A. Co-ordinator reviews C.A. Co-ordinator Div. SS Staff.	
6.		(a) cttee reports (b) MGI meetings + memoranda. (c) MGI meetings/preparation/Memoranda /manuals. (d) In service training/manuals memoranda /team meetings		Professional Adviser.		Lighter criteria for registration	(a) Deputy Director. (b) Case conference convenors in each district.	District officers are "area managers." Iheir PO's act as Case Convenors NAIC. Share respons. for operational monitoring of the system.	Case Convenors.	NSPCC involved in case conferences to see if they have any info to share or role to play		District case conference convenor.	Health Ed. SSD. Police others as indicated.	Case conf. Convenor District Prin. officer	Brings agenc agencies together quickly. Should lead to concerted action sometimes a "borderline case" may appear cumber some.

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21(c)	23	26	27	28	29
7.		(a) Ad hoc individ. basis (b) Via ARC rpts + memoranda. (c) MGI meetings. (d) S.W. team meetings.			No specific time limit. Evaluated periodically Child abuse procedures this Q. is in the main taken to mean.	Greater emphasis + resources into working with potentially abusive families. Greater adherence to procedures	Adviser in child care at HQ (custodian) supported by a named clerk.	none	Line managers Area officers and team leaders			Designated officer.	Health, Ed. police, SSD.	Designated officer or deputy (SSD)	
8.	Area officer MGI team meetings with Assist. Director. Child abuse co-ordinator attends meetings and case conferences.	(a) Guidelines given to chairman S S cttee. + sub-cttee. (b) Involvement in compilation of revised bklet and given a copy of the finished product. (c) As above. Membership of ARC working groups and rep on ARC. Area officer MGI. team meetings. (d) Each individ. copy of G. In service training + supervision by senior social workers			Continually being amended.	Wider criteria for registration, increased recognition Growth of unemployment.	Child Abuse coordinator.	Each child on register is reviewed 3 or 6 month by a review panel. Area officers chair these meetings.	(1) Senior social worker. (2) Review panel.	Over individ cases. Standing member of Case Con. Membership of ARC (+ sub/working groups). Joint participation in training progs.		Area officer.	SSD, NHS, GP. Police, NSPCC. Probation Headteacher C.A. Co-ordinator	Area officer	Enables agen-agencies to plan. Avoids duplication. Identifying cases requiring priority treatment.
13.		(a) as cttee. Report and attachment. (b) Memo and copy of procedures manual (c) as (b) + multidisc in-service training. (d) as (c)		Director of S.S. plus senior staff are also involved in final assessment interview.	As decided by ARC	Cumulative additions to register each year. New reg remain relatively stable each year.	Assistant Director of SS is custodian of child abuse reg.	Required to review all cases 2 x year and report to District review panel (multi-discipline).	Primary workers agency Report to District review panel responsible for monitoring on an interagency basis.	Formal - within NAI procedures formulated by ARC. Informally at earlier stages in NAI cases + generally in preventive work.		Area Directors of SSD.	SSD police Health. NSPCC Prob-Probation. Schools Others as appropriate.	Area Director of SS.	Multi agency info. speed of response forum for inter agency examination of case other methods less cost effective in the long term.

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21(c)	23	26	27	28	29
14.	Area Review Cttee. policy statement.	(a) Cttee. Reports. (b) copies of these guidelines. (c) as (b) (d) copies of guidelines held by their local line manager.			Operational plan is incorp. in policy statement updated March '83	Greater awareness of NAI (agencies/public) Social factors unemployment? Single parenthood? poor marital relationships.	Principal assistant child care at HQ (County Hall).	Ensuring Case conf. recommendations are implemented. + conference re-convened if appropriate. Area Manager retains over sight of these cases not necessarily actively supervised by SS.	Area manager (called District Controller in this L.A. and social work Team leader.	NSPCC on ARC and Area Ad-Advisory training on NAI. Always invited to case conference irrespective of involvement.		District controller	NHS Comm. nursing, police NSPCC legal adviser education S.S.	District controller or his assistant controller	Professionally provide the best collation and exchange of info. Cost is not of paramount importance.
17.	Briefing meetings. Reports of cttees. including ARC. These however are not regarded as primary communication channel. Generation of content is subject to consultation at draft stages.	(a) Discussion with non exec. sub group. formal rpts/ seminars as required. (b) Procedures Manual, executive memoranda briefings. (c) as (b) (d) Procedures Manual plus any mechanism deployed by middle mgt.	Accred = No staff appraisal prog. which is performance, competence development linked.			More accurate identification less nervous registration introduction of de-registration facility.	Principal officer (operations).	none	Area Managers and District grounding review conferences.	Part of ARC NSPCC guidelines interlock and formal case consultations of Area /insp level should occur Also marital violence unit in county (joint).		Area manager	SSD Police Relevant DVS NHS HVS schools probation + others as appropriate.	Team Leader or more senior area MGI personnel.	Perhaps do not make intervention effective But conflicting interests have succeeded in protecting numbers of children.

Authority Number	Question numbers (including parts of questions)														
	2	3	6	7	9	15	16	17	18	21 (c)	23	26	27	28	29
18.	Procedural guidance booklet ARC	(a) Directors report. (b) SW handbook, Proc. tklet memoranda, discussion. (c) as (b) (d) SW handbook. proc. tklet.			Indefinitely	Increased monitoring of cases once placed on register	Assistant Controller (child care & family service).	Responsibility for monitoring progress of "Local" cases on at risk register.	Varies according to decisions being made. Generally S. SW. but certain issues decided by Director.	Represented on ARC + invited to all initial case conferences. Informal liaison cont at local level.		Area Director	GP H.V. S.W L.A. Solicitor Police NSPCC Probation and any other relevant agency.	Area Director or substitute.	Clear forum for comm and D M between agencies thus avoid duplication or misunder standing.
20.	Through area Coord. Cttees. attended by all workers who have responsibility for child abuse cases.	(a) – (b) Retain a copy. (c) Retain a copy. (d) A copy if retained in procedures manual. When represented all workers.	formal rep to a panel which determines acceleration beyond point 30 Method accompanied by appeals system.	Director of SS via a panel of reps train all levels + an external examiner drawn from a CCEW course.		Increased awareness H.V. S.S. etc in detecting risk factors and recognition of SIGNIFICANCE by training. (my italics)	P.O. at H.Q. accountable to the Assistant Director (child care)	Resp. for all CA cases in their area, subject to a monthly check through a co-ord conference. Also responsible for convening case conf. on suspected CA cases	Area Offices with check by head office (HQ) during visits to area offices or attendances at Co-ordinating Conferences.	NSPCC NEGLIGIBLE one inspector serves part of the county quite possibly this officer will not be replaced after his retirement.		Area Officer.	Health Police always and all relevant agencies associated with the family	Area Officer	Not always the most co effective Meetings ca be over attended – talking sho But are a forum, channels of comm. open even if som ignore the opportunity
22.		b) Manual circ- c) culated to all staff a) available to them if they wish to see it.		Panel of 5 social work staff.		Not able to answer	Advisor children and young parents.	Required to monitor cases in their own areas.	Area manager through senior social workers.	Varies across county. Inspector in one area but not in others		Area Managers	Police NSPCC Probation Education District Health Authority	Area Manager	

Number	2	3	6	7	9	15	16	17	18	21(c)	23	26	27	28	29
24.		(a) cttee reports. b) c) Procedures d) manual.			Ongoing	number beginning to reflect other trends drop in numbers in care and increase in confidence and expertise only those on reg who require it	Divisional co-ordinators	Implementing reviews every six months	Senior S.W. Area managers	SSD is made aware of cases in which NEFCC have an interest and agreement is reached re roles. NEFCC - place of safety orders. SSD conducts any care proceedings considered necessary		Area Managers	Health Police Education Voluntary and others considered appropriate to the case	Area Manager	Generally well attend seen as a reflection their value thus they a cost effective method of info exchan and D M
27.		a) Not specifically comm. to committee. b) AFC meetings + Dept meetings + manual. c) District review cttee meetings + AFC procedures. d) Area team meetings. Training sessions manual.			As considered appropriate in consultation with AFC.	Only a case conference can register a child. Now a more strictly enforced criteria apply	Principal Officer (Child Abuse).	Chair initial and review case conferences and manage child abuse cases in their own area.	Area Team officers			Area Team officer	S.S. Comm phys. G.P. N.O. NEFCC Probation and Police others where relevant.	Area Team Officer	An initial full case conf. is essential Reviews cou perhaps involve onl those profe sions directly involved wi the family conjunctio with a peri review.
28.		a) Study day on CA organised. b) All staff c) dep.area - d) direct to attended briefing conference drafts of proposed proc. circulated for discuss to all staff during preperation most issues discussed in social work teams before implementation				until 1983 registration was open. But now depends on case conf. and only if case satisfies IHSS criteria. Many cases not meeting criteria have been removed from register.	Register Custodian employed by S.S. runs reg. in Health Authority premises.	Monitor forms sent to key workers via Area Directors who decide for themselves the degree of supervision which they will exercise.	Part of normal S.W. supervision undertaken by senior SW's as Team Leaders.	Formal so far as they comply with inter disc. CA procedures but informal at officer level.		Area Director but actual work usually undertaken by S.W. assisted by clerical staff.	All having some knowledge of family or likely to be involved in the future. Includes all S.W.'s	Area Director.	Only if carefully planned an tightly controlled ensure appropriate mem ship. Full but speedy input and agenda agre in advance. Good chairm ship is vit without it C.C.'s use less and e dangerous.

Authority Number	Question numbers (including parts of questions)														
	2	3	6	7	9	15	16	17	18	21 (c)	23	26	27	28	29
33.	Copies of guidelines to all social work staff.	a) Ctte rept. guidelines to each member. Copies in members library. b) Dept. proc. manual memoranda/meetings guidelines booklet. c) Dept proc. Min. guide ticket forms, checklist. d) Dept P. Min G. ticket forms checklist interdisc training.				Increased awareness. Lack of de-reg procedures. (recently intro.) Social conditions (unemployment)	NSPCC special unit P.O. child abuse.	Overall respons. review procedure filling in monitoring forms.	P.O. (child abuse) Team leaders NSPCC special unit and area officers.	NSPCC special unit. Custodian of the register and administers the monitoring procedures.		Area Social Services Officer.	S.S. Health Police G.P.'s Hospital Solicitor (county) Schools services, If appropriate, Probation, Education, Welfare nurseries etc.	Team leaders and Area Social Services officers.	Importance exchange o info. facts initial discussion shared wit all agenci vital. However treatment decision should be made in th Team invol with treat ment.
37.		a) Explanatory b) c) booklet. d)			indefinite but renewable	Increased awareness, adverse publicity protection offered by registration better liaison with other agencies.	Principal Officer (Child Care).	Mandatory occasionally 3 monthly. Always 6 monthly.	Area Officer	Close liaison links at field level formally through case conference.		Area Officer	S.S. NSPCC Police Health Ed. G.P. H.V D.N. Probation.	Area Officer.	C.C.'s are not conven to make decisions f statutory agencies b to recomm action, sha and collect info. C.C.'s aim ensure that agencies ac together no 'think alik

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21c	23	26	27	28	29
38.	Regular + formulated reviews of existing cases	(a) Reports/ agenda items (b) Membership (c) of ARC (d) Procedures Manual Training Memoranda Supervision etc.		Assistant Directors	Child Abuse unit its work + procedures developed are reviewed at least annually by ARC.	Increase awareness of procedures + perhaps a real increase in the incidence of CA related to social stress	(a) Principal SW officer. (b) Case work consultant	Area officers responsible for categories "emotional abuse" "FII" "Neglect"	Carework Consultant	NSPCC on ARC invited to CC's where appropriate. consulted re: all new referrals + encouraged to co-operate + liase at officer level.	(a) P.S.W. officer casework consult 5 senior SW's 1 SW 1 SWA + clerical support (b) Principal SW officer	Casework Consult. + Prin. SW officer	SS, Health, GP, police, Ed, Legal.	P.S.W. officer or Case work Consultant	The CC ensures that all relevan info is col lated and that future mgt of the case is properly co ordinated.
39.	ARC handbook of CA procedures.	(a) (b) (c) (d)			Continuous review	Criteria for Reg. amended April 83. In accord with DHSS guidelines.	Area managers through reviews and case conferences (as 16)	Area Managers SSW's.	Formal/Informal case discussions of attendance at CC's members of ARC			Area manager	SSD, NSPCC, DHA, police, G.P. Educat probation solicitor	SSD principal assistant operational services.	Essential t share info agree an approp. pla to protect the child + families in terests. Al though stat utory DH is duty of LA, this almost always fol lows an agr eed plan by conference.
40.	Via Senior Assistant CA - consultation etc.	(a) Cttee. Report if requested. (b) Child abuse proc. Bklet. (c) As above (d) As above	Still under discussion	Yet to be decided but will probably be a variety of senior personnel.			Senior assistant (child abuse)	None Specifically to ensure, ultmately that the review forms are completed by SW's in their area	Team leaders Area officers	NSPCC small team + student unit in this area + participate totally in locally agreed procedures		Social worker /admin at request of chairman.	SS, DHA, Ed. Police + any one else involved in the case	Area SS officer always or Deputy area social services officer	CC is the only way to share info but those attending should have a contribution to make otherwise should consider not attending.

Authority numbers	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21c	23	26	27	28	29
44.	Separate procedure + practice manual	(a) Rpts. to cttee. (b) Thro' manual/agt meetings. (c) as (b) (d) as (b)				Change in criteria led to more neglect cases but improved reviewing has lowered numbers on register	Quarterly figs currently produced by reg. keeper (GENERAL SERVICES MGR) annual Rpt by research officer.	NiL. proposals have been made to decentralise the register to divisions with a copy at HQ.	Supervision of SW's involved in cases (two PSW's) + through review mechanisms of CC could be Div. Director. Princ. area officer or Area officer	NSPCC Only investigate referrals to them.		Inital Conf. Div Direct or P. Area officer. Review Conf Div Direct Princ. Area off. or Area officer.	SS. Health, Ed. Police, etc etc as appropriate.	Convenor (See 26)	Time consuming but ensures that max amount of info. on which to make decision is available.
47.	Personnel contact case conferences. Case discussions	(a) Not communicated. (b) (c) (d)					Principal officer grade 1 from SSD	Delegated through assistant Director + team leaders subsidary role to HQ staff	Area management	Established with NSPCC + Area Health & child care centre ie. Special unit		Team leaders	NSPCC. HV. police, teachers. probation officers.	Team leaders or clinical medical officers.	No other format gets so many people to share so effectively these are life and death decisions.

Authority Number	Question numbers (including parts of questions)														
	2	3	6	7	9	15	16	17	18	21(c)	23	26	27	28	29
49.	Handbook of inter agency procedures drawn up by ARC.	(a) Reported to Committee. (b) All have (c) personal (d) copy of guidelines				Growth of awareness of CA. Formation of District review cttees. New phenomenon of child sexual abuse.	1) Principal admin officer 2) principal assistant for child care.	6 monthly reviews. Agree all admissions register.	Team leader under oversight of Area. manager.	Required to operate the citys agreed child abuse procedures.		Team leader supervising key worker.	Any agencies involved with child (health G.P.E.d probation service + police.	Team leader in complex cases either Area Manager or Group leader.	But danger putting off decisions constantly reviewing sase.
52.		(a) Copies of manual provided. (b) Via manual and initial party. (c) as (b) above. (d) as (b) above plus in service study periods and memoranda.		Assistant Director Fieldwork		New procedures have professional approach Enhanced liason. Closer co-operation between agencies.	Social work consultant (child abuse) and custodian of the register (one person)	none	Assistant director field work through area managers. (Team leaders in this authority).	Good local liason although in last year NSPCC gradually withdrawing from Caseseg due to good SS cover.		The Area Manager (team leader in this LA) or his deputy only if he is unavoidably absent.	S.S. Health (NDHM) Police education G.P. Consultant (Medical).	The area manager or his deputy only if he is unavoidably absent.	CC's can be and mostly are effecti However the issue of ac ually making decisions a opposed to recommendat ons is not always best achieved in this form. Cost effect veness is n a serious consideratio as it may b very difficu lt to prove.

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21 (c)	23	26	27	28	29
53.		(a) Handbooks distributed to cttee membership. (b) Same. (c) Same. (d) Distributor of handbooks and In service training.	And subject to a formal submission to a professional panel	Panel headed by Deputy Director of S.S. Rep of Personnel officer and area officer	But subject to improvement/review in the light of experience.	Probably linked to the many uncertainties + stresses in society today.	NSPCC	None	SSW's. Case conferences District Review committees.	NSPCC manage register run a special family unit in Calderdale with attachment of 2 SW's who carry a limited case load work intensively with families & attend all case conferences. Promotion of discussion opportunities of training in CA + offer a consultative service.		Area social services officer.	All agencies who can provide information about child + family + who have professional responsibility for the safety of the child and for providing services	Area social services officers.	I do not know if any other method if C/A is to be subject to a multi disciplinary approach – which is the policy of this authority.
55.	Inter agency meetings, items on MGI meetings various levels personal discussions by P.O. (C.A.)	(a) cttee has considered reports but this hardly covers areas of guide lines. (b) Writing, discussion, training. Case following. (c) as (b) (d) as (b)		Divisional Officers.	none	Improved identification in various agencies.	Principal officer child abuse. Register Administrator.	In case conference leadership.	6 monthly case conference is the minimum.	Cttee + sub cttee Inspector is worked with as appropriate some contact with regional officer & special unit.	(a) SS.P.O. (C.A.) Register admin. clerical officers (b) P.O. field work legal director.	Child abuse team if not done by Divisional staff.	Always SS.H. Police usually Ed. + Probation.	Initial Divisional officer review Area officer or P.O. (CA)	The CC is necessary for passing information and agreeing action some agency decisions are not always best taken at conference

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21 c	23	26	27	28	29
56.	Child abuse proceed G's circulated to SS staff + key personnel of the agency eg Doc's. Headmasters, HV's probation officers etc.	(a) C.A. Pro G's provided for all members of SS cttee. (b) CA Pro.G's for all senior MGT. (c) as (b) (d) as (b) (e) CA Pro.G's for all ARC mbs.			Initial G's + Central reg. est. in 1976. First handbook produced in 1978. Updated in 1983. (C.A. Procedural Guide).	Notification and identification more sophisticated.	Principal SW (children)	Area mgrs have respons. in absense of principals worker (children)	The key worker nominated by initial conference normally level III S Worker.	1) NSPCC records checked on referral. 2) Invited to all CC's and reviews. 3) Represented on ARC.		District Team Managers.	SS. Probation, Health, NSPCC Education, Police.	Initial CC Area managers. Review Team managers.	A mult disciplinary approach is inevitably c tly, but c sidered to the most e ective way dealing wi child abus
58.	Procedures manual prepared by ARC.	(a) Copies of the area review proced. manual. (b) as (a) (c) as (a) (d) as (a)				Changing policies re - registration and de registration.	Field work manager (children + families.	Chairman of CC's that make recommendations on the placement or removal of names of children from the register	Senior workers SSW's Area Mgt + fieldwork mgt (children + families)			Area Team Manager	N.SS. Ed Police probation + any other relevant agency.	Area Team Manager	It depends how they a conducted at what st
59.		(a) Cttee Report. b) c) Memoranda d)				1) New referrals 2) No policy for deregistration until mid 82.	Field work manager + professional assistant.	Area Coordinators. 1) Chairing CC + review conferences. 2) Monitor statutory reviews.	1) Team leader or supervising officer in Team. 2) F.W. manager + assistant.			Area Coordinator.	All statutory agencies in the area.	Area Co-ordinator like an area officer).	No research on this iss

Authority Number	Question numbers (including parts of questions)														
	2	3	6	7	9	15	16	17	18	21(c)	2	3	6	7	9
60.		(a) Occasional rpting on activities of ARC's work. (b) Discussion at Area Managers meetings/ memoranda. (c) Guidelines discussed at Team leaders meetings + with individual teams. (d) All have copies of G's semina 2 x p.a Co-ord attends team meetings to reinforce procedure.			2 yrs setting up registration /monitoring system/ reviews through area multi-agency committees.	Increased awareness of agencies and general public, earlier referrals + cooperation between agencies including police.	Co ordinater CA register	Through the Divisional Review system, registered children in their area. Computer system enables quick access to names.	(a) Team leaders through supervision. (b) Divisional reviews, sits on Area review cttee offers facilities for parents + children Participate in joint training.	NSPCC special unit attends all child care + divisional reviews, sits on area review cttee offers facilities for parents + children. Participate in joint training.		Area Managers	SS. NFUC Health Fd. Probation (if known) Police HIS (if known) Housing (if known)	Area Managers	Nb It would be more eco critical if o ly one or t persons wer involved bu not conduci to interage cy working nor for coll ating all t info. requir on which to bee decisio making.

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21(c)	23	26	27	28	29
62.	Published Guidelines	(a) Cttee Rpts commenting on and attaching DHSS circulars G's contained in info pack given to all members. (b) Have sight of our own. (c) Copies of the above. (d) Own copy of published guidelines.			The Child abuse Policy Cttee meets Quarterly		The NSPCC special Unit monitors the NAI register on behalf of the child abuse policy cttee.	As 16	Children not reg. because they are at risk. Cttee records those injured or suspected of having been injured not those at risk. See 16.	NSPCC Special unit entirely funded by Manchester SS cttee. The unit services the CA policy cttee convenor + chairs case conferences, maintains NAI register		See 21	Member agencies of the CA policy cttee SS.Ed. Health, police.	NSPCC Special unit	
63.	Regular Annual prog. of training for Supervisors As well as practitioners.	(a) Report (b) Training + Manual. (c) Training + Manual. (d) Training + Manual.			It is reviewed constantly by ARC of multidisciplinary Group.	Until recently we had no acceptable system for removing children from the register.	Run by NSPCC Paid for by SSD monitored by multi disc group under the ARC.	Only through the mechanism in 16.	Senior social worker.	NSPCC set up special unit at our request this is 100% paid for by US organises register, reviews, services CCs Provides special advice some casework, from Central soueces provides help in training.		Area Director	All Required SSD. Health. Police. Probation. Education. Legal	Always Area Director or Deputy.	
65.		(a) Cttee Reports. (b) procedures /involved in drawing them up. (c) Meetings/ training/ procedures. (d) Meetings/ training/ procedures.		Senior Assistant Director	Child abuse is a S W problem don't quite see how we can have an operational plan.		Principal SW Child Care.	Involved in monitoring panel + also Have to chair CC's	Team Leaders	An NSPCC Inspector does some work in the Authority. We use their expertise for advice of needed. (From MGI. special unit).		Area Manager	All interested parties but, police/ Health professions invited routinely.	Area Manager and Principal SW (child care) on rare occasions.	It ensures communicatio between ager cies, ensure treatment plan, + ther efore, avoids a lot of ti spent on interagency squabbles should be applied to situations Such as the

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21(c)	23	26	27	28	29
68.		(a) Cttee reports (b) Dept. Procedures/ Manual + attendance at meetings. (c) as (b) (d) as (b)				Now greater turnover on Register work is now much more focused children de-registered if not thought to be at any risk	P O Child abuse.	They are required to counter sign reviews of children placed on Register.	P O child abuse	Vey little contact		PO Child abuse	SSD.Police. HV.EDWO. head teacher LA solicitor, Hospital Dr. 'GP always invited where applic. (GP's rarely attend).	PO (Child Abuse)	Are CC's da bodies? It has been suggested that the CC is a consultative forum not taking decisions but making recommendations (EG police decision to prosecute) Success depends on good chairmanship. Many are allowed to go on far too long.
71.		(a) Cttee report. (b) Memoranda-Senior Review cttee guidance Booklet. (c) as (b) (d) as (c)			The plan is put into affect with no time limit to apply (See copy of operational plan).		SRC Chaired by Ass. Director field services. Is serviced by PO (child care).	Area managers through their nominated reps. periodically review the At Risk Reg. with the PO child care.	The Area Officer (eg which there are 6)	Members of the SRC + the ARC regularly meet with the NSPCC. Referrals are often made by NSPCC to Dept.		Area officer.	SS HV's GP's police probation Education. School, Med. officer other pertinent persons.	Area officer	The Area Officer is the da. The conference advises him. Bringing together all those concerned and within 24 hrs enables an effective decision to be made on what action should be taken and by whom.
72.		(a) Report. (b) Consultation in formulation of guidelines. (c) Ditto - plus circulation of finalized version of G's. (d) Circulation + reaffir-			Non-specific subject to continual update.	Changes in Policy tightening of policy for registration. Children can only be registered as result of Case Conference Recommendation.	The Central Register for CA is main tained by the District Health Authority.	None	Team leaders on day to day basis + 4 monthly reviews are sent to workers from the Central Register.	Work of Respective agencies does sometimes overlap and is complementary. But there is no formalized work sharing with NSPCC.		Social workers (usually the key worker) often medical SW's sometimes team leaders, sometimes the child care co ordinator.	Hosp. field SW, HV.. schoolstaff Police. NSPCC + FSU (where app.) SS count officer child care co ord. etc.	Divisional officer (Area manager) or team leader.	Obviously the most cost effective method is for individual SW's to take decisions in consultation with their Team Leader. However given CA is a multi disc affair

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21 (c)	23	26	27	28	29
72 (cont)		-nation through in service training													DHSS stipu tions gove ing Case C format. It difficult see how da process ca be made mo cost effective.
73.		(a) as in Q.2 all methods used.					Area officer (Child abuse prevention)	Accountabil- ity for all work carried out by SW's Usual moni- toring through supervision.	Both Area officer (child abuse protection through CC's + Area off- icer respon- sible for specific SW.			Area Officer (child abuse prevention).	SSD, AHA. police, ED, NSPCC Probation GP's schools	Area officer CA Prevent- ion.	Efficient u of a confer ence enable sensible pl nning invol ed. Prevent many proble caused by lack of com unications. CC's need n be a time co nsuming acti vity.

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21c	23	26	27	28	29
78.	Staff supervision	(a) Report to committee. b) All have c) copies of d) procedural guidelines				More Considered use of the register + clearer criteria have tended to offset the increase in referrals which may have been caused by the General increase in stress/unemployment + increased use of the procedural guide.	Specialist officer (Child abuse)	None	Area managers and assistant Area Managers	Invited to all conferences and reviews - they come if family is known to them.		Specialist officer	Probation NSPCC (see 21) Health. Police, SDD. Ed. GP's invited but seldom attend.	Specialist officer	Not for decision making as that is SS, responsibility. Best format for sharing info if chaired properly.
79.		(a) Discussion related to procedures manual. (b) as (a) (c) In service training. (d) In service training.			Planning le de regestration by constant 3 monthly assessment + review.	The overall numbers not changed much there has been movement. Quite a number of children have been removed and new cases added. Reflects contain population movements.	Principal fieldwork officer special services.	Undertake regular 3 month reviews of all cases.	Area/Hospital SS + deputies.	NSPCC have representation on review panels + may also undertake work with SSD colleagues.		Area/or hospital, SS. officer or PO special services officer. training. (d) In service training.	SS. Health (Probation NSPCC. EWO. if involved) and legal rep. as occasion demands.	PO special services. Hosp. or/ Area . services officer.	For some time new all agencies have agreed to ½ day each. Set aside for CC's previews Covering a certain geographical patch.
80.		(a) Each member received copy of document. (b) Ditto plus inservice training. (c) as above (d) as above		+ Deputy Director		-Change in CA procedures -Greater awareness on the part of all professional staff	Child care advisor	None	The Area Review panel	formal at quartley review panel + ½ year review committee. Informal at CC's discussions.		Key worker via assistant Director (b) Ditto plus inservice training. (c) as above (d) as above	Police probation, NSPCC. Health Education, Legal Dept. Hospital staff/GP's	Assistant Director	It is not constrained by scarce Dept. resources

Authority Number	Question numbers (including parts of questions)														
	2	3	6	7	9	15	16	17	18	21c	23	26	27	28	29
82.	All relevant SS. staff are issued with ARC Booklet "Alerting Procedures in the Mgt. of cases of suspected or confirmed Child abuse."	(a) Verbal + written reports. (b) Deputy Director is a member of ARC (c) Area officers meeting (d) By team leaders/in service training carried out by ARC. Child Abuse training officer who also carries out multi-disc training for agencies represented on ARC.		P O. child + family services together with area manager.	Under continual review and modification.	Major review of Register undertaken late 1970 + a more specialist approach to CA -Intro of special child care team. All cases subject to case conference. -Review of reg. to (1980) ensure reg. was a "meaningful tool" -Review system	Senior officer (Special child care team)	Area mgt. are resp. for oversight of 6 monthly CA reviews within their Area. This also applies where in a few cases the key worker is other than SSD worker.	The key worker in conjunction with their appropriate mgt usually the Team Leader.	Only minimal contact in cases of mutual involvement, and minimal allowance at ARC.	(a) special child care team. One team leader, 4 level 3 SW's. (b) PO (child + family services). to assistant director. (Child + family services)	Area Manager	SSD. Health. Ed, Dept. Police/ Probation	LA. Policy that area officers chair CC's	The CC ensures an effective method of resource development, access to all agencies and ensures that duplication of effort is avoided.

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21c	23	26	27	28	29
84.		(a) If relevant in cttee rpts. (b) Discussion /manuals/in service training. (c) as (b) (d) as (b)				Very few in the city of London and its comparatively small residential population.	Joint register with Hackney SS. where the NSPCC carry it out on behalf of the borough	Maintain liason with the London Borough of Hackney	Social Workers SSW's + Group Principal	NSPCC have a special unit in Hackney and there is close liason		Group principal	This varies depends on Case and situation	Group principal (eg Hospital or community)	This is difficult to answer as the purpose of CC's is necessarily the most cost effective way, but useful on that the agencies concerned meet. A CC does not necessarily make decisions but makes recommendations. The decisions have to be made by the SSD.
86.		(a) By rpt. + issues of copies of G's. (b) as in Q2 (c) as in Q2 (d) as in Q2	Managers have organisation/decision responsibility. All SW's are qualified.		It is constantly updated through constant updating of guidelines. A sub group ARC undertake this responsibility on an ongoing basis.	All professionals concerned have become more prepared to take risks	The Barnet District Health Authority	They must review all cases on the Register every 6 months + chair all reviews and case conferences	The SW's superviser + the principal management officer/family care oversees all CC's "review records."	Give NSPCC an annual grant + they supervise approx 20 cases a year for us. But they are reviewed within departmental procedures every 6 months.		Area managers or Principal Social workers in the hospitals	Police, Area Specialist Child Health SNO. HV. GP. NSPCC (if app.) Area mgt. or PSW. Hosp. SSW + SNR. Hospital Consultants and DRs, as appropriate	Area Manager in Area less PSW Hospital or Paediatric register	Ultimate decision is that of LA staff, with Staff. Resp CC can only recommend a possible outcome, action or decision that ought to be taken This includes Recom. only to remove. Sub group ARC makes decision re-removal. (includes membership to ARC sub group).

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21c	23	26	27	28	29
87.		(a) Rpts.to cttee + manual to interested members. (b) In service training + procedures manual. (c) as (b) (d) as (b)	Only level II and above deal with Child Care Cases.		Continous review at quarterly ARC meetings	Increased awareness by professionals. Co- professionals.	Central Child abuse service	Co equal with head of Central Child Abuse Service.	Team leader		(a) SSW (Soon to be team leader. (b) Assistant chief SW services officer	Central NAI service	All concerned.	Team leader soon to be Head of Central Service	Because it ensures th info from all who kn the child/ family is available the decisi maker
88.		(a) Cttee reports + copy of procedures. (b) as (a) (c) as (a) + decisions + memos. (d) as (c) + training.			In process of redefining all client strategies.	Professional assessment procedures improved. Better understanding between agencies of what constitutes child abuse.	Area managers for own cases with support + oversight from the custodian.	as 16	area managers	Efforts are being made to standardize procedures between agencies		Area Manager	Medical (H. GP. HV) Ed. Policy + any other agency relevant SS staff as appropriate.	Area manager Senior SW	So long as the CC is well minuted
89.	Copy to each SSW. PO. + generally available to others.	(a) Copy in members Rm. (b) Copy of G's Rep on ARC (c) Copy of G's. (d) Via managers/G's clear procedures that carry them along.			G's currently being rewritten ARC task	Realistic vigitance & & intervention	ARC secretary maintains the register.	They monitor the cases + procedural correctness in their geographical areas.	SSW's resp. to principal area officers. ARC monitors correct procedures.	NSPCC District officer sits on ARC Officers work together on some cases.		Relevant Area SSW.	SS (Chair) Medical. Nursing Police Rep from originating agency relevant SS staff as appropriate	Senior SW's	Because of Gestalt ef ect of mul disciplina discussion task setti and review
92.		(a) Cttee. reports (b) as in Q2 (c) same (d) same				-Greater publicity leading to more referrals. -Econ.stress putting pressure on families.	A standing officer panel	Representative on panel. Monitoring individual cases.	Officer panel	NSPCC Refer cases to panel + act as key workers, where appropriate. No joint ventures or special schemes.		Child abuse case conference clerk	Police, Health.SS, solicitor - always NSPCC /Ed/Housing as appropriate.	To date assistant Director SS (field) From 1-8-83 a specified Area Officer with assistant as substitute.	Standing c nferences held 2 x w ek. Planni easier + r ducing was age of tim

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21c	23	26	27	28	29
93.	Discussions at mgt. meetings	(a) Copies made available to them. Cttee rpt. when booklet published. (b) General distribution. (c) as (b) (d) Personally address guideline memoranda to all workers + copy of bklt issued to all staff.		Appointment by interview with assistant director	Not time limited there is an expected performance prog. but not a plan.		Fieldwork services officer. Post about to be withdrawn from the structure.	They monitor the work done with the cases + submit reports to centre.	Area reviews work with the families the operation of Review System monitored from HQ.			Area manager convenes all conferences held in the borough	All (in booklet)	Area Manager	Question inappropriately slap CC's only make recommendations. They are investeen in good agency co which can not be co evaluated The most st effect response CA may wel be to ign it.
94.		(a) Contact with senior affairs + ARC procedures guide. (b) POs group /ARC. G's (c) Area mgt/ team leaders group/ARCG's d) Team meetings with Assistant Director.			Not time limited		Child abuse co-ordinator	None	P A children (Fieldwork)	NSPCC Special unit. -NSPCC in borough of Haringey.		Team leader	Health.Ed. SS. (NSPCC) probation police if appropriate	Area managers	It is diff cult to envisage an alterna tive multi disc forum for the purposes o decision making.
97.		(a) Distribution of handbook. (b) as (a) (c) as (a) + in service training + memo recharges (d) as (a) + inservice training + memo recharges				-tightening up of procedures. -increased awareness through training. -Economic Social factors high proportion - unemployed, ethnic minorities groups, Poor Housing. One parent families.	Principal assistant children (field work)	none	PA children (Field work)	NSPCC special unit funding via LB to finance unit. -Consultant -Support/training Formal PA Child/Unit leader Informal PA Child & unit leader	-NSPCC Special unit. -NSPCC in Borough of Harin-gly.	All agencies rep. on ARC can convene CA CC's but register administrator has specific written responsibility for convening if required.	SS, Health, Police, NSPCC Education when appropriate.	PA children (Fieldwork) NSPCC special Unit leader. Area officers (6).	If efficie tly chaire with clear statements about pur pose of Conference If numbers are limite to these able to co tribute to the facts the assess ment of ri

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21c	23	26	27	28	29
99.	Study days on CA. 6 monthly all participating agencies invited.	(a) (b) Via ARC guidelines + Depart. policy (c) Monthly meetings - changes discussed. (d) Each SW. has a procedures manual		-Senior Assistant Director -Director	Continuous abuse Policy sub cttee of ARC meets regularly	There ware variations caused by change in methods rather than referrals.	Senior Assistant Director	3 + 6 monthly reviews of families on the register	Fieldwork Supervisors and Area managers	Only very small prop. dealt with by NSPCC 3-5 p.a. - who report to Area managers (who chair all CC's) on forms provided		Area managers	Police HV. GP SNO. area advise child health. probation, Courts officer others as required.	Area managers	All internal decisions are made by the first case conference and communications are set up for each case and agreed.
102.		(a) Cttee report. b) manuals c) ARC work- d) ing parties training.					Specialist Senior Social worker.	They are responsible to the Case management team	Senior Social Worker			Area team leader	Police. Health. Ed. SS + Vol. agencies + FSU.	Area team leader	Yes Providing they are economically chaired + managerial
107.		(a) (b) This discussion of G's (c) as (b) (d) as (b)			Regular 6 monthly review system.		Custodian of the register ie. assistant director	Area Managers are responsible for reviewing their area cases regularly	Assistant Director Fieldwork	Both NSPCC attend ARC. Also have strong informal links with area offices		Area managers	SS Health. Ed. Vol. agencies Police as relevant	Area managers	
109.	a) Handout procedures to all officers at yearly CA conferences. b) ARC minutes c) Attendance of area officers at Area Review Meetings.	(a) ARC procedures manual deposited in cttee rm. + ctt. reports. b) as 2 ABC c) As (2A) + memoranda + direction of Area officers d) as (c) above.				Figures remain stable allowing for additions + removal from Register. But a few large families with subject on 'A' reg. + 3-5 siblings on 'B' reg. could account for the increase	Principal fieldwork officer social services.	Area officers are responsible for monitoring the cases held by their team.	Each area officer and his senior social workers	NSPCC group manager is ARC monitor. NSPCC officers attend CC's plus informal liason as + when.		Area officer /his administration	SS. Ed. community Health GP. Hospital (inc. SW. paed Nursing staff) Police. NSPCC - other - probation	Area officers or consultant Paediatrician in hospital.	Not necessarily Cost effective, but ensures multi disc. Decision making and shared knowledge in an attempt to reduce or prevent abuse

Authority Number	Question numbers (including parts of questions) 2	3	6	7	9	15	16	17	18	21c	23	26	27	28	29
110.		(a) by rpt + presentation of Multi-disc. procedures booklet. (b) as in Q2 (c) as in Q2 (d) as in Q2	Only SW on SW level III carry CA cases.		Whilst family on register + for 2 yrs after removal	Increased awareness of factors contributing to child abuse by professionals and public.	Assistant Director (Childrens services)	They chair all CC's and ensure all families on 'At Risk' reg are visited regularly.	-Area Controller or Senior S.W. (Team leader). -Assistant Director Childrens Services	On Practitioner level ter + for the collaborator is S.W. or Senior to Inspector. Area manager of NSPCC is member of ARC.		Area Controller (from 1.8.83.) It will be Principal SW (Children)	NSPCC Ed. GP. HV. Dr. (Comm) Juvenile Bureau. Probation. Always invited - others as required	Area Controller now Principal Social worker (Childrens)	Ihe answer is yes whi there is t need for multi dis-ciplinary consultati
114.		(a) info reports. b) handbook c) handbook d) handbook					Substantial review of names on register.	Principal officer	Local oversight	Case Conference.		Area manager (usually)	SS Comm. Health. NSPCC Police. Ed.	Area manager of principal officer	Not cost effective but certai ly most effective.

Section 2. Questions 30 - 42

SECTION 2: INQUIRIES INTO CHILD ABUSE

This section deals with the impact that inquiries/investigations into Child Abuse have had on Social Services Departments.

Four types of inquiry/investigation have been listed - these are as follows:-

Public Inquiry	(Statutory, adhoc, ordered by a Minister)
Formal Inquiry	(Non-statutory, adhoc, ordered by a Local Authority)
Inter-Agency Inquiry	(Set up by different statutory bodies)
Internal Investigations	(Less formal internal administration investigation by an authority)

30. What purposes do you consider Public Inquiries serve?

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31. Do you consider that a Public Inquiry is in a position to evaluate realistically the management function in Social Services Departments?

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32. Do you consider that the present method of conducting Public Inquiries into N.A.I. to children is appropriate?

YES ☐ (1) NO ☐ (0)

Please state briefly reasons for your answer.....

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33. (a) In light of the recommendations of Public Inquiry. Reports of the past 15 years, do you consider that these have led to a change in the management of Child Abuse cases across authorities?

YES ☐ (1) NO ☐ (0)

(b) Do you consider management efficiency has:

Increased	☐ (2)
Stayed much the same	☐ (3)
Decreased	☐ (4)

(c) Are there any other factors which you think are responsible for changes in management efficiency?
Please Specify.

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34. In your opinion do the findings of Public Inquiries directly influence future management strategies:

Very influential	☐ (1)
Influential	☐ (2)
Not very influential	☐ (3)

35. In the light of the findings of different types of Inquiry/investigation, please could you rank the following in terms of their practical use to your Department.

Public Inquiry	(1)
Formal Inquiry	(2)
Inter-Agency Inquiry	(3)
Internal Investigation	(4)

36. Has your Department been the subject of any of the following:-

Public Inquiry	(1)	Inter Agency Inquiries	(3)
Formal Inquiry	(2)	Internal Investigation	(4)

37. What period of time elapsed between the incident and the convening of the inquiry/investigation?

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38. What role, if any, did the Social Work Services Officers play in the period between the incident and convening of the Inquiry/Investigation?

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39. How long did the Inquiry/Investigation take?

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40. What do you identify as the main cost of the Inquiry/Investigation in terms of the Department's resources?

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41. Did the recommendations of the Inquiry/Investigation lead to a change in the management of Child Abuse Cases in your Department?

Substantial change	(1)
Minor change	(2)
No change	(3)

Please elaborate briefly on your answer .....

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42. In you opinion, what are the most cost-effective ways of inquiring into allegations of mismanagement of Child Abuse cases?

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Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
1.										
3.	Depends what terms of reference they are given (see DHSS study of Inquiry) Report HMSO 1982	Depends how constituted and managed.	Cannot answer yes or no it may be in some cases	The changes have been in relation to inter professional communications, collaboration (See Stevenson + Hallet 1980) There are some examples of good practice many still of bad but generally there has been an increased willingness to share infor Anxiety + moral panics can reduce efficiency.	Jan 78 - May 78	Supportive	27 days	Do not understand this question	Out of hours social workers receiving a referral thought to be for child abuse required to seek support and advice in dealing with case.	Probably internal enquiry linked with interagency enquiry possibly using external assessor
5.	Emphasis the public accountability of the agencies involved	1) Usually take place too long after the event. 2) They cannot avoid the invalid wisdom of hindsight 3) They tend to discount the other demands on management.	My understanding is that there have been few public enquiries ordered by the Minister and that the slanted press reporting is damaging irrespective of the formal recommendations.	Increased Managerial and Professional awareness. Better multi disciplinary communication and working. (33b) Increased in relation to CA but because of priority given to it, has diminished efficiency in other areas.	In two cases. well over a year.	Clarified issues and information for purposes of Ministerial response in Parliament and to advice Ministers/LA's on need for enquiry.	A week	Totally disabling to staff morale and functioning	The police are now automatically invited to all child abuse case conferences	If the matter relates to a Social Services Department an inquiry by the Social work Service (DHSS). If wider by the area review Committees.

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41(b)	42
6.	Where there has been a serious occurrence, giving rise to public anxiety it may have the effect of drawing attention to the need for better practices and of satisfying public concern	Too general a question. It depends on how it is constituted how competent its members are, and how it carries out its task	Impossible to answer. Some have been conducted appropriately. Some very ineptly and insensitively.	Increasing experience of practitioners/managers in the management of child abuse.	Internal investigation within 5 days followed by inter agency inquiry after 3 months	Attended key meeting of Central review cttee to advise on process but took no direct part in the investigation.	Internal investigation - 2 days Interagency Inquiry about - 10 days	Fee of external Chairman cost of producing Report staff time.	More attention given to preparation of cases for court several other small matters.	Internal procedures affecting those agencies directly involved but this may be insufficient to retain public confidence in cases where serious error is indicated or where media publicity has been extensive.
7.	Highlight common procedural problems short falls in provision of services, training and inter-agency communication that can be beneficial to other agencies	Difficult one! It is at least an objective attempt	Framework appears too legal Irresponsible press coverage. Agencies likely to be defensive		6 weeks	None	2 months	-time -Damaged professional relationships. -Possible inappropriate responses to House cases	Underlining of 1) Conferences convened under CA procedures. 2) Clear role for key worker	
8.	Public accountability of statutory agencies. The earlier inquiries helped with recognition of child abuse and influenced agency policy and practice.	No tend to concentrate on care + Supervision provided to the individual Child/family	1) Adversarial. 2) Affects agency morale and seeks scapegoats. 3) Individual case taken in isolation of other departmental work 4) Recommendations of earlier enquiries were significant but they can become	Liason with other agencies, Setting down of Social services and growth of experience and qualified Social workers						Inter agency Inquiry a small group representing relevant agencies called together without delay. Should also include a member from, the Welsh office Social work service, this is a Clywd ARC resolution

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41(b)	42
8. Cont.			repetitive and reach point of diminishing returns.							
13.	They meet a ritualistic need for scapegoating as a means of relieving corporate guilt, on a psychological level. This is not necessarily an unhealthy thing from a community point of view. Most of the actual findings however could be arrived at by their means.	No such an enquiry would have to go for outside its terms of reference to gain a realistic view of the conflicting stresses and demands on Social Services management	Too legalistic and pushes those involved into intrenched defensive stances whether or not they have anything to be defensive about, although some valuable recommendations have flowed from them.	Increasing familiarity with a threatening syndrome has decreased tension and increased objectivity Greater awareness of the roles needs of other agencies has created mutual inter disciplinary trust and formulation of valid joint management arrangements	More valid to look at the time elapsing between identification of the incident and the convening of the inquiry which was about 2-3 weeks.	None This was a multi agency inquiry commissioned by the ARC	Two meetings of an inter disciplinary group - about two weeks	Senior manpower time in arranging for the inquiry to be held, in providing evidence and interpretation and in attending the inquiry and circulating its findings then implementing these.	Inquiry findings revealed no short comings but some administrative errors and some ambiguity in inter agency instructions which were rewritten.	Referral to the ARc which should have powers delegated from member agency to commission an inquiry, call for evidence, examine the case and recomment, having recomment, having regard to the circumstances whether or not the results of the inquiry be published

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41(b)	42
14.	I do feel that they rather serve a constructive nor a professionally competent purpose. They apparently serve to satisfy the media rather than the needs of professionals.	No There are other issues, which override a fair and realistic assessment of both the management and caseworkers competence	The adversarial action of the proceedings tends to focus on individuals rather than the overall case management.	Greater awareness better diagnosis greater co-operation and increased research programmes	NO					An internal investigation both from a cost and professional view can produce the most thorough competent and effective means of inquiry
17.	Demonstrate formal concern and maxialize visibility of issue.	Limited the quasi judicial approach makes it more difficult but they could get closer by asking the right questions and evaluating evidence from that perspective. No published yet has got close to this issue.	But now they are counter productive. The initial impetus was important but there has been little of positive value since except to show how little impact they have perhaps		1. 1 year 2. 20 months Internal 3 months.	None	1. 3 months 2. 5 months Internal 3 weeks.	1. Staff - Paralysis caused by anxiety with significant effect upon working capability both in Volume + judgment. 2. Senior Management Significant diversion from routine duties 3. Time and Energy put into restoring normal working practices and relationship	Change in the Dept. is substantial, but enquiries are only part of the contribution to developing a total management strategy in child care their actual contribution is therefore minor.	By treating them as all other management issues and deploying normal regulatory management functions.
18.	To satisfy media type outrage and seek scapegoats to produce a report often the event that may lead to changes in practice.	No	Judicial type approach in conflict with objective professional approach Problems of "evidence"	Fear and thus defensive type approach more likely to be followed.	No					Having a system that avoids them using the ARC effectively.

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41(b)	42
20.	Highlight organisational and professional deficiences and ensure an open examination of problems and difficulties, within an accepted platform of Public accountability	Not always but provides an appropriate means whereby agencies can be critized and even pillowed for their deficiencies. Use of material by the mass media exaggerates and masks the fundamentals but does ensure that people know and can criticize what is going on.	There needs to be a format which is understood and appreciated by everyone involved or subject to the inquiry.	Sensitivity to "public" "opinion" i.e. tighten up and keep our fingers crossed that the same does not happen to us	No					Immediate and thorough examination by an experienced person(s) who have knowledge and understanding of child abuse - who is independent of all concerned agencies, and has sufficient status to present reports to all levels. Generally speaking we doubt whether there can ever be a cost - effective approach to the problem especially since inquiries have to serve a political as well as a professional function.
22.	1. Reassure public 2. Pillory Social Services Departments.	Not really because of the inherent subtleties of mgt EG the effects of cuts and service reductions are not always obvious. There are hidden costs.	See 31	Difficult to speak for other LA's but lge no. of Govt. circulars (if adhered to) should improve mgt efficiency if at the expense of other work	no					Internal inspection by out own staff with if required assistance from DHSS Social work officers

Authority Number	Question numbers (including parts of questions)									
	30	31	32b	33c	37	38	39	40	41(b)	42
24.	They are seen to be the most effective in serving the public interest.	Public Inquiries tend to be too legalistic in content.	Public inquiries tend to be conducted in an adversarial atmosphere	Each public Inq. report has made some positive recommendations.	4 months	None - although they were informed of the setting up of the investigation.	11 months to consider of the report by the SS cttee.	Time taken in carrying out investigation and compiling report.	Report of the Inquiry led to Departmental procedures manual being amended to accommodate greater involvement by senior Area + Divisional staff in treatment and care programmes, further developments of inservice training and appropriate offices being restructured.	An inter agency inquiry under the auspices of the Area Review Committee.

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
27.					No					No
28.	Mainly satisfy public ontary for a scapegoat.	No	There are usually conducted on adversarial lines so that concentration upon "blame" error etc evokes a defensive response rather than a willingness to evaluate practice.	33(a) Earlier over Maria Colwell did but not in past 5 yrs. (34) Influential much less so after recent inquiries most of the changes now having been made.	Inquiry 1 yr Our internal investigation commences as soon as death is reported follow by an inter agency meeting if necessary. Within about 1 month.	None	8 months to publication of report.		The only changes arising directly from the inquiry were a strengthening of staff appointment of PO with specialist knowledge and of Deputy Area Directors. There was a major reorganisation of the inter displinary procedures but this had commenced before the Inquiry.	Every agency should have a system of an ongoing education of work not only of child abuse work and special inquiries can be fitted into this monitoring (which has been recommended by the Barclay report) which is an essential part of the cost of a professional service. The cost in terms of the anxiety and distress to staff is minimized when the inquiry is part of this normal routine, and when staff are less defensive there is a better prospect of an inquiry being effective in improving practice.

Number	30	31	32b	33c	37	38	39	40	41b	42
33.	In cases where there is dispute between agencies over the facts of a case, or where there is very serious doubt of the service provision, a public Inquiry may establish the facts. Avoidance of cover up Public opinion needs to see 'justice' done (often unfortunately to lay blame).	Depends on its terms of reference	It is too legalistic interested more in blame than improvement The adversarial aspect is too strong	A determination by members of the SS cttee to adequately resource this area of work as a key priority of the council	No					Interagency Inquiry
37.	Mainly not much. Occasionally - good platform for debate and knowledge of work done by LA's in this area	No	Too "court like" invariably opportions blame emotive on the one point ryone involved or subject to the inquiry.	General awareness of wider problem. More pertinent research.	No					Panel of external social work experience in Local Authority SS and Child/Care/ Child abuse. Enquiry would be formal not public and report available to public.
38.	One would hope that they can highlight any difficiencies, either within agencies or within the wider "Welfare Services" structure, in terms of dealing effectively with child abuse.	That might depend very much on who is represented at such Inquiries with a brief to inquire retrospectively into cases, I wonder how much attention some bodies are willing/ able to take	Not having bad direct experience no comment to make.	-Increased awareness by all agencies -Media pressure. -Steady growth and maturity of Social Services organisations since Seebohm.	4 weeks 6 months	-Nil -Attended meetings of working groups	-one whole day + prep time - imposs to measure. -5 sessions - as above	Costs could be identified in teams of "manpower" hours, but also in terms of anxiety caused to those officers directly involved.	-Led to establishing Child abuse Unit. -modifications re info shared between SS + Local Health Authority	The most cost effective way must be to avoid the need for them in the first instance. Hence Shropshires decision to invest resources in Special unit and well

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
38. Cont		of other pressures and responsibilities faced by Social Services.								structured, well supported procedures. The one "formal inquiry" required since the establishment of the Special unit proved to be an effective means of review organised quickly and able to conclude its business in one day's meeting.
39.	Indicate a formal approach to highlighting deficiencies in organisational and agency structures.	No	As stated in 30.	A greater awareness of the need for sharing information and tasks. Clearly defined aims and contracts.	5 months	Very limited involvement but entered into some discussion phases	4 months	Staff involvement		Interagency Investigations.

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
40.	To examine the management of Child Abuse Case from which lessons may be learnt leading to improve managment.	It depends on who sits on the Inquiry and who is called to give evidence YES. If the right people assess.	They appear to be very formal, expensive and simple format might be more appropriate.	A greater general awareness of the problem & constant renewing of procedures.	1. A few weeks. 2. Almost immediately.	None	A few weeks.	Time/manpower	Improvement in recording /message taking in Child Abuse cases. procedures.	I would refer you to the BASW publication on Inquiries which contains many very sound suggestions.
44.	Identify errors of judgement and poor service.	No	In a quasi-judicial arena, in public, the majority of responses tend to be defensive.	Better Social work training more experienced managers.	No	None.				Inter-Agency Inquiry.
47.	To act as a watch dog. To establish and maintain standards. To enable legislation to be changed. To indicate adequacy of resources and responses.	This is dependent on the calibre of the enquirers and their Chairman In theory they are in such a position. In practice several enquiries have been disappointing in the calibre of their reporting.	They lower morale in Social and allied personal services in that they reveal fact but they do not bring in new resources IE sharp contrast the Nell Case 1946 & Maria Coldwell 1973.	Professional concern, training, development & experience	Less than 1 month.	None	Less than 1 month	Staff time is not used in a different way.	Related to care over their case conference notes their writing, their circulation of they way they were passed to the recipients.	1) Having good chairman - not necessarily if any profession in particular. 2) Having proper secretarial admin. back up. 3) Having parall member of Inter-agency & inter professional members consistent with their ability to handle the material received. 4) Membership to be as locally based as possible because of

Authority Number	Question numbers (including parts of questions)									
	30	31	32b	33c	37	38	39	40	41b	42
47 Cont										travel and other costs. 5) An attainable target - is no point in holding an inquest as such - a need to bring both a better standard of service. This is an impossible question to answer without having some terms of reference ie like an inquiry would need to have.

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
49.	Very limited, have served their purpose in danger of becoming repetitive. Why should there be enquiries at Great Debate, into child abuse deaths and not after deaths in the community or hospital. Such Enquiries may assist the Committees to confirm to the rate payers that they are in control.	Yes if sufficient time is devoted to the Inquiry and if people are prepared to cooperate.	See Q.30. Following the excellent DHSS review of Inquiries there is little else to be said.	1) Cttee statement that Child Abuse cases must have number 1 priority. 2) Training and refraining of SW's & Managers handling such cases.	1 year	None	1 month	1) Full time involvement of 1 senior officer to advise interpret to panel. 2) Preparation of evidence & major. 3) Attendance of witnesses.	This led to major review and formalizing of CA procedures. More into training.	Area Review Cttee enquiries. By Su Group of that cttee.
52.	To open up the crisis to public scrutiny and serve to correct any areas of professional mishandling for future cases. Can be Counter productive - highly stressful on staff.	Not always although some interesting findings have arisen from Public Inquiries.	Do not subscribe to legal/adversarial procedure. Believe less rigid format more appropriate and more likely to establish trust with individuals/groups.	Increased It has in many cases become more rigid and less flexible in social work terms. Many workers/managements have become frightend of a local situation.	No	Advisory	2 days in each case.	-Staff time and stress on individuals. -Most particularly those who felt themselves under investigation/ on trial." trust with individuals/ groups.	It is/was felt that the system adopted locally is efficient but can be "let down by individual officers." (a) Failing to comply with proceed (b) Being intimidated by clients. (c) Failing to apply professional judgements ie being "sucked in."	Internal Inquiry linked to an inter-agency inquiry possibly followed by a formal inquiry. These should be held as swiftly as possible and not be bound by the legal procedures of Public Inquiries.

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
53.	The findings are made known - by which method other bodies and organisations become aware of mistakes which were made and lessons learned.	I am not aware that any Public Inquiry has ever attempted to evaluate the management functions within a Department. However it may be possible for such an Inquiry to Maintain a more objective view than say a local enquiry.	No. Media interpretations are often erroneous & detract from the growth of professional expertise that is bringing greater preventive measures to Social work.	Increased Growth in numbers - Diversification on Review of monitoring systems as delegated by Area Review committees in conjunction with the NSPCC who hold the Register. a Wider publicity and availability of reading material for training purposes. Increase of resources into management of Child abuse. Stricter control through procedures.	No					Multi disciplinary enquiry under the aegis of ARC Committee Procedures
55.	Public Investigation Response to criticism or public anger. Show complication of inter agency and shortage of resources.	If conducted properly yes!	There does not seem to be a "method", they vary greatly.	The DHSS guidelines were expanded (perhaps because of Criticism of previous approaches)1	Various	None	weeks Inquiry to Maintain a more objective view than say a local enquiry.	Staff time measures to Social work.	The need for procedural guidelines amendments come from most reports	It depends on where this mismanagement occurs and why. If it is internal - so is the improvement If it is interagency so is the improvement If it is shortage of resources so is the improvement If the

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
55 Cont.										source is disputed or unknown, larger attempts to find it will be needed.
56.	Heighten awareness of child abuse. Highlights the need for ongoing review of Departmental procedures.	Consider that a public inquiry should evaluate any aspect relevant to the case including if appropriate the management function and procedures together with the resources available to agency or agencies concerned.	Do not feel in a position to comment.	Greater awareness of problems associated with Child Abuse.	No.					Unfortunately the most cost effective methods of enquiry into this area is internal inquiry is not necessarily the most professionally effective way of ensuring the safety of the child.

Number	30	31	32b	33c	37	38	39	40	41b	42
58.	To identify wether there has been any negligence or difficiency in service leading to the death of the child. To demonstrate Public Accountability			Increased knowledge and skills. Greater willingness for inter agency cooperation improved procedures.		None				Providing services to avoid the need for such inquiries.
59.										
60.	Reassurance concerning cover-ups or possible injustices, illustrates complexity of decisions and difficulty in preventing abuse; reminds public and local Govt officers of accountability	The Ministry should ensure that there is a member who has this ability. The problem is that Public Inquiry tend to become bogged down by the administration and process rather than interested in management function.	Too similar to a court learning, without the advantages. Emphasis on finding a guilty party	Publicity concerning abuse articles in professional journals Increase in complex legal issues DHSS recommendation on procedures and criteria	No					The question is not specific enough The Nature of the allegation and the circumstances of the case should determine the form of the inquiry. The only point I would make is that the earlier the investigation the more effective it is likely to be.
62.	The focus public attention upon aspects of the family likes of a section of the community. They illuminate such lives so clearly that I marvel	Not such. Enquiries have been constituted invariably they have been led by lawyers who themselves have a frightful track record.	They are not enquiries so much as Inquisitions The dominance of hindsight is palpable.							

Authority Number	Question Numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
62. Cont	at how little we have seen.									
63.	These questions are also unconsistent. They assume all inquiries so far conducted have a degree of consistency in their composition, objectives, organisation etc. They have not		Hundreds of things- -money resources increased. -Better training at all levels. -Fully qualified SW's. -Better understanding of other disciplines. To name a few more important than 33a.	See 32b	3 days	None	Approx week	Manpower 3 senior staff for one week		There is no answer to this question. It must depend on the type of problem its public visibility. -The effect on the child how the error (?) was committed & discovered the attitude of other disciplines the attitude of council members to professional competence.
65.	Can relieve pressure/anxiety when things have got out of hand.	No	It is usually adversarial without the rules of law. The Inquiries conclusions are often distorted by the media.	Social workers have learned that systems set up around Child abuse are not only supportive in that responsibility is seen to be shared but that systems can save time and effort.	It was in 1976 and the people involved in the investigation are not here to be asked.	None	A week roughly	Deputy Directors Time.	The procedures were well difined and it was their operation that was faulty so it led to training courses etc.	Internal examination with outside assessor.
68.	Satisfying the publics need for a thorough open investigation.	No		Greater knowledge and awareness of child abuse.	No					Form of inquiry recommendations in BASW report on child abuse enquiries.

Authority Number	Question numbers (including parts of questions)									
	30	31	32b	33c	37	38	39	40	41b	42
71.	There is a suggestion that Public Inquiries reinforce accountability but at the same time they raise public anxiety and distrust in Social workers generally. Capability is clearly shown to rest with the social worker and possibly the Senior worker.	No	There has to be a public debate which may need to discuss a under area than the specific inquiry SS Depts. need to develop their inter-relation-ships with their public.	Short term changes - which tend to fade away shortly after the Public Inquiry. The training and develop of individuals who are managers because they wish to be so, and not merely promoted Social workers.	No					Depends on the allegations and the case itself. There must be different levels of response from the day to day internal investigation of allegations made by neighbours, relatives other professionals etc. ((cont)...

Number	Question Number: 42			
71. Cont	where the alleged mismanagement has led to serious harm to the child (bodily or otherwise) These need to be fully investigated within the internal workings of the department and do need reporting upon to the Director. Ie where the alleged mismanagement follows a serious or fatal accident/injury to the child there does need to be some public accountability. Inquiries should be carried out quickly	by those competent to do so who understand the nature of the SW task, & can also analyse the mgt systems and org structure that surrounds key worker(s). No useful long term public interest as served by a long drawn out judicial type inquiry Constant monitoring of the service provided on the DD made on the organisation and of the available resources (manpower being a prime resource) needs	to be under taken so that explicit decisions regarding the levels of service to be given can be made. Constant interchange and feedback with the public through increased P.R. work is also vital when things go wrong if mismangt fatality the law should take its course. If not we should examine the reasons for the failure and respond accordingly, explaining the situation realistically to	those to whom we are accountable.

Number	30	31	32b	33c	37	38	39	40	41b	42
72.	They serve a PR function. They allow blame to be attributed without resources being given.	No	Adversarial nature of inquiries not helpful Great Stress on workers involved Internal observers and public findings better.	Pressures on team leaders Possible decrease in specialization.	No	PR function. They allow blame to be attributed without resources being given.				Internal investigation using skilled worker without mgt responsibility. As head person, external observer with Access to all papers & witnesses Reports polished (? in council papers without names. Better-Regular By skilled worker acting for Director/ cttee of random selection of NAI cases.
73.	Public Accountability but I do not consider it. achieves this.	No	I have no direct experience but impression is that they become quasi legal affairs.	I think your time limit is artificial. Enquiries over the last 10 yrs have considerably altered agencies response.	3 months	nil	2 weeks	Staff time		Formal independent inter-agency inquiry.
78.	Ritual Blood letting	No	Not cost effective	It is not so much public Inq perse, so much as the fear of such which has driven managers to	None	Only required to be kept informed.	3 months approx	Staff time, plus cost of retraining 2 ex members of staff.	The inquiry did not show the need for anything other than minor changes	Internal inquiries are cost effective for the individual Dept may not provide as wide a dissemination of information in

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
78. Cont				spend a disproportionate amount of time on the subject.						a public inquiry.
79.	Can raise much stress for those involved and much misunderstood for those not involved. IE. Press & General Public. However - may be able to offer a more objective scrutiny especially of senior management.	If well informed members should be able to grasp this issue but lack of experience may limit understanding.	The time scale is often very protracted and could be damaging to staff & clients. -May also affect the accuracy of the statement.	Stability in Social Services. The period 71-74 (Reorg) was fraught with change & a increase in CA - Over the last few years there has been more stability leading to more effective planning.	4 weeks	DHSS SWS - all LA officers - senior mgt - investigator mid mgt liason + support to staff insured.	2 months to prepare report	Manpower time.	Better formal communication arrangements between Health & social services.	Immediate inquiries by senior mgt of all agencies involved followed by if allegations are substantiated - a full report to constituent members + the DHSS SW Ads. Where there has been loss of life or serious injury - an independent Inq. along the lines of a public inquiry in the event of any agency involved being discontented about the outcome of the local enquiry.

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
80.	Appeasement	No	They are often far too detailed and I suspect practioners read them.	A willingness or otherwise of local agencies to work together on cases and collaborate in training progs. size of Authority Geog. proximity is lapatient. -personnel	No					Formal inquiry charged with providing an early report
82.	Little if the recommendations of such Inquiries are not enforceable by the Sec of state Many LA's agree to Inquiries merely to allow the public "blood-letting" but pay little heed to the structural implications of such findings.	No usually 1 member of the Inquiry team comes from a LASS background and the other 3 are unlikely to appreciate the problems of agency management, or indeed, have any direct experience of agency management.	The adversarial nature is unhelpful and main participants have little opportunity to amend or correct inaccuracies or misunderstandings.	-increased training opportunities. -More qualified personnel	3 years	marginal	2½ months	1. Human 2. Diversion of management time.	The most substantial change related not to the child abuse scene but in the overall mgt of the Department the then Director leaving as a consequence.	Internal confidential investigation, the fundings of which are scrutinized by DHSS officers if necessary.

Number, question number (including parts of question)

Number	30	31	32b	33c	37	38	39	40	41b	42
84.										
86.	Ensure that public sees justice being done and that improved practive may result.	If properly briefed yes.	If properly prepared and briefed.		No					
87.	Assuages or purports assuage public anxiety and recalls really valuable to the nove salacions of over national press.	No	As in 30	I do not believe that mgt inefficiency is the primary cause for child abuse	2 yrs	Unhelpful at time of incident. Interfering busy bodies after trial of mother + during. Displayed a profound lack of knowledge of post seeboha SSDs	34 days	Loss of morale work of officer there at all levels.	Most changes had taken place prior to Inquiry the only change post inquiry relates to Case conference nunites	The DHSS should have a panel of assessors chosen in turn a panel of Directors of SSD, lawyers with approp. experience Doctors services as required. This panel of assessors should have access to personnel + documents of all agencies involved. Having assessed the nature of the case the panel could advise the Minister as to whether an Inq. is necessary and if so what form it should take. The DHSS should bear all costs

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
88.	None other than to appease the public.	No an adversarial situation situation does not provide the best way forward.	as 30/31 .	Greater understanding interagency co op more experienced workers more overall experience in SSDs	2 months	Not known	5 months	I am told "time" taken in mgt preparing reports for DHSS	The procuedures + actions by persons in the Dept was not critized	Interagency sensitive/ objective senior mgt.
89.	Some people may be led to believe that "Something is being done officially."	No	The status of enquiries so far has not been clear the method has produced too many words at too much cost.	DHSS guide lines Personal Interest of Director of SS.	No				Regular ARC monitoring of how the Guidelines are followed in practice. ARC members being seen to require the best poss practice in their own depts. /agencies Reports to ARC demonstrating that sensitive and sensible DH takes place. A multi agency procedure that expects cases to progress towards better care of the child, to involve parent in this so the names no longer need to be on the register. These procedures should normally preclude the need for	No

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
									formal inquiries. If a formal inquiry were need, the Director of SSD as chairman of the ARC would meet the vice chairman (health specialist in comm. medicine) and choose a working party of ARC members who would deal with the matter.	
92.	To solve consciences and seek scapegoats	No	Everybody is forced to be defensive rather than to help seek the essential truths.	In this authority a general attempt to provide a better professional service	No					Senior professionals from another area, trusted by staff inquiring immediately and informally at request of Departmental mgt and working confidentially to Departmental mgt

Authority Number	Question numbers (including parts of questions) 30	31	32(b)	33c	37	38	39	40	41b	42
93.	Appease public and ease political anxiety	It could do but it doesn't generally do so	It forces all individuals into defensive postures and therefore examines statement rather than unearthing facts.	See Q 33 Growing conviction of Managers that procedures are reliable and worthwhile and therefore increased commitment to them.	No					Single reputable investigator to enquire into and produce an account of action in relation to the case, all witnesses assured of non publication and non victimization.
94.	May influence a change in legislation recommend practice/Procedural improvements (not always implemented by LAS by society) (through the media) assured that workers are accountable + blame apportioned.	No members of panel usually represent several disciplines, it is questionable whether they can understand the particular complex ties of SS mgt.	The cost in terms of money stress + low morale is disproportionate to the value of resulting recommendations which are not always implemented as the decision is left to the discretion of the particular LIA	No						Informal inter agency investigation without the need. The need for legal representation.
97.	Little, apart from attempting to placate public outcry	No	Lack of clarity about the limitations or aims of the inquiry	Training commitment to allocate resources,	2 months	Not known	8/9 months	Officer time 3 officers were involved in inquiry.	Change in Chairmanship of Case Conferences.	ARC retaining responsibility for considering all child deaths + having standing panel available at all times. ARC retaining responsibility for setting up formal inquiry under

Authority Number	Question numbers (including parts of questions) 30	31	32 (b)	33c	37	38	39	40	41b	42
97 Cont										Independent chairmanship
99.	Of very little value usually someone has to be the scapegoat.	No because are would have to be aware of management attitudes across the board, together with formal + informal lines of communication, and every authority appears to vary widely	Loss of Dept in morale. It must be difficult to decide "who to "blame".	Learning from mistakes of others (mainly lack of communication) Close attention paid to this as experience acquired mgt efficiency improves.						Interagency inquiries
102.	I was a member of SALACE working party the HARR views set out.	It can be well handled.	It depends on the method adopted - ill management	Effects been to boost child abuse Industry. I'm now concerned about the margins of child abuse.	3 months	None	1 week	Preparation		See SOLACE
107.			Tendency to provide material for media to distort, to judge with benefit of hindsight. To overlook conditions prevailing at time. (eg staff shortages) + to judge rather than make constructive suggestions.		No					An immediate internal or inter agency inquiry to establish the facts and make recommendations enquiry should be private though a report may be published if public interest requires.

Authority Number	Question numbers (including parts of questions) 30	31	32b	33c	37	38	39	40	41b	42
109.	Informs the public satisfies public anger/identifies areas of mal-function or inadequate services including office services. Alerts ARCs to examine their own areas of responsibility	Firm reports read it is clear that a number of inquiries indicate a lack of supervision by senior officers/breakdown of photo-copiers + staff accommodation inadequacies etc as management ineffectiveness.	To my knowledge public Inq. differ some are inquisitorial and some adversarial inquisitorial preferred. The mgt of inquiries is a controversial subject, some causing enquiry members to strongly disagree.	ARC competence/review of policy + procedures/ monitoring of register also increased awareness by all staff involved and more intensive training programmes.	no					Difficult to say as the Dept has had no such involvement. The adversarial inquiry leads to the necessity to examine legal costs of employees whether LA meets that cost quite apart from legal costs incurred by LA.
110.	To satisfy the need to scape goat often seems to be the outcome. To improve procedures therefore preventing other occurrences of abuse Highlight dificiencies in skill expertise thereby giving a guide to training needs	No	To isolate HAI duties from the total of local SSD duties and then look for gaps in procedures + practice without recognising the stress of limitations + lack of finance to LA as a whole is misleading the public and creating unreal expectations	I am not sure efficiency is the right word in 33(a) (c) Watchfulness awareness, caution, overprotectiveness + fear, combine to create mgt "efficiency" However it would be wrong not to recognise some increase in efficiency perse.	No	None	1 week	Staff time	Time more such that no organisation Have resourced it?	
114.	Public accountability	no	slow and ponderous were involved in inquiry.	Improved quality of organisational arrangements in General	Immediate	None	1 week	Staff time	Time More such that no organisation Have resourced it.	

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