# MORE THAN A DEATH: Dangerous dynamics and their impact on social work practice at the Children Young Persons and their Families Agency.

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## Abstract

Child deaths are a tragic and sadly, all to familiar occurrence for child protection services both in New Zealand and abroad. It is the authors view that, to date, the response provided in the wake of such tragedies has been to review cases with a view to ascertaining the degree of fault or blameworthiness apparent in the manner in which the child protection service managing the case, acted. Having determined this, action is then taken to alter systems and procedures with a view to preventing future deaths. While the result of this is at times successful in rectifying elements of process or systems failure, this kind of response does not take into account the impact that a range of dangerous dynamics may have had leading up to and at the time the child died.

This research takes a fresh look at five cases known to the Children Young Persons and their Families Agency where children on the caseloads of Social Workers died from non-accidental injury. A range of dangerous dynamics are identified and defined. These are then applied to each of the sample cases with a view to determining whether or not they were apparent leading up to and at the time the children died. Conclusions are drawn on the basis of the findings and recommendations are made with respect to future management of cases where dangerous dynamics exist in the relationships Social Workers have with families with which they are working.

The purpose of this research is twofold. The author's primary intention is to contribute significantly to the body of knowledge that exists with respect to understanding child deaths and the role Social Workers have in relation to such tragedies. In addition, it is intended that the findings of this research will contribute to the prevention of future deaths of children on the caseloads of child protection workers.

# Acknowledgments

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education. Without mentors like this in my life I have no doubt that this project would not have come to fruition.

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# Glossary of terms

**Case** – For the purposes of this research 'case' will be used to refer to all persons involved in the events surrounding each child. It is in no way designed to have a depersonalising effect but is used as a means of capturing detail regarding each situation as a whole.

**CFC** – Commissioner for Children

**CYP&F Act 1989** – The Children Young Persons and their Families Act 1989

**CYPFA** – Children Young Persons and their Families Agency

**CYPFis** – Children Young Persons and their Families information system.

**CYPFS** – Children Young Persons and their Families Service

**FGC** – Family Group Conference

**KPI** – Key Performance Indicator

**MRES** – Manitoba Risk Estimation System

**NSPCC** – National Society for the Prevention of Cruelty to Children

**NZCYPFS** – New Zealand Children Young Persons and their Families Service

**OLE** – 'On Line Inquiry' (computerised recording system).

**PQA** – Professional Quality Assurance

**QPI** – Quality Performance Indicator

**RES** – Risk Estimation System

**SES** – Special Education Service

**SWis** – Social Work information system

Chapter 1

# Introduction

The subject of this thesis relates to the question of

> whether or not a set of definable dangerous dynamics were apparent leading up to and at the time of the death of children known to the Children Young Persons and their Families Agency (CYPFA).

It is thought by the author that the presence of dangerous dynamics in the relationship a Social Worker has with the families with which they work, potentially heightens the degree of risk for the child. At times such risk is raised to fatal proportions.

## BACKGROUND

This thesis has developed from a personal experience of supervising a case while employed by the Children Young Persons and their Families Agency (CYPFA) in which a child was killed by his parents. This experience fuelled an ambition on the part of the writer to both acquire specific knowledge in order that further child deaths could be anticipated and avoided and to provide CYPFA staff with knowledge to enable them to prevent future deaths.

In gathering information relating to the area it quickly became apparent that various overseas authors had undertaken studies and identified a range of factors which could be influential to case management decisions and outcomes for children (Reder, Duncan and Gray, 1993; Morrison, 1995). It also became abundantly clear that many of the cases reviewed by CYPFA, as a result of a

child's death, revealed the presence of what will be referred to as dangerous dynamics in the relationship child protection workers had with the families with which they were working (An Internal Review into the Death of XY, 1993; Killing our Kids, 1994). However, while these dynamics had been identified in relation to some of the reviewed cases, no study had been undertaken across a range of cases, hence the focus of this research.

To date, CYPFA has primarily used information gathered from case reviews to provide both an overview of the characteristics of children who have died as well as develop what is referred to as 'Best Practice Opportunities' (CYPFS, 1997). In addition, the outcomes of child death case reviews have at times resulted in alterations to CYPFA policy and procedures (for example, implementation of a framework for risk estimation, RES). However, at no time has anyone utilised the information arising from the case reviews to examine the presence and impact that a set of definable dynamics may have had on the outcome for the child. These dynamics are referred to as 'dangerous' as their existence can be seen to raise the level of risk for both the child and Social Worker.

These circumstances, coupled with the fact that the death of a child is one of the most feared events faced by care and protection Social Workers, have led to this attempt to contribute to existing knowledge and research in the area. It is hoped that the outcome of this project will lead to the development of knowledge and training which in turn will assist staff of the CYPF Agency to be better equipped to anticipate and prevent further deaths of the children and young people with whom they work.

Chapter 2

# Literature Review

## DANGEROUS DYNAMICS DEFINITIONS

It has been said that:

> Not only does the death of a child from abuse horrify us, but front line professionals, especially Social Workers, have become extremely sensitive to the critical and often mindless rage that is heaped upon them at the news that another child known to the statutory agencies has died.
>
> (Reder, Duncan and Gray, 1993, p.1)

Reviews into the deaths of children known to child protection Agencies have historically taken the stance of identifying where responsibility may lie. Once responsibility and/or error have been established, statutory agencies have often acted to implement systems to avoid future deaths. According to Reder, Duncan and Grey (1993) there are a number of drawbacks to such an approach.

1. No two scenarios are ever alike so whilst introduction of new systems may rectify any gaps that contributed to the death there is no guarantee that those systems will be effective in the event of other increasingly dangerous situations.
2. Identifying responsibility implies fault on someone's part which in turn results in Social Workers becoming increasingly defensive about their role in a case where a child has died. Defensiveness decreases a Social Worker's ability to examine their role in relation to other cases they have allocated to them.

3. By examining child deaths from an accusatory perspective, little attention is drawn to the dangerous dynamics which can be apparent in the relationship between Social Workers and their client which contributed to the deaths.

(Reder, Duncan and Grey, 1993, p.2)

The most substantial research completed in relation to dangerous dynamics is that which Reder, Duncan and Grey (1993) conducted in the United Kingdom. The authors set about reviewing all known reports into the deaths of children from non-accidental injury in order to apply a clinical approach to cases at the centre of inquiries. Incentive to pursue this line of research was fuelled by what the authors perceived to be an accusatory style adopted by inquiry panels which was underpinned by a belief that blame must be apportioned in the event of a child's death. They maintained that such a style had an impact of increasing social work defensiveness rather than helping to examine roles in difficult cases, and, decreasing the effectiveness of practice improvements because the reviews revealed little new information about how things can go wrong.

Some time prior to Reder, Duncan and Grey's study (1993), Greenland (1987) also picked out key themes emerging from cases within the child protection field. This study focused on individual cases as part of an international review of situations in which children had died as the result of non-accidental injury. A large part of Greenland's study related to one hundred cases in Canada. These 100 cases spanned a 10-year period. The 100 cases were analysed with a view to identifying common characteristics and patterns. Reder, Duncan and Grey (1993) used Greenland's (1987) findings as a basis upon which to form some comparisons with their own work - notably concepts relating to what is referred to as 'closure' – a dynamic whereby a family withdraws from the outside world. Greenland (1987) expanded his study to include British cases and went on to develop what he referred to as a 'high risk check list' to be used as a guide by

front line professionals. Evolution of this check list was the primary outcome of Greenland's study.

In developing the checklist, Greenland (1987) noted a range of dynamics which will be referred to as 'dangerous' in this research. One example of this is that he went as far as noting that "...failure to gain access to a previously abused child should be regarded as one of the most critical danger signals" (1987, p. 167). Having established that, this concept was not then included in the 'check list' and Greenland (1987) did not develop the notion further. In this sense while he established ideas around dangerous dynamics, they were not labelled as such nor did he take them any further in relation to child death inquiries. Greenland's research was focused more towards identifying predisposing characteristics than examining the nature of the relationship Social Workers had with their clients prior to and leading up to a child's death.

Reder, Duncan and Grey's (1993) work picked up on the themes Greenland (1987) had developed and was the first to advance ideas associated with the theory that the dynamics of the relationship Social Workers have with their clients have the potential to be dangerous. The authors used information from 35 child death reviews to examine the dynamics of the relationship Social Workers had with their clients leading up to and at the time the child died. They did this by reviewing all available inquiry reports into fatal child abuse to see whether their new approach could help to re-analyse cases at the centre of the inquiries and allow new lessons to be learned. The authors aimed to make sense of events which culminated in the tragic death of children and also to understand more about the behaviour of the families and the professionals involved.

They found that the way professionals worked together and the way child protection Social Workers worked with families often contributed to the degree of dangerousness apparent in a case. Reder, Duncan and Grey (1993) clustered

their findings around a number of themes. These included inter-professional communication, professional networks and family professional systems.

Dynamics relating to the manner in which professionals shared information and communicated with one another, confusion of their roles, perceived hierarchy in the multidisciplinary network and a polarisation of views relating to the management of cases were all evident in the cases Reder, Duncan and Grey (1993) reviewed and were related to the manner in which professionals shared information and communicated with one-another.

In terms of the relationship between Social Workers and the families with whom they were working, the authors found evidence of families closing down from contact with helping professionals, especially child protection workers. Also noted were families which demonstrated false or disguised compliance with formal plans and families relocating themselves without warning, thus avoiding the attention of child protection agencies, and at times behaving in a manner which hinted at the possibility of future harm for children. A particularly complex dynamic relating to the relationship Social Workers had with families concerned occasions whereby child protection workers visiting a home, didn't sight the child but received reassurance from the family that the child was well. Some time later the children involved in cases where this sequence of events took place were known to have died as a result of neglect. The significant factor in this scenario was that both in the mind of the child protection worker and the family, talking about the child allowed them to believe that the child was alive and being well cared for. In reality, as soon as the child protection worker left the house, in the minds of the parents the child then ceased to exist and there was a corresponding lack of adequate care. This dynamic will be referred to further in relation to one of the five sample cases in this research.

Reder, Duncan and Grey (1993) also found evidence of patterns of decision making and thinking on the part of Social Workers which contributed to

dangerousness. These dynamics included case work plans which focused on working at concrete solutions to care and protection problems. Concrete plans were often seen to exist at the expense of focusing on what were considered by the authors to be problems which had an emotional base. For example, in response to a problem relating to neglectful supervision of children, a Social Worker developed a plan which focused on enabling a family to build a fence around their property to contain the children. While this was found to be successful in containing the children while they were at home, it did not address the fact that the children received neglectful supervision regardless of where they were. The problem of neglectful supervision was thought to have more to do with the parents' perception of the children and their role in safely managing them than it was to do with a lack of adequate fencing.

Further findings included evidence that under some circumstances Social Workers were inclined to resist acknowledging the significance of what they saw happening within a family and to consider events in isolation from one another thus failing to gain a comprehensive overview of a child's circumstances. This was thought by the authors to be due to insecurity on the part of the Social Workers causing them to be reluctant to commit themselves to a definitive view on the case and to a lack of awareness of the importance of gaining an informed overview of a child's situation when making decisions. The most common example of this dynamic included situations when Social Workers, upon receiving new information about a case, did not evaluate that within the context of what was previously known about the family. In addition, the authors found evidence of a pattern of behaviour on the part of professionals which resulted in the opinion of others being minimised as a means of avoiding further work with a case.

Further afield, Morrison (1993) in his work with the NSPCC team in Rochdale developed similar ideas to those Reder, Duncan and Grey (1993) documented. Though Morrison has not conducted research in this field, he developed a range

of concepts which relate to Professional Dangerousness. Morrison defines Professional Dangerousness as:

> ... the process whereby professionals involved in child protection work can behave in a way which either colludes with or increases the dangerous dynamics of the abusing family.
>
> (Morrison, 1993, p. 1)

In examining Professional Dangerousness, Morrison (1993) notes that professionals must look beyond structures, procedures and resources surrounding child protection work to include the societal context in which child protection systems operate. Ambivalent attitudes within society to child protection are thought to result in individual practitioners becoming confused as to what their mandate is with regard to protecting children and intervening in family life. This is perhaps best illustrated in the manner in which the New Zealand public has recently reacted through the media to two incidents concerning the management of cases known to CYPFA. In one case in Auckland, it was alleged by the media that a delayed response was provided to notification that a five year old had been presenting at school unable to sit down allegedly as a result of having been sexually abused (Daily News, 17 November 1998). CYPFA was criticised through the media for having provided what was perceived to be a less than adequate response to this situation. One week later, and in partial response to the Auckland case, the mother of two children wrote to the Editor of a provincial newspaper complaining about Social Workers having provided an immediate response to her children being left home alone (Daily News, 24 November 1998). The paradox in this situation is clear – on the basis of what the media reported, regardless of whether the response to notifications of child abuse and neglect is delayed or immediate, the result in these cases was public criticism. Social Workers are subsequently 'damned if they do and damned if they don't' and the message received from society is one of ambivalence and lack of perceived confidence in the quality of service provided by the child protection agency.

Morrison (1993) states that society's classic defense mechanisms have been denial, minimisation and inaction all of which are found at the root of Professional Dangerousness and which can result in the following:

1. Ignoring of clinical judgments.
2. Conflict avoidance or minimisation.
3. Ambivalence or confusion or misunderstanding about roles.
4. An absence of sensitivity and absolute standards for the care, safety and development of children.
5. An absence of awareness of personal and professional behaviour and responsibility.
6 Failure to maintain a focus on the child.

(Morrison, 1993, p. 2)

According to Morrison (1993) a result of this is that "A danger develops that the professional systems unwittingly copy, mirror and replicate the behaviour of the abusing families" (Morrison, 1993, p. 2).

There are common themes between the work of Reder, Duncan and Grey (1993) and Tony Morrison (1993). While Reder, Duncan and Grey (1993) focused on child protection Social Workers, Morrison broadened his scope to focus on the range of professionals working within the child welfare sector. Despite this difference the focus taken by both is one which concentrates on the relationship that professionals within the child protection field have with the families with whom they are working. In this respect, when examining case work in child protection, both sets of researchers were interested in applying an analysis to the cases which had at their heart both a systems approach as well as an emphasis on interpersonal relationships. The latter forms the basis for this research.

Reder, Duncan and Grey (1993) organised their information around three main themes; relationships within the families, interactions among members of the

professional networks and relationships between the families and professionals. Morrison (1993) focused on multidisciplinary networks and their relationship with families within the child protection system, and the emotional impact the nature of child protection work has on workers.

Fundamental to their findings is a connection between dangerous outcomes for children and inter-professional communication and sharing of information. Like Reder, Duncan and Grey (1993), Morrison's (1993) work has highlighted the importance of the impact the multi-disciplinary network has on outcomes within child protection. How professionals shared information and worked together was found to be fundamental to the effectiveness of agencies in protecting children and promoting change within families. Morrison (1993) notes the existence of a number of factors relating to multi-disciplinary networks that exist. These include the multi-disciplinary process, boundaries, rules, beliefs and resistance. All of these are influenced by the societal context within which agencies operate. For example, a society which values the importance of working together in a collaborative manner is more likely to contain agencies that are clear about their role and have well established processes to enable effective working relationships. In New Zealand, the Government initiative of Strengthening Families (CYPFA Business Plan, Fiscal 1999) provides a clear process to be used by those working in the child welfare sector. Strengthening Families is designed to maximise the use of available resources and improve the manner in which agencies work together. This is done by identifying a 'lead agency' whose role it is to ensure that service provision is well co-ordinated and those involved are working together collaboratively.

Closely associated with Professional Dangerousness are concepts that Morrison (1995b) has defined as Dysfunctional Learning Cycles and Transference and Counter-transference. Both refer to the way organisations operate and may be evidenced by examining both the behaviours exhibited by workers as well as the

nature of the relationship the workers have with their clients, that is, the families with whom they are working.

The Dysfunctional Learning Cycle describes an environment where feelings and doubts held by workers cannot be expressed and a climate of defensiveness and resistance to share and reflect on practice results. Morrison (1997) believes that a Dysfunctional Learning Cycle within an agency is a result of the agency's inability to effectively manage anxiety. Morrison states that:

> Failures at an organisational level to contain anxiety appropriately can permeate all aspects of the agency's work as well as affecting its relations with the outside world and other agencies.
>
> (Morrison, 1997, p. 5)

In this kind of environment anxiety is seen as unprofessional, a sign of weakness or of not coping. The consequences of prolonged engagement of the agency and staff in such a dysfunctional coping cycle includes:

1. Depersonalisation as clients cease to be individuals and become statistics.
2. Detachment and denial of feelings as the language of intervention becomes bureaucratised into packages and throughput.
3. Ritual task performance concerned only with procedural compliance.
4. Constant counter-checking in which cases never get beyond assessment.
5. Redistributing responsibility through projection and blaming of individuals or other agencies.
6. Reframing or minimising the true nature of concerns.
7. Clinging to the familiar even when it has ceased to be functional. (Morrison, 1997,p.7)

Alongside Dysfunctional Learning Cycle is the dynamic referred to as Transference/Counter-transference. Transference describes a process whereby the client transfers or projects feelings, perceptions or behaviours arising from a previous relationship onto the worker. Counter-transference can be described as the same process in reverse whereby the feelings, perceptions or behaviours generated in the worker are either in response to the client's transference, or, the worker's own unresolved issues. Morrison states that Counter Transference can be seen as provoking the following responses from the worker:

1. Over identification: the worker needs to absorb the child's pain, resulting in an absence of psychological boundaries between worker and child. The child and the worker's pain become inseparable.
2. Rescuing: the worker believes they alone can save the child.
3. Helplessness: the worker resonates with, and joins the child's sense of futility, and loss of hope.
4. Anger: the worker's anger on behalf of the child or her/himself is suppressed because of lack of permission to express this, and guilt about feeling it in the first place.
5. Over-controlling behaviour: this is designed to ward off the worker's anxiety, reflecting the child's own attempts to control its own world.
6. Victim bahaviour: This is especially likely if the worker has suffered similar traumas as the child, or is feeling actually abused by the child. This may result in feelings of isolation and fear.

(Morrison, 1997, p. 9)

Ultimately, the impact of both Transference/Counter-transference and Dysfunctional Learning cycles is a decreased ability on the part of the worker to

protect children and work with families. Unchecked, these processes can lead to distorted perceptions and bias, impaired communication, blurring of facts, feelings and opinions, ignoring of information, inadequate analysis, action based on personal agendas and polarisation of professional networks. Morrison (1996, p. 10) states that this "is a prime source of dangerous practice".

Legislation, organisational culture and management are viewed by Morrison (1996) as key factors that combine with the nature of child protection work to have an impact on workers. If poorly managed, these factors can culminate in what Morrison (1996) terms 'Professional Accommodation Syndrome'. Professional Accommodation Syndrome is developed from the work of Roland Summit (1983) in relation to what he referred to as the 'Child Sexual Abuse Accommodation Syndrome'. Morrison (1996) has adapted this term to enable understanding of the interaction between the primary stress of working with abused children, and the secondary stress stemming from the agency's response to this.

Professional Accommodation Syndrome is made up of a number or components:

1. secrecy
2. helplessness
3. entrapment and accommodation
4. delayed or unconvincing disclosure, and,
5. retraction

(Morrison, 1996, p. 12)

The impact these have on staff in child protection can be paralleled with the impact Child Sexual Abuse Accommodation Syndrome has on children who are sexually abused. The result for staff is that they feel isolated and helpless; they hesitate to speak about the impact their work is having and due to a sense of powerlessness they are unable to act to protect children or assist families.

Morrison (1996) has also developed a range of dynamics first identified by Dingwall, Eekelaar and Murray (1983). These include cultural relativism, natural love and the rule of optimism. Cultural relativism provides an infinitely elastic set of norms and standards in respect of family life and the care of children which immobilises professionals when dealing with families of a different culture or ethnic background. Natural love assumes that all parents love their child by virtue of the fact that they are the parents - and that this prevents parents from harming children. The rule of optimism when present, results in Social Workers finding the most positive explanation of a situation regardless of the true nature of the case.

Three sets of dynamics relating to avoidance on a family's part to engage with child protection services have been identified. Morrison (1993) refers to resistance as playing a central role in disabling child protection workers from using their professional authority in an appropriate manner. Four types of resistance are identified - hostile, passive aggressive, passive helpless and challenging-chaotic. Hepworth (1993) refers to manipulative behaviour to describe similar dynamics in the relationship Social Workers sometimes have with their clients. This can be compared to Reder, Duncan and Grey's (1993) definitions of closure, disguised compliance and flight. Morrison (1996) also documents three typical Anxiety Responses professionals may experience - fight, flight and freeze.

Other studies relating to Dangerous Dynamics have tended to concentrate on single aspects of either social work practice or an element specific to the nature of the case being managed. Valentine (1994) and Harris (1987) separately focused on the issue of defensiveness both as it relates to the Social Worker and as it exists within social service organisations. Valentine's (1994) findings concerning defense mechanisms operating within child protection agencies are consistent with the concerns raised by Reder, Duncan and Grey (1993b) as they relate to the focus of Child Death Inquiries. Valentine (1994) found that four specific defense mechanisms may operate within social service agencies in relation to work with child abuse. They are:

1. The assigning of responsibility for the child's welfare to one worker.
2. The detachment from, and denial of, the feelings that child abuse engenders.
3. The responsibility without authority that many Social Workers experience.
4. The regulation and control of child protection work as provided by legislative frameworks.

(Valentine, 1994, p. 74)

These elements are also closely associated with Morrison's (1993) work in relation to Dysfunctional Learning Cycles within organisations. Each relates to the manner in which an agency can contribute to the likelihood of dangerousness in casework where anxiety is a central issue.

Harris (1987) relates the concept of defensiveness to the individual practitioner and comments that certain practices are thought to be individually chosen by the worker as a means of self-protection with the cost being the safety and well-being of the child. Amongst these practices are:

1. Positive Defensive Social Work - adherence to elaborate and detailed procedures as a means of minimising the likelihood of scrutiny in the face of disaster with a client.
2. Negative Defensive Social Work - adoption of hard and fast rules that are applied across a range of cases despite indicators to the contrary.
3. Suppressing Information - production of records which effectively 'cover the Social Worker's back' sometimes at the expense of having accurate case notes.

(Harris, 1987, p. 64)

A common factor in all defensive practices is that they attempt to avoid incurring blame for tragic occurrences that might have been avoided and can be directly related to the manner in which the organisation and individual manages anxiety.

From a purely systems perspective, Jones (1991) argues that the harm which emanates from child maltreatment can come from both the maltreatment itself and also from the professional's response to its discovery. Jones refers to this as Iatrogenic Harm (Systems Abuse). Components of Systems Abuse include:

1. Over zealous professional intervention – may result in alienating children and families with eventual negative outcomes.
2. Repeated interviewing or multiple interviews – child is subject to many interviews often with different professionals.
3. Repeated physical examinations – may be implemented to substantiate the occurrence of maltreatment.
4. Defensive decision making – professionals not prepared to take risks in case plans for fear of negative repercussions. This can lead to inflexibility in investigations which in itself may create harm to children.
5. Withholding of treatment – the fact that the absence of treatment can be harmful.
6. Over treatment – the relentless provision of treatment and social work services for a child and family where change is manifestly impossible.
7. Negative experiences while in foster care. This can include numerous changes in placement, foster care drift and harm caused to children in foster placements by foster parents.

(Jones, 1991, p. 60)

On a similar theme Wiltshire (1995) refers to Destructive Rescuing to describe the actions of some workers within child protection. Wiltshire includes in

Destructive Rescuing, behaviour that results in workers operating in rescue mode. While workers are focused on over zealous intervention and rescuing, the outcome for the child can be one of isolation from the family, lack of clarity of role and a failure to recognise and deal with the child protection issues.

Parton and Parton (1989) identified the use of legislation and authority as a factor which can impinge upon a Social Worker's ability to protect children. They discovered that a Social Worker's lack of confidence, particularly when working with confronting parents, stems in large measure from uncertainty about the legal power and authority that is vested in them by the statutes. The impact of this is that workers were found to focus on the needs and rights of parents to the exclusion of children and that they became uncertain and anxious to protect themselves rather than effecting change and protecting children.

Stanley and Goddard (1995) focus on the relationship that develops between the Social Worker and parent who abuses his or her child. They make note of the special stresses that can develop in some of these relationships where the parent is violent towards others as well as towards the child. Hostage Theory analyses case failure from the point of view of the client/worker relationship, particularly the effect of an abusive caregiver on the worker's ability to intervene effectively. The theory is applied to family members and workers in care and protection cases where the abuser uses bullying or charm to gain control of the situation. The presence of Hostage Theory results in the family and worker either being paralysed into inaction or actively defending the abuser by adopting their view of the situation. A number of signs of hostage behaviour include:

1. The worker avoiding clients or avoiding conflict with them.
2. The worker seeing only one of the caregivers.
3. Early termination of the case.
4. Denial or minimising the severity of the situation.
5. Rationalisation of the abuser's behaviour or the child's injuries.

6. Unfounded optimism about changes being achieved.
7. Underestimating the level of violence in the family.
8. Return of the child to households where violence still exists.
9. Denial of own feelings of being scared or threatened.

(Stanley and Goddard, 1993, p. 4)

Bibby (1994) has also identified a similar set of factors and states that when violence occurs Social Workers tend to blame themselves and each other. Goddard and Stanley (1995) and Bibby are in agreement that such a response seriously hinders the worker's ability to protect children and increases the likelihood of dangerousness within the case.

With respect to the individual worker, Hansen, Diamond and Ludwig (1989) note that the existence of Burnout can result in decreased effectiveness and ability to help families because of the stresses of the job, the needs of families and the workers limited ability to help. Burnout can be apparent in case work when Social Workers are seen to forget details of the case, become immobilised by the work they have before them, lose the ability to plan and achieve tasks and fail to turn up at work due to ill health.

A full definition of each Dangerous Dynamic is outlined in Appendix A.

**NEW ZEALAND RESEARCH**

In New Zealand, CYPFA policy directs that:

> ... formal reviews are conducted following the death of a child or young person in the care of the Director General or with whom NZCYPFS has current or recent involvement.
>
> (CYPFA Handbook, 1998, section 4, p.3)

A decision as to the level of review to be conducted is made by the Chief Social Worker in consultation with the Commissioner for Children. There are three case review options, two at a National level and one at a local level. Case Reviews are completed by experienced and qualified practitioners who have had no prior involvement with the case and it is usual for Practice Consultants[1] to be asked to participate in reviews. From time to time a member of another organisation is asked to participate as part of a review team, as for example in one of the cases referred to later in this research a member of the New Zealand Association of Social Workers (NZASW) was invited onto the review panel.

In all cases the reviews have the following terms of reference:

1. Construct a synopsis of the case.
2. Identify any significant practice issues resulting from the Agency's management of the case.
3. Analyse these practice issues with reference to Agency policy and legislation.
4. Present the findings.

(CYPFA, 1998, p.13)

From time to time the reviewers will be asked by the Chief Social Worker to interview other professionals. It is expected that a detailed report is completed as part of the review. Outcomes are often generated from the review and the site associated with the case is expected to take any necessary action to address practice deficits. Review reports are detailed documents that contain a range of information.

New Zealand inquiries have assumed a similar focus to those in the United Kingdom (Reder, Duncan and Grey, 1993). It is the author's view that these reviews have, to an extent, been designed to focus on practice deficits and

[1] Practice Consultants are employed to provide advice on case management as well as administer PQA. They often complete case reviews.

rightness or wrongness as well as degree of blameworthiness. As a result, review reports have been used as an opportunity to determine, for example, whether the child's death was preventable and what gaps existed in the practice of staff and agency policy. All review reports are forwarded to the Commissioner for Children for his perusal and acceptance of recommendations and outcomes.

CYPFA has, on two separate occasions, collated information from Case Review reports (*Review of Investigations into Deaths Occurring Between April 1992 and September 1993 of Children known to the CYPFA*, (1994) and *Patterns and Reflections*, (1997)). These documents were designed to assemble a summary of factors associated with review outcomes and detail best practice opportunities on the basis of the practice issues revealed in each case.

*Patterns and Reflections* (1997) documents characteristics of selected cases and is based on the findings of 12 case reviews that relate to children and young persons who died during 1994 and 1995. *Patterns and Reflections* is accompanied by a set of practice notes *Creating Opportunities for Best Practice* based on practice deficiencies found by the review teams. While both documents provide valuable insight into the nature of cases where children known to the Agency have died, neither examine the selected cases from the perspective of whether or not dangerous dynamics were apparent prior to and leading up to each child's death.

The *Opportunities for Best Practice notes* provides a detailed breakdown of the elements that made up each area of practice deficiency as well as a series of best practice guidelines. These guidelines offer a description of practice that, if applied to casework, would result in unsafe practice being minimised.

Aside from these studies, little attention has been paid in New Zealand to focusing research on child deaths from the perspective of whether or not dangerous dynamics contributed to the degree of dangerousness apparent in the

case and ultimately the death of the child. Only recently has there been a move to convert review reports into documents to be used by staff to increase their knowledge and prevent future deaths. Aside from *Patterns and Reflections* (1997), case review reports have been utilised in training courses set up and run by the Training Units within CYPFA. Courses such as 'Unhealthy Families' and 'Dangerous Dynamics' have frequently referred to some of the case reviews as a means of illustrating points and educating staff about some of the pitfalls inherent in managing difficult and dangerous cases.

## CONCLUSION

Dangerous Dynamics can be used as a means of describing the nature of the relationship a Social Worker has with their client. This may also apply to aspects relating to both the workers as individuals and to their employing organisations. Such dynamics are referred to as 'dangerous' on the basis that when present, they significantly raise the apparent level of risk and dangerousness for the child and Social Worker.

Two separate studies have significantly contributed to the current knowledge relating to dangerous dynamics; Morrison (1993) and Reder, Duncan and Grey (1993). Both originate from the United Kingdom and have developed theories and concepts relating to the nature of the relationships between the worker and their clients, workers and their organisations, and between workers and their relationships with other organisations

Child death reviews completed in the UK are said to have focused on the degree of fault in relation to the staff involved with cases where children have died. The New Zealand experience has been similar with the exception that the outcomes of a number of case reviews have recently been used to inform best practice and provide an analysis of the characteristics of particular cases. No New Zealand

data exists in relation to case reviews that focus specifically on the presence of dangerous dynamics.

Chapter 3

# Methodology

## DESIGN

Documentary Analysis

The nature of this research concerned an examination of intervention characteristics of cases known to the CYPFA where a child had died. The research took the form of a documentary analysis, which involved an examination of CYPFA files relevant to the cases which were selected for the research. In choosing a research method a number of factors were taken into consideration. Case review reports commissioned by CYPFA were known to contain a vast array of information collected from a variety of sources. As will become clear through the course of outlining the advantages of documentary analysis as a research method, this chosen method also presented a number of disadvantages for the researcher. However, it was decided that in relation to what the author set out to achieve, the advantages of a documentary analysis were thought to outweigh the disadvantages.

The author expected that the files CYPFA held for children and their families would contain sufficient detailed information to enable a study to be undertaken without necessitating direct contact with the staff involved with the case. Accessing files as opposed to contacting staff was deemed to be advantageous for three reasons:

Staff associated with the case would not have to be contacted. It was anticipated that contacting relevant staff would be problematic both for the researcher and staff involved. Approaching staff to be involved in research regarding a case where a child died might rekindle what was certain to have been a traumatic

experience for the staff member. Further, it was thought that this would result in relevant staff being reluctant to participate in the research. A number of staff were also likely to have moved out of the Agency since the child's death and would therefore be more difficult to contact, and, the cost and time associated with a project of this nature was prohibitive given the resources available.

Secondly, all cases had had formal case reviews completed by experienced practitioners. These reviews involved formal interviews of CYPFA staff as well as, at times, interviews of other professionals associated with the case. The nature of the information contained on the case files was expected to be detailed and sufficiently comprehensive to allow a documentary analysis to be an effective means of researching the area. In the event the author had chosen to approach staff directly it would have been far less possible to access other professionals, thus the depth of information available for the project would have been limited to what the CYPFA staff contributed.

Finally, it was anticipated that data would be easily accessible. All cases had files associated with them and while the children had died, the case files were expected to be either archived or stored in office filing systems. No difficulties were anticipated in retrieving files from either of these locations.

On this basis, the author decided to proceed with a form of documentary analysis. Sarantakos (1995) states that documentary research may be employed in the context of a range of studies – case study research and both quantitative and qualitative studies. For the purpose of this research content analysis has been chosen. Content analysis is based on studying text in a very detailed and analytical way. Further, conclusions are made on issues that are beyond the meaning and purpose of the text. Reid and Smith (1981) refer to this type of research when discussing the study of intervention characteristics. He states that "Samples of case records (or samples from records) may be used as a basis for

studying practitioner activity or other forms of intervention" (Reid and Smith, 1981, p. 349).

Sarantakos (1993) notes that:

> As a method of social research, content analysis is a documentary method that aims at a qualitative and/or quantitative analysis of the content of texts (and) as a qualitative technique it may be directed at more subjective information, such as motives, attitudes or values.
>
> (Sarantakos, 1995, p. 210)

Sarantakos (1995) identified five steps in content analysis:

1. Selection of research topic
2. Formulation of the research topic
3. Research design
4. Collection of data
3. Analysis and interpretation of the data.

(Sarantakos, 1995, p.211)

Reid and Smith (1981) note that the limitations of case records for the measurement of intervention is well known. They cite incompleteness, inaccuracy, selectivity, and bias as typical problems. In addition they state that the nature of case recording often precludes any 'fine grained' analysis of what practitioners do. Conversely, they comment that narrative records do provide an excellent means of gaining an overview of the activities of a complex problem.

The information used for the purpose of this research was a combination of case review reports, and a detailed analysis of both the case files for each child and their sibling(s) file. Case reviews are commissioned by the Chief Social Worker in response to the death of a child known to CYPFA. Completion of a review involves both assignment of terms of reference as well as the submission of a

detailed report. In this research, completing a documentary analysis required gaining access to the review report for all sample cases. It was expected that the case review reports would be somewhat biased by the knowledge of the reviewer and would to some extent have been predetermined by the terms of reference of the review. However, the advantage of including the case review reports was that they were more extensive than the case files in that they encompassed a wider range of data, information and opinions not recorded on the files.

It was likely that case files would contain information which had been filtered through the eyes of the Social Worker and others allocated to the case. At the same time, the files were also expected to paint an accurate picture of events surrounding that and other workers' involvement with the case.

Presentation Format

Collecting data through content analysis requires identifying categories in order to make the classification of the data possible. Categories must be clearly defined, independent and exhaustive (Sarantakos, 1995). Each of the dangerous dynamics was defined in the form of a set of key headings and assembled into a matrix. This was then used as a framework to compare against the text of files and case review reports (see Appendix B).

The matrix was also used as a format to collate data and facilitate examination of the extent to which there was evidence that the dynamics were apparent in each of the sample cases. Data was collated in the form of key sentences, phrases, words and statements with all identifying individual and family information omitted. In some cases a brief explanatory note is included alongside the collected data to facilitate clarification and ease of understanding.

The format for this was straightforward in that the matrix allowed for the data associated with each of the five cases to be documented alongside one another

according to each of the dynamics. All data was identified by way of noting its file reference and page number.

One further means of documenting evidence was established. This involved a table utilising the same matrix design and was used as a means of recording the number of separate pieces of evidence associated with each of the dangerous dynamics as they were identified in each case. This table provided a means of gaining an overview of the number of individual pieces of data occurring for each dynamic in each case. Recording the data in this manner subsequently allowed for analysis as to whether any trends were apparent in relation to the frequency of occurrence of evidence associated with each dynamic. This table is documented and referred to further in the following chapter.

**ETHICAL ISSUES**

An Ethics Proposal was completed and submitted to the Children Young Persons and their Families Agency as well as the Massey University Ethics Committee (Appendix C). The Chief Social Worker (CYPFA) responded by approving the research proposal and entering into a Deed of Confidentiality with the researcher. The Massey University Ethics Committee also subsequently approved the proposal (Appendix D).

When considering this research topic a number of ethical issues were immediately apparent:

1. The proposal centred on reviewing information recorded on client files and held by CYPFA National Office in the form of case review reports. Information from case files is not available to the public and very few case review reports are made public by CYPFA. Subsequently, use of this information, in the form of a thesis, raised significant ethical issues with respect to confidentiality. Because of the sensitive nature of the information confidentiality became an ethical issue on two fronts. Firstly, case information related directly to the children, young people and their families with whom the Agency was involved

leading up to and at the time the child/young person died. Secondly, the case review reports contained information that disclosed the identity of both the children and young people as well as their families. To protect these individuals and families all identifying information was omitted from the thesis. In addition to this, each case had had a CYPFA Social Worker and supervisor allocated to it, in some cases more than one of each and in some of the cases other professionals had also been involved. Identifying details relating to CYPFA staff, other professionals and the office(s) involved with the case was also omitted.

2. The nature of this proposal was such that there was a potential for harm to occur in the following areas:

- CYPFA staff involved with each case.
- The families of the children who died.
- CYPF Agency.

It was anticipated, based on the outcome of Reder, Duncan and Gray's (1993) research in *Beyond Blame*, that this research would highlight flaws in casework practice. The flaws that were identified in *Beyond Blame* were directly related to the staff involved with each of the cases reviewed. Reder, Duncan and Gray (1993) discovered that in some cases it became apparent that the actions of staff were not always consistent with professional and ethical casework management or policy and practice guidelines. On the basis of this, the author predicted that this research could reveal a similar outcome thus reflecting poorly on the worker(s) involved.

Any examination of a case leading up to and at the time of a child's death was also thought to have the potential to raise personal and professional issues for the staff involved. Experiencing the death of a child with whom one is working is one of the most feared outcomes of casework within a child protection agency. Trauma associated with such an experience is not confined to dealing with the

death. Official reviews, which often involve lengthy interviews and scrutiny of a worker's performance, may be part and parcel of the procedure CYPFA implements in response to a death. Often, availability of staff and completion of court hearings hampers the timing of such reviews. Staff experience reviews as a stressful and lengthy process, the outcome of which often reflects deficiencies in practice.

Using the identified cases for the purposes of research had the potential to rekindle what were often painful memories for the staff involved leading up to and at the time each child died. This potential was realised with respect to two cases used in this research. The Managers of the Areas within CYPFA in which these files were located, contacted the author expressing concern on behalf of staff as to the purpose of the research. Such was the degree of concern expressed by staff to the prospect of being reviewed again, that the author offered to meet with those staff to clarify and explain the nature of the proposed research. However, further discussion with staff about details relating to the nature of the research allayed concerns they had and the files were made available with no further questions.

For both offices, the raising of such issues was indicative of the anxiety staff felt in relation to the files becoming the focus of attention for yet another 'review'. Also, one office was concerned about the fact that the child had died some years before and, to quote the Area Manager, "Staff just want the matter to be able to be laid to rest". The staff from the Area in which the file was located had a strong sense that until the case was left alone the child, in their minds, would never be able to rest.

Just as there was the potential for harm to workers and other professionals involved with each case, so too there was the potential for harm for the families of the children and young people who died. Use of information directly relating to

the circumstances surrounding the tragic event of a child's death had the potential to provide a painful reminder to the family involved.

CYPFA is often the focus of media attention. Often the reason for this relates to a critical incident, for example the death of a child. The performance of CYPFA is largely measured by the public through what is relayed through the media. This research focused on casework with a view to specifying the significance of negative dynamics on practice. In this sense, it was primarily designed to focus on evidence that potentially revealed practice deficits as opposed to identifying practice strengths. Consequently, the end result had the potential to be a document that reflected poorly on case management by workers employed by CYPFA. This in turn, it was thought, could possibly result in negative media attention and have the potential to further compound the degree of ambivalence the community has about both child protection in general and also the manner in which CYPFA staff perform their duties. This risk was balanced with the perceived benefits to staff of critiquing casework management with a view to identifying information which could then be used to enhance the quality of decision making already taking place. In this sense this research was seen by the researcher as a means of contributing to the ongoing process of continuous improvement of service delivery, reflective of the assertive stance CYPFA has taken to enhancing the quality of work undertaken by those involved with case work management.

**POLICY AND PURCHASE OF SERVICE DELIVERY ISSUES**

Government contracts CYPFA to provide Care and Protection, Youth Justice and Adoption services. CYPFA strives to meet the terms of the contract and at the same time maintain a position of most preferred provider when it comes to re-negotiating the contract. Incidents that undermine credibility could result in CYPFA being disadvantaged. This research has the potential to be a double edged sword, on the one hand significantly contributing to the prevention of further incidents of child deaths while on the other revisiting case files which

have, through completion of case reviews, been identified as containing practice deficits.

## ACCESSING DATA

Process Used To Identify Cases

For the last five years a number of children known to CYPFA who have died have had some form of case review completed. Records of cases subject to formal reviews are kept at CYPFA National Office. CYPFA uses the following categorisation to encompass the various ways children have died:

- A: Accidental - drowning, house fire, car accident.
- N: Natural causes.
- PA 1: Physical Abuse inside family.
- PA 2: Physical Abuse outside family.
- SH 1: Self-Harm - hanging.
- SH 2: Self-Harm – overdose.
- SH 3: Self Harm – other.
- SIDS: Sudden Infant Death Syndrome.
- Homicide.

All child deaths are recorded on a spreadsheet at CYPFA National Office. This sheet contains details relating to the child's name, the office involved with the case at the time the child died, date of birth, date of death and the cause of death. This spreadsheet was used as the first point of reference for deciding which cases required further consideration for inclusion in this research. In making an initial decision the author travelled to CYPFA National Office and went through the spreadsheet. This was the first of three trips to National Office through the course of the research to access files and information.

Selection Criteria

In coming to a decision as to which cases would be suitable for further consideration, specific criteria were listed and applied to all cases listed on the National Office spreadsheet. The criteria were

- The case review had been completed - this eliminated a number of more recent deaths where the review was either still to start or was underway but incomplete.
- The case was not known to the author by way of direct involvement or involvement with the Site within which she worked.
- The case had been known to CYPFA for a period of no less than six months - thus enabling some involvement to have taken place.
- The case involved non-accidental injury (PA 1, PA 2 and Homicide) - this eliminated the range of cases where children known to the Agency have died as a result of an accident, suicide, natural causes or Sudden Infant Death Syndrome (A, N, SH 1-3 and SIDS).
- The cases chosen represented a cross section of both Maori and non-Maori children.

At the conclusion of this process eight cases were identified as being suitable for further consideration. The identified case files were subsequently located and requested. Once these files had been received (see next section relating to accessing files) and read, a further decision was made as to which five were most suitable for use in the research. The initial proposal for this research indicated that four cases would be used. However, after viewing the available files, a decision was made to utilise five cases on the basis that it was evident that that number of cases would contain an optimal amount of information given the scope of the research. Inclusion of any less than five cases was thought to be likely to result in the volume of data being inadequate. Similarly, inclusion of any more than five cases was thought to be likely to result in the volume of data being unmanageable.

The decision as to which five cases would be used was made using the following criteria

- Length of time CYPFA had been involved with the case (the longer the involvement the more data available to draw on), and,
- Ethnicity of the children in each case. The author wanted to ensure that the ethnicity of selected cases was representative of the ethnicity of the total number of cases CYPFA deals with.

Cases chosen involved four males, and one female child death. Three children were Maori and two New Zealand European. Their deaths occurred between mid 1991 and late 1994.

Accessing Files

Every client of CYPFA has a client number. This is generated at the time the child is entered onto the computer system - SWis (Social Work information system). In addition, each client often but not always, has a paper (personal file). In the past some Sites have elected to establish 'family' files for the storage of information – this can only be done via the paper file system and involves all paper based information relating to a child and his or her siblings being collected on the same file.

In addition to this, each of the cases selected for this research also had a file at CYPFA National Office. This file contained details relating to the child's death and subsequent case review.

Accessing the files for each of the initial eight sample cases involved determining which office the files were located in. The easiest way of ascertaining this was to find the client on SWis and check the location code recorded there (this number indicated which office within CYPFA the file was located). A copy of the SWis notes (case notes on the computer) were printed off for each of the identified cases.

From the Client Details screen on the SWis file, the child's siblings were identified and their case notes were also printed off. This was done to ensure that all information relating to the identified child was available. The author anticipated that information contained on siblings files may not have been linked to the files of the sample cases. In order that this could be checked, and the information taken into consideration, the sibling's SWis files were accessed.

Simultaneously, a letter was sent to the Area Manager responsible for each Site where the children's paper files were thought to be located. This letter detailed the purpose of the research and requested that the identified child and his or her sibling's paper files be sent to the researcher.

Some paper files were found to contain a copy of the case review report. It was the author's understanding that copies of these reports were not filed on the client's paper file. For cases that did not have a copy of the review report on the paper file, the author negotiated with CYPFA National Office to access the child death files held at National Office. These files were not released to be sent to the researcher but had to be viewed at National Office. The reason for this was the sensitive nature of the information held on the files and concerns that the security of these documents could be jeopardised if they were released from National Office. The author was advised that one file was located in separate secure storage at National Office – as distinct from the remainder which were in a secure filing cabinet on one of the main floors.

A number of difficulties were experienced in locating and then acquiring relevant paper files. In particular, two of the children's files could not be located. These two files belonged to children whose deaths had had a high profile within CYPFA and through the media. For some time neither the 'home Site' nor National Office staff were able to locate the files. With the assistance of a CYPFA archivist both files were found - one in a Site and the other in secure storage at National Office.

The file located in the Site was eventually acquired with no further difficulties. The file in secure storage was accessed at National Office with the permission of the Chief Social Worker.

Once the five cases were identified they were assigned a number from one to five. From that point data relating to the case was recorded on the matrix (see Appendix B) under the allocated number. Care was taken to ensure that data from the SWis, paper and National Office files for each case was recorded under the same case number. In this sense each child then became Case One, Case Two and so on. This was done in the interest of ensuring that identifying information was not included in the data or subsequent findings and discussion.

**CONCLUSION**

A clear process and framework was established for organising and collating evidence from the selected files. In addition, a selection criterion was developed for the identification of five sample cases. Once identified, strategies to manage ethical and political issues were incorporated into the methodology. What follows is a summary of the findings as they relate to the data collected from the sample cases.

Chapter 4

# Findings

It has been said that:

> Not only does the death of a child from abuse horrify us but front-line professionals, especially Social Workers, have become extremely sensitive to the critical and often mindless rage that is heaped upon them at the news that another child known to statutory agencies has died.
>
> (Reder, Duncan and Grey, 1993, p. 1)

The purpose of researching this area of child protection practice was to take advantage of an opportunity to make some use of what is left in the aftermath of a tragedy such as a child's death. What has resulted from this analysis of files and review reports is a powerful collection of information relating to the nature of the relationship CYPFA staff had with the families of children who died. The real challenge in considering what follows is to focus on the fact that if better outcomes are to be achieved for children and further deaths prevented, then practice related lessons need to be learnt from these tragic events.

## OVERVIEW

The data associated with this research was recorded in the form of a matrix (see Appendix B). The matrix enabled all relevant evidence to be captured and recorded according to Case number and dynamic. In addition, the number of separate pieces of evidence for each dynamic is recorded in Table 4.1. This enabled ease of reference to the volume of data relating to each case and dynamic.

**Table 4.1: Volume and type of evidence associated with each dynamic recorded per case.**

| Dangerous Dynamic | Case 1 | Case 2 | Case 3 | Case 4 | Case 5 |
|---|---|---|---|---|---|
| Transference/counter transference | | | | | |
| Inter-professional communication and sharing of knowledge | 1 | | | | 1 |
| Use of Legislation and Authority | | | | | 1 |
| Functional /dysfunctional Learning cycles | | | | | |
| Systems Abuse (Iatrogenic Harm) | | | | | |
| Closed Professional Systems | | 1 | | | |
| Polarization | | 1 | | 1 | |
| Exaggeration of Hierarchy | | 1 | | | |
| Role Confusion | 2 | | 1 | 1 | 2 |
| Professionalism | | | | | |
| Pervasive Belief System | 1 | | | | |
| Information Treated Discretely | 4 | | 9 | | 1 |
| Defensive Social Work | | | | | |
| Concrete Solutions | | 1 | 3 | 2 | 1 |
| Minimization | 3 | | 2 | | 4 |
| Fragmentation | | | 2 | 2 | 1 |
| Agency Defense Mechanism | | | | | |
| Cultural Relativism | | 1 | | | 1 |
| Natural Love | | | | | |
| Rule of Optimism | | | 1 | 1 | 1 |
| Enmeshment | | | | | 3 |
| Selective Interpretation | 1 | 2 | 1 | 1 | 1 |
| Knowledge Deficit | 1 | | 2 | 1 | 1 |
| Burnout | | | 2 | | |
| Destructive Rescuing | | | | | |
| Belief Systems of the Worker | | | | | |
| Response to Experience of Violence | | | | | 1 |
| Not Exist Double Bind | | | | 2 | |
| Re-framing – Blurring Care and Control | 1 | | 1 | | 2 |
| Disguised Compliance | | | 2 | | |
| Flight | | 1 | | 1 | |
| Resistance | | | 2 | 1 | 2 |
| Manipulative Behavior | | | | 1 | 1 |
| Hostage Theory | | | | | 2 |
| Covert Warnings | | | 2 | | |
| Closure | | | 1 | 2 | 1 |
| Systems Failure | 4 | | 3 | 3 | 1 |
| Anxiety Response | | | | | |
| Total | **18** | **8** | **34** | **19** | **27** |

From the two matrices it is possible to make a number of general comments relating to the findings of this research.

It is apparent that all sample cases, to a varying degree, contained evidence suggesting that a number of the dangerous dynamics were present leading up to and at the time each child died. This result provides an answer to the question of 'whether or not a set of definable dangerous dynamics were apparent leading up to and at the time of the death of children known to the Children Young Persons and their Families Agency (CYPFA)'. Clearly, a number of the dangerous dynamics featured strongly in the relationship Social Workers had with the families of children who died. This is an important finding.

**SPECIFIC FINDINGS**

The volume of evidence recorded against each dynamic varied markedly. On average, 21 pieces of evidence relating to the dynamics were recorded across the five sample cases. Case Three contained the largest amount of evidence with 34 separate pieces and Case Two had the lowest with eight. This is represented in Table 4.2.

**Table 4.2: Volume of evidence recorded per case reviewed.**

| Case Number | Volume of Evidence per Case |
|---|---|
| Case One | 18 |
| Case Two | 8 |
| Case Three | 34 |
| Case Four | 19 |
| Case Five | 27 |

For those dynamics where evidence was recorded, the number of separate items varied from one incident through to 14. Of those, three dynamics were exceptional for the amount of evidence accumulated - Information Treated Discretely had 14 separate incidents, Systems Failure had 11 and Minimisation

had nine. Of those dynamics that had evidence recorded the average number of incidents was 3.8 per dynamic.

Table 4.3 outlines the number of separate pieces of evidence apparent for those dynamics where evidence was present (NB not all dynamics are detailed in this table on the basis that evidence was not apparent for some).

**Table 4.3: Volume of evidence recorded per dynamic.**

| Dynamic | Volume of Evidence |
|---|---|
| Inter-professional communication and sharing of knowledge | 2 |
| Use of Legislation and Authority | 1 |
| Closed Professional Systems | 1 |
| Polarisation | 2 |
| Exaggeration of Hierarchy | 1 |
| Role Confusion | 6 |
| Pervasive Belief Systems | 1 |
| Information Treated Discretely | 14 |
| Concrete Solutions | 7 |
| Minimisation | 9 |
| Fragmentation | 5 |
| Cultural Relativism | 2 |
| Rule of Optimism | 3 |
| Enmeshment | 3 |
| Selective Interpretation | 6 |
| Knowledge Deficit | 5 |
| Burnout | 2 |
| Response to Experiences of Violence | 1 |
| Not Exist Double Bind | 2 |
| Re-framing Blurring Care and Control | 4 |
| Disguised Compliance | 2 |
| Flight | 2 |
| Resistance | 5 |
| Manipulative Behaviour | 2 |

| | |
|---|---|
| Hostage Theory | 2 |
| Covert Warnings | 2 |
| Closure | 4 |
| Systems Failure | 11 |

A number of dynamics did not have any evidence recorded across any of the five cases. These included:

1. Transference/Counter-transference
2. Functional/Dysfunctional Learning Cycles
3. Systems Abuse
4. Professionalism
5. Defensive Social Work
6. Agency Defence Mechanisms
7. Natural Love
8. Destructive Rescuing
9. Belief Systems of the Worker, and
10. Anxiety Response.

There are a number of possible explanations as to why this has occurred, all of which will be discussed in more detail in the following chapter.

Closer examination of each of the sample cases revealed the following by way of evidence relating to the dynamics that featured in the case:

- Case One had evidence recorded across the following dynamics:

| | |
|---|---|
| Inter-professional Communication and Sharing of Knowledge | 1 |
| Exaggeration of Hierarchy | 2 |
| Role Confusion | 2 |
| Pervasive Belief System | 1 |
| Information Treated Discretely | 4 |
| Minimization | 3 |
| Re-framing Blurring Care and Control | 1 |
| Selective Interpretation | 1 |

| | |
|---|---|
| Knowledge Deficit | 1 |
| Systems Failure | 4 |

- Case Two had evidence recorded across the following dynamics:

| | |
|---|---|
| Closed Professional Systems | 1 |
| Polarisation | 1 |
| Concrete Solutions | 1 |
| Cultural Relativism | 1 |
| Selective Interpretation | 2 |
| Flight | 1 |

- Case Three had evidence recorded across the following dynamics:

| | |
|---|---|
| Exaggeration of Hierarchy | 1 |
| Role Confusion | 1 |
| Information Treated Discretely | 9 |
| Concrete Solutions | 3 |
| Minimisation | 2 |
| Fragmentation | 2 |
| Re-framing - Care and Control | 1 |
| Rule of Optimism | 1 |
| Selective Interpretations | 1 |
| Knowledge Deficit | 2 |
| Burnout | 2 |
| Blurring Care and Control | 2 |
| Disguised Compliance | 2 |
| Resistance | 2 |
| Covert Warnings | 2 |
| Closure | 1 |
| Systems Failure | 3 |

With respect to Case Three, it is noted that 'Information Treated Discretely' had nine separate incidents of evidence recorded against it. This is six times the average amount of evidence recorded for all the dynamics across all five sample cases.

- Case Four had evidence recorded across the following dynamics:

| | |
|---|---|
| Polarisation | 1 |
| Exaggeration of Hierarchy | 1 |
| Concrete Solutions | 2 |
| Fragmentation | 2 |
| Rule of Optimism | 1 |
| Selective Interpretation | 1 |
| Knowledge Deficit | 2 |
| Systems Failure | 3 |
| Not Exist Double Bind | 2 |
| Flight | 1 |
| Resistance | 1 |
| Manipulative Behaviour | 1 |
| Closure | 2 |

- Case Five had evidence recorded across the following dynamics:

| | |
|---|---|
| Inter-professional Communication and Sharing of Knowledge | 1 |
| Use of Legislation and Authority | 1 |
| Exaggeration of Hierarchy | 2 |
| Information Treated Discretely | 1 |
| Concrete Solutions | 1 |
| Minimisation | 4 |
| Cultural Relativism | 1 |
| Fragmentation | 1 |
| Re-framing - Care and Control | 2 |
| Rule of Optimism | 1 |

| | |
|---|---|
| Enmeshment | 3 |
| Selective Interpretation | 1 |
| Knowledge Deficit | 1 |
| Response to Experience of Violence | 1 |
| Resistance | 2 |
| Manipulative Behaviour | 1 |
| Hostage Theory | 2 |
| Closure | 1 |
| Systems Failure | 1 |

**INTER-RELATIONSHIP OF EVIDENCE WITH MORE THAN ONE DYNAMIC**

At times the same evidence related to more than one dynamic. For example the evidence indicating that Social Workers "... were predominantly influenced by the comment of other professionals which indicated that (the mother) was a good parent... " (Case 2, Case Review, p. 3) was thought to relate to both Polarisation and Exaggeration of Hierarchy because the definition of these two dynamics is consistent with what can be inferred from this evidence. Other examples included hostage theory and response to experience of violence. This problem was managed by deciding which dynamic the evidence most clearly fitted. If it could be clearly related to more than one dynamic it was recorded as such and is referred to in the analysis that accompanies each dynamic in Chapter Five.

**STATE OF THE FILES**

As files were made available to the author it became apparent that the range of Sites to which they belonged had a variety of filing systems in use. Some Sites had established 'family files' for the sample cases and other Sites had individual files made up for each child in a family. A number of issues were apparent in relation to the state of the paper files:

1. One file contained a number of documents that were not attached to the main body of the file. These were tucked inside the front cover and scattered throughout the file as opposed to being securely attached to the file.

2. It was not unusual for files to lack folio numbers thus resembling a collection of papers attached to a file as opposed to a well organised file with appropriate numbering.

3. Some children had more than one paper file. In the event a file becomes too large to contain all relevant documents it is common place for a second volume to be established. In one case, more than one paper file was established, however, this was not necessitated by the volume of documentation. It appeared that two separate Sites had established two separate paper files and these had not been merged.

Just as issues existed with respect to the state of the paper files for the sample cases, so too were there issues relating to the state of the computer (Children and Young Person information system - CYPFis / Social Work information system - SWis) files:

1. Two children had duplicate client numbers. This occurred in two ways. One case had a duplicate file as the result of the surname being spelt wrongly and the second had the names correct but in the wrong order. As a consequence two files had been established for both children. The most logical explanation for this would have been failure on the part of the Social Worker who established the second file to ensure that one did not already exist. In one case a duplicate file was discovered at the time the child died. The staff responsible for the case, despite knowing that the duplication existed, did not take action to merge the files. As will become clearer in the analysis of this research, the problem of duplicate files significantly contributed to disorganisation in the manner in which some of the sample cases were managed.

2. Two of the five sample cases lacked adequate details to enable the reader to establish who was 'family' to the child. This involved some cases lacking

details relating to family members and the child's relationship to them, the child's date of birth, ethnicity and address. This lack of details made it difficult to discern who was in the family and the nature of those relationships. At times this went so far as to involve a lack of information relating to siblings and parents of the child and in one case no details relating to family existed.

3. Two cases had little information recorded in the case notes relating to the involvement of CYPFA. The author had expected, when acquiring a copy of the SWis case notes, that at least two of the cases would have a sizable amount of case notes documented. This assumption was made on the basis that both cases had been known to CYPFA for a considerable period of time and that the Agency had been actively involved over this time. One of the two had 18 pages and the other 13. Of the 18 pages in the first case, only seven related to actual case notes and in the second case, of the 13 pages only six related to case notes. This was consistent with the remaining three cases all of which had been known to CYPFA for a shorter period of time – 18 pages, 11 of which were case note related; six pages, two of which were case note related; and eight pages, four of which were case related. As will be discussed in the following chapter, herein lay a significant issue with respect to both case work practice and evidence to support the existence of dangerous dynamics. The resultant dearth of case related information on the files meant that it was extremely difficult to ascertain what it was that CYPFA was doing with the case - including what the care and protection issues were.

**SYSTEMS FAILURE**

Through the course of reviewing files and case review reports it became clear that there was a significant body of evidence relating to failure of systems – both information and process. This occurrence did not fit comfortably into any definition of the identified dynamics but appeared to have a worrisome presence in four of the five sample cases. This phenomenon occurred so frequently that the author chose to include 'systems failure' as a separate dynamic. For the

purposes of this research, systems failure was defined as any break down in the systems or procedures designed within CYPFA to support information being transferred from one Site to another or from one file to another as well as systems as they related to the general functioning of the office. This included any breakdown in procedures relating to establishing files and any failure of the information systems in general. The most common example of systems failure related to poor transfer of information from one office to another thus resulting in the intended receiving office either not learning about the client or only receiving a part of the total available information. This was evidenced in the following examples:

> "The transfer of files between the three offices was either not actioned or actioned after lengthy delays."
>
> (Case 3, Case Review, p. 19)

> "Case ownership and information confusions were important in the course of the case as they interfered with (an) office making early sustained contact and early re-assessment of the care and protection issues for the children."
>
> (Case 4, Case Review, p. 29)

A direct consequence of this was that information was treated discretely in that events were considered in isolation from each other and fragmentation developed in the decision making process. In this sense, systems failure contributed to the existence of other dynamics but stood out as distinct phenomenon warranting separate consideration and analysis.

**PRACTICE ISSUES**

While the purpose of this research was to critique files against criteria relating to dangerous dynamics, in doing so it was difficult not to be drawn into a closer analysis of some of the practice issues which were evident from the file information. Such issues were broad ranging. This problem was largely due to

the very nature of some of the dangerous dynamics which meant that for evidence to exist supporting their presence, practice issues were also likely to be present by implication. A good example of this related to Information Treated Discretely, a dynamic defined as a circumstance in which events are considered in isolation from one another with no coherent overview emerging. On more than one occasion, this dynamic existed because the Social Worker had failed to familiarise him/herself with the background to the case and had subsequently made decisions which later proved unsatisfactory. This failure to be fully cognizant with the case often arose from not having acquired access to all available case related information, a fundamental task when investigating allegations of abuse or neglect. The existence of this dynamic was directly attributable to a practice issue relating to a lack of informed decision making which arose from a failure on the part of the Social Worker to get access to all relevant information.

Many of the practice issues identified had already been noted in the case reviews. For the purposes of this research the following warrant comment.

Case Note Recording.

Such was the lack of attention to the requirements of good case note recording that in all five cases it was not possible to identify a logical sequence of events relating to the Social Workers management of the case. Social Workers used SWis as a means of expressing personal opinion. In addition SWis was also noted to be used by Social Workers to make reference to their own administration of a case. With respect to the paper files similar issues were apparent. There were hand written notes undated, unsigned or signed in a manner which was illegible. Given that one of the requirements of recording is to provide a record of activity and information, not only for CYPFA staff but also for the client in the event they request access to their file, the standard of recording on these files was inadequate. One has to question how any worker can gain an

informed overview of a case when hand written notes are not able to be read and SWis files are incomplete?

Compliance with Process and Policy.

Evidence existed of staff not fulfilling the requirements of what is perceived by CYPFA to be good practice. For example, investigation plans (or plans of any nature) rarely existed and consultation with the Care and Protection Resource Panel (a statutory requirement) did not occur in at least two of the cases. The impression this left was one of general disorganisation and lack of clarity about what CYPFA was trying to achieve in relation to the child and family.

Lack of Adequate Supervision.

In reviewing the files of the sample cases it was apparent that there was a lack of supervisory involvement. None of the cases revealed any evidence that a supervisor had had a role in either overseeing or managing the case. In addition, there was a distinct absence of evidence to suggest that a supervisor had been involved with supporting, guiding and managing the Social Worker. That being the case, it was not surprising that a range of dangerous dynamics relating to hostage theory and manipulation of the worker were apparent leading up to and at the time the children in the sample cases died.

Decision-making and Evidence of a Process in Relation to Investigation and Assessment.

As the result of critiquing case reviews, in 1997 CYPFA acted to introduce a framework for the analysis of risk. While this provided all care and protection staff with a consistent means of thinking about and analysing risk, it was never intended to replace the requirement that full and proper investigations and assessments be conducted. There was limited evidence on the files of the sample cases to indicate that the Social Worker(s) were implementing any framework in relation to investigation and assessment.

Sound Decision Making.

In one case, the Social Worker had called to the home one night and found all the children home alone. Her response to this was to ask the eldest child (who was 10 at the time) to get his mother to contact CYPFA when she got home. This was clearly an inadequate response to a care and protection issue which, in the authors opinion, could not have been any clearer and warranted immediate action to ensure the childrens' safety was secured.

Information Gaps.

The author found it difficult to grasp what CYPFA was trying to achieve with each case by viewing just the SWis and paper files. While there was evidence of adequately detailed case notes, it was more often the case that large gaps existed. The problems this presented were alleviated for the purposes of this research as the case reviews were far more detailed reports. If it had not been that the case review reports contained a significant amount of 'bridging' information as a result of the Social Worker having been interviewed, it would have been very difficult to glean an accurate picture of who was doing what and why with respect to managing each case. This factor raises an important issue in that Social Workers can be seen to have a significant amount of case related information in their heads that it seems, does not get recorded on client files.

**LACK OF FOLLOW UP AFTER THE DEATH**

There was a pattern of inconsistency relating to follow up by CYPFA after each child had died. Some Sites entered information on the SWis file and left the case open, while others chose to note that the child had died and then immediately closed the case. While the Agency has a requirement that a series of reports are written immediately following a child's death there are no clear guidelines referring to where information is recorded, and what action is required with respect to management of the case – especially relating to any siblings the child may have had.

## CONCLUSION OF FINDINGS

Data gathered through the course of this documentary analysis has pointed clearly to there being a range of dangerous dynamics present in the relationship Social Workers had with their clients leading up to and at the time the children died.

Through the course of reviewing each case it became increasingly apparent that there was evidence to suggest that the manner in which CYPFA managed systems relating to both information and processes within the office was at times problematic and / or deficient.

A number of the dynamics appeared to have no evidence to support their presence in the sample cases. In addition, at times inter-relatedness was established as the same evidence applied to more than one dynamic. Both of these factors will be discussed in more detail in the next chapter.

Of note were both the state of some of the paper files and the range of practice issues that arose through the course of completing the review. While the purpose of this research was not to become engaged in practice issues, at times it was difficult to overlook these given the impact they had on the case.

The final point of note in the findings is the fact that CYPFA does not have any practice guidelines concerning management of cases where siblings exist where children have died from non accidental injury. While there is clear policy relating to reporting to the Chief Social Worker, and involvement of the Police in the event of a death, there are no guidelines to indicate best management of siblings after a death.

Chapter 5

# Discussion

## FORMAT

For the purposes of clarity, dynamics have been grouped into three categories thereby aiding the analysis and discussion of the research findings. In contrast to Reder, Duncan and Grey (1993) who considered a wide range of categories as they related to child death inquiries, the author identified the following:

1. Social Work decision-making.
2. The family-professional systems.
3. Inter-professional communication – systems, policy, legislation, multi-disciplinary functioning.

While these categories had fluid boundaries, thus allowing for some dynamics to overlap, it was possible to identify one primary category for each dynamic. The following discussion follows this format.

## SOCIAL WORK DECISION MAKING

This category encompassed a range of dynamics directly related to the manner in which assessments were conducted and decisions were made throughout the life span of the case. Reder, Duncan and Grey (1993, p. 83) state that: "The aim of assessment is to guide action". Social Workers have a pivotal role in identifying problems and their severity as well as gathering other relevant information to help form an opinion about the degree of risk to the child. In this sense assessment is an ongoing process during which new information has to be evaluated and interpreted alongside what is already known about a case. As Reder, Duncan and Grey (1993, p. 83) comment: "Assessment is thus both an activity in itself and a process of understanding."

Assessment requires Social Workers to have a framework against which to gather information and make decisions. This includes skills in information gathering, decision making and having confidence to make judgments. Dingwall (1986, cited in Reder, Duncan and Grey, 1993) comments that information needs to be available at an appropriate time in a usable form and he classifies four types of information, each requiring a different response.

1. When information is unknown, procedures are required for locating and developing new knowledge.
2. Information may be known but not fully appreciated or interpreted, perhaps because of a false sense of security, pressure from competing tasks, distrust of the information source, distraction by a different problem or an inability to distinguish what is relevant and irrelevant.
3. Information may not be fully assembled because no one person sees enough of the picture to recognise its significance.
4. Information may be available but does not fit current models of understanding.

(Dingwall, 1986, cited in Reder, Duncan and Grey, 1993, p. 84)

Professional Dangerousness

Sitting alongside assessment and management of information is a collection of factors which are attributed to a failure to act on the part of Social Workers. According to Morrison (1993) a combination of societal belief systems and the practice of professionals, both as individuals and in their work is at the root of what he refers to as Professional Dangerousness. The vulnerability of the individual to Professional Dangerousness is demonstrated by the degree to which the sample cases revealed evidence that each dynamic relating to Professional Dangerousness was apparent. Over the five sample cases a range of evidence was present to support an assertion that dynamics relating to

decision making, assessment and Professional Dangerousness were evident. Each will be discussed in relation to the specific dynamic.

Information Treated Discretely

The assessment process only has meaning when all information is pooled together and used to contribute to an informed decision at any given point in time. This involves consideration of both current and historic information thus requiring that all possible sources of information are tapped into with a view to gaining a comprehensive picture of what is happening in the case. Failure to do so results in new information not being incorporated into the case and thus not contributing to an understanding of how that information impacts upon the case in general.

Of all the dynamics examined, "Information Treated Discretely" revealed the greatest amount of evidence. The number of incidents in which events were considered in isolation from each other, and the case in general, was remarkable. Three of the five sample cases revealed evidence of this dynamic and there were nine separate incidents of evidence recorded.

The majority of incidents related to management of information contained within the various files CYPFA maintained for the collection of information. It was significant that in one case the reviewers noted in their report that: "The review team had difficulty locating all the information and making sense of the information that was available" (Case Three, Case Review, p. 18). Given this, one is lead to consider the state of neglect the files must have been in at the time the review was underway. For individuals whose task was to collate information in order to complete a review, to comment that they had difficulty locating information is noteworthy. When considering this statement and the evidence that follows, it becomes clearer why the Social Workers allocated to the case proceeded to treat information discretely.

Other examples included:

- Client files on the computer database were duplicated and held in separate offices. The offices that established the second and third notifications did not have access to the initial notification at the time they were considering how to proceed with an investigation. This resulted in the second two notifications being considered in isolation to the first and as a result no coherent over-view of the case was established (Case One, Case Review, p. 6).
- The child who died had an older sibling and this child was known to CYPFA. Information on the older child's file was not considered when notifications for the child who died were received by the Agency. The result of this was that incidents which had been documented on the older child's file did not contribute to the overall picture of what was happening for the family; three incidents of abuse or neglect, two incidents of Domestic Violence and transience were not taken into consideration (Case One, Siblings SWis File, p. 19).
- Information concerning previous notifications about the family were not documented on this child's file and there was no evidence of that information being taken into consideration during involvement with this child (Case Three, SWis File, p. 5).
- Two separate files existed for the child. One had correct spelling of her name the other incorrect. Notifications listed under the incorrect spelling were not considered when a different office recorded subsequent notifications. This resulted in information being held by two separate offices and it was not until the case review that all information gathered about the child and her family was considered (Case One, Case Review, p. 6).
- Information relating to the family was not held in one place at any one time. "Transfer of computer and paper based files between offices was either not actioned at all or actioned subsequent to the child's death" (Case Three, Case Review, p. 14).
- "Critical information was not accessed and resulted in assessments which did not address the critical issues." (Case Three, Case Review, p. 8).

- "(An office) does not appear to have had knowledge of historical information from (another) office who did not appear to have knowledge of (a third office's) involvement." Transfer of the paper file was not requested or actioned until two months after the child's death. (Case Three, Case Review, p. 19).

A second theme related to an omission on the part of the Social Worker allocated to the case to make decisions and complete assessments based on both current and historic information. This was evidenced in the files by comments that indicated that in hindsight the Social Worker would have acted differently if she/he had had access to all the information. Case One revealed a situation in which the Social Worker made an assessment on the basis of no historical information. The Social Worker acknowledged to the review team that "...if she had the historical information available her assessment would have been different" (Case One, Case Review, p. 16). Given an awareness of all the historical knowledge, new allegations of physical abuse are likely to have been treated more seriously than they were.

Failure to identify that children had siblings was another issue that contributed to the rate at which information was treated discretely in some cases. In Case Three the office responsible for managing the case leading up to the child's death was not aware that the child had an older sibling who was known to two other CYPFA offices. The review report noted that:

> It is significant that (an office) did not know of the existence of (a sibling) or her file until well after (the child's) death. The Review Team only learned of the existence of (the sibling's) file from informal information received from a member of the community.
>
> (Case Three, Case Review, p. 19)

This resulted in information relating to the older sibling in the family not contributing to the total knowledge applied when making decisions and assessing the case.

Case Five indicated evidence of known incidents not being considered as part of the full context of the case. This is documented in the case review in the following way: "Notifications received in November 1992 were viewed as isolated incidents and were not seen in the context of the Notifications of 1991 and the FGC's" (Case Five, Case Review, p. 86).

Case Three indicated a similar pattern. In this case, through the course of following up a notification involving care concerns, the CYPFA Social Worker was contacted by the Health Social Worker. The Health worker advised that the child's sibling had been seen by Hospital staff to have her ear twisted, to be sworn at and smacked and was admitted to hospital with a closed black eye. This was not recorded on that child's file, nor was it followed up with an investigation of any nature. At the time the child was in the care of a family member. When asked if this family member may have hit the child causing the black eye the mother thought that was possible. Furthermore, when it was discovered that the same family member also had the care of this child, the information about the older sibling's black eye etc. was not considered in the context of this child's care (Case Three, SWis File, p.8).

In three of the five sample cases many opportunities existed for Social Workers to consider the information they had to hand in the context of the whole case. Doing so would have resulted in any new information being considered within the life-span of the case thus potentially altering the meaning that was attached to each new piece of information. As Reder, Duncan and Grey (1994, p. 84) state: "Taken separately, each of these items of information might be viewed as unremarkable. Considered together, they produce a very worrisome picture". Individually and collectively, over a period of time in each of the three cases,

workers related discretely to separate items of information and an overall picture did not emerge. Some of the most significant factors associated with information being treated discretely were the way in which Social Workers failed to access existing records, check with other CYPFA Sites that had involvement with the case and failed to take into account previous incidents in the case. Making assessments and decisions in this manner contributed to an absence of overall comprehension of what was happening in the case.

Selective Interpretations

Reder, Duncan and Grey (1993) considered in their research whether professionals unwittingly resisted acknowledging the significance of what they were seeing because of insecurity about committing themselves to a definitive view or because they feared taking responsibility for initiating the child protection procedures this would have demanded. As a result, Social Workers are thought to begin to accommodate to conditions that are later recognised as appalling. At times this may be evidenced by professionals expressing excessive confidence following minor improvements and observations not being translated to represent their true meaning.

This is the only dynamic which related to all five of the sample cases. In one case the intake Social Worker was aware that the household the child lived in at the time the notification was established was one in which family violence was apparent. It was noted in the case file that:

> (The mother) describes her house as being violent at times. She told me that she was getting out and taking (a child) and (another child) with her. I reminded (the mother) that 10 years ago she was telling me that she was getting out.
>
> (Case One, SWis File, p. 5)

Despite the mother identifying to the Social Worker that the child's current environment contained significant violence, and knowing that there had been

problems for a while, the seriousness of the situation was not focused on in the subsequent investigation and assessment. It appears the Social Worker chose to focus on the fact that the mother had indicated that she was leaving the environment. This was clearly perceived by the Social Worker to be an indication of a minor improvement for the children and thus resulted in the Social Worker electing not to take any action to ensure the children's care and protection was adequate.

In another case, reports from health professionals indicated that the mother was providing good care for her child and that there were no care or protection concerns. This is contrasted with the fact that significant concerns had been identified through the course of the investigation in relation to drug taking, disciplining, handling of the child, domestic violence and transience. It is noted in the case review report that:

> Unfortunately it would appear that some of these obvious concerns were not identified, and were somewhat clouded by glowing reports from health professionals.
>
> (Case Two, Personal File, p. 7b)

The Social Worker focused on information and opinion received from health professionals to the detriment of translating the evidence relating to care and protection concerns into an approach to the case that was clearly worthy of an investigation. Limited indication of positive change for the children existed but what evidence there was of this carried more weight in the decision making process than was warranted when considering the full context of the case.

One of the cases contained evidence that the mother had called on at least one occasion in the past stating that she was going to harm the children if CYPFA did not respond immediately. On the second occasion the Social Worker stated that while the mother was saying that she wanted to get rid of the children, it was the Social Worker's assessment that all that was needed was for her to have a rest

from them. It appeared that this assessment was based on the mother having taken positive action to access assistance and she settled for the offer of respite. While the mother stated that she needed a break from the children, the Social Worker chose to interpret this as a positive indicator that the risk for the children would diminish if the mother felt she had been provided options for respite. The Social Worker did not take into account that the mother had stated very recently, that she would harm the children if CYPFA did not react immediately. On both occasions, the mother was thought, by the Social Worker, to be in need of a rest from the children as opposed to more child protective action needing to be taken to ensure the children's safety.

The significance of positive prior knowledge was a key theme in Case Two.

> ... prior knowledge of the case appeared to have narrowed or predetermined the focus of the second investigation, e.g. (the mother) had already been assessed to be a 'good mother' who wanted the best for her child.
>
> (Case Two, Case Review, p. 6)

Prior knowledge relating to the mother's ability to make changes significantly contributed to the Social Worker focusing on the case in a way that resulted in undue confidence in the mother's ability to again make changes. Such undue confidence was not balanced against new information that had come to hand with respect to the care the children were receiving nor was it considered in the light that while changes had been made, care and protection issues for the children still existed. While minor improvements had been known to occur in the past and the mother was considered to have been a 'good mother' the Social Worker accommodated to this, because although given new information, action focused on child protection was not taken.

Case Five described a situation in which two Family Group Conferences (FGC's) had been held. At the second FGC the family decided that the child was not in

need of care or protection. At the time, the concerns CYPFA had for the child related to neglect, violence in the home, the children being left home alone and historical sexual abuse. The Social Worker accepted the FGC recommendations and documented the following:

> ... the whanau felt that (the child) is not subjected to unnecessary physical discipline and that the disciplinary methods employed by his parents are undesirable but controlled.
>
> (Case Five, SWis File, p. 18)

The degree of selective interpretation apparent in the Social Worker's assessment largely resulted from the fact that the whanau thought that things had improved. This is evidenced in the case note by the following:

> (the father) attended the FGC and it was agreed that he no longer exposed the children to risk of physical abuse. The family supported his explanations as to his methods of discipline as being reasonable and that (the father) did have control of his anger.
>
> (Case Five, SWis File, p. 18)

In the same case, four months earlier, the same Social Worker and supervisor made a decision not to undertake a formal investigation for a number of reasons. Those reasons were documented as:

> ... the safety of the children whom could be exposed to increased risk if interviewed. Tendency of the father to be violent – toward anybody.
>
> (Case Five, SWis File, p. 18)

These two separate decision points are indicative of selective interpretation being a key feature of the Social Worker's assessment over a period of time.

Case Four referred to a family that was transient, there were allegations of sexual abuse and neglect, and violence existed in the home. The case review team believed that because the office was working with a number of similar cases, this resulted in the Social Workers accommodating to conditions that were later recognised as unsatisfactory. This is evidenced in the review team's report as follows:

> From comments made to us by workers in (the office) where they are working with numbers of families perceived to be severely dysfunctional, it appears to us that there is an element of "accommodation" present in their acceptance of the dysfunction within this family.
>
> (Case Four, Case Review, p. 32)

The fact that the Social Workers as a group in this Site were engaged with a number of severely dysfunctional families is said to have had an accommodating impact.

Pervasive Belief System

Only one case was found to have evidence to suggest that pervasive belief systems had distorted and dominated decision making. In this case the child was seen by the duty Social Worker at the time the notification was documented. It was noted by the Social Worker that: "... although small she (the child) is well covered..." (Case Three, Personal File, Intake Form). The notification related to issues of neglect in that the child was said to not be receiving adequate meals and was not adequately clothed.

The Social Worker seemed to believe that 'well covered children' are healthy well cared for children. This lead to the focus of the case shifting to contacting the Plunket Nurse to ascertain their involvement as opposed to completing a thorough investigation and assessment of the concerns which related to neglect.

Reder, Duncan and Grey (1993) note that pervasive beliefs may be determined by socio-political attitudes, strong personal or professional views or inferences drawn from ongoing work with a family. It is the author's opinion that a view is often held that chubby, healthy looking babies equate to adequately cared for babies. In this case, significant issues included the fact that the child was on occasion not well cared for, not adequately fed and she was noted to be small.

Concrete Solutions

A significant body of evidence existed in some of the sample cases supporting the fact that undue reliance was placed on very practical measures as a means of dealing with or monitoring problems that were essentially emotional. In addition, evidence existed to suggest that practical measures were also, at times, used as the only means of identifying indicators of whether or not the standard of care and protection provided had improved. Practical measures, or concrete solutions, refer to strategies such as relocating a parent who is in a violent relationship as opposed to addressing the emotional basis to her being in the violent relationship in the first place. Concrete solutions can be seen as quick fix solutions and while they are often a valid strategy to use in casework, in isolation they can be ineffective in dealing with care and protection concerns especially when they have an emotional base to them.

Case Two involved the Social Worker assessing that a change in location was sufficient to indicate that there were no grounds for further involvement of CYPFA. The first notification received for this case related to the mother's inability to provide adequate care and was closed at the point at which the mother was located and thought to be in a stable environment. The Social Worker's case note reads: "Mother was advised during interview on May 14 that there would be no further action from DSW now that her permanent address was known..." (Case Two, SWis File, p. 25). The family having been located was seen as a significant reason for then being able to close the investigation.

Case Three highlighted more evidence of concrete solutions being implemented. After a history of threatening to harm the children if CYPFA did not take them into care, of moving from home to home, of being in a violent relationship and of not managing the eldest child well, the mother was involved in another fight with the children's violent father. The response by CYPFA to this was to work with the mother on the basis that: "(the mother) agreed to work with the NZCYPS to ensure the children's safety, to follow up (the child's) speech development and to have ongoing support" (Case Three, Case Review, p. 11). In addition, the plan also incorporated a referral to Housing Corportion and medical checks for the children. "The Social Workers felt this would address concerns about the children's safety" (Case Three, Case Review, p. 11). Reder, Duncan and Grey (1993) noted that rehousing was sometimes relied on as the main intervention to improve childcare – they identified eight cases in their review that had evidence supporting this.

In the same case one child was taken into care four times but:

> ... only limited action was taken to address (the mother's) inability to cope with her situation ... We (the reviewers) question the usefulness of respite care under these circumstances ... Continuous provision of respite care by (offices) was not useful as a permanent solution.
>
> (Case Three, Case Review, p. 16)

Such a plan focused on concrete solutions to issues that had existed for a long period of time and were more to do with relationships, child safety and parenting than speech development and provision of ongoing support.

Case Five included an example of how a concrete solution had a serious outcome for the mother. In response to the father leaving the mother a minimal amount per week to care for the children the Social Worker assisted the mother to get access to an ATM card. Upon discovering this, the father assaulted the

mother. While the strategy assisted in addressing the issue relating to the mother's access to money, it did not address those issues relating to family violence and unfortunately, it inadvertently precipitated a further incident of violence.

In the same case the reviewers specifically commented on use of concrete solutions as a means of trying to address more emotionally based problems. When this case is considered in its entirety it is not difficult to see the risks associated with concrete solutions being applied in isolation to other strategies. The first notification included an incident of domestic violence in which it was known that holes had been punched in walls, and there were concerns relating to historical incidents of sexual abuse involving the mother and the children. The reviewers noted that:

> The emphasis of this intervention was on the provision of material assistance for the family ... The Whanau Agreements that were entered into were more focused on the provision of resources for transport than ensuring that there was a contractual casework relationship ...
>
> (Case Four, Case Review, p. 15)

The Whanau/Family Agreements were intended to deal with matters relating to family violence, sexual abuse and a father's inability to provide care for one of his children. Provision of resources to facilitate transport, in the absence of other components of the plan designed to meaningfully address the care and protection issues within the family, meant that little changed with respect to the environment the children were in and the quality of care they received.

The risk associated with relying on concrete solutions is that doing so can serve to lull the Social Worker into a false sense of security that work is being done to address the emotional and relationship problems apparent in a case. In such cases the need to offer practical solutions to the problem over-rides the

importance of developing a broader intervention incorporating both concrete solutions and meaningful strategies designed to deal with what may be problems that have an emotional base.

Enmeshment

Enmeshment is characterised by the Social Worker doing more than 50% of the work because there is a lack of commitment by the family towards change. Morrison states that:

> It is significant that the majority of British child abuse inquiries have identified enmeshment or over involvement with families as a much more frequent problem than under involvement.
>
> (Morrison, 1993, p. 20)

Evidence of enmeshment was only identified in Case Five. All three incidents in this case related to attempts being made to engage parents in a plan designed to address issues of family violence and neglect. In the early stages of involvement with the case it was noted that referrals to SES and the GP were not actioned, as the mother refused to comply. This was despite the Social Worker making the referral, arranging the appointments and then providing transport for the GP visit. The mother initially indicated she would comply but at the point of leaving for the visit queried the value of going, then refused to go.

Initiative and efforts to get the children both medical and special education assistance were at the insistence and instigation of the Social Worker with minimal co-operation from the mother. It was clear that the Social Worker was doing more than 50% of the work in meeting the objectives of the plan. As time went by the Social Worker's perception of the mother developed and despite continued non-compliance with the case plan the Social Worker noted on the file that:

> ... (the mother) is rather a shy person and I have found it necessary to be sensitive to her feelings, making sure to allow

> her time to make her own informed decisions. She is very proud and responds positively to patient guidance.
>
> (Case Five, Case Review, p. 8)

This was noted within a context of the Social Worker having had: "... very little to do with the children" (Case Five, Case Review, p. 8) throughout the course of her involvement with the case. The care and protection issues for the children related to violence and allegations of harm by the stepfather.

Later in the case, and through the course of working on a different plan, it was apparent that despite his central role in parenting the children and being identified as violent towards both the mother and the children, the Social Worker had not spoken to the father. The father was not spoken to until some time after a Whanau Agreement was negotiated. The Social Worker noted on the file that: "Hopefully it won't be too long before (the father) and I can discuss (the child)" (Case Five, SWis File, p. 18).

Given this, the father did not become engaged in working on the plan and as a result the mother and Social Worker assumed primary responsibility for ensuring the plan objectives were met. In this sense the Social Worker became enmeshed with the family as opposed to working with them on resolving the care and protection issues apparent in the home.

Morrison (1993) notes that enmeshment can occur both between Social Worker and family as well as between agencies working with a family. This is characterised by separate agencies working on a plan in isolation to one another and without consultation. The effect on the family is said to be a series of contradictory interventions which are confusing and at worst immobilising. While there was no evidence of this aspect of enmeshment in any of the cases reviewed here it is an interesting variation on the simpler theme relating to enmeshment between the Social Worker and client/family.

Rule of Optimism

Clear links can be made between the rule of optimism and selective interpretations. Dingwall et al (1983) have identified that front line professionals make assumptions about the quality of care that can be expected from the different families they visit. They are said to adjust their sights accordingly and apply a 'rule of optimism' in which they find the most positive explanation of a situation, one which creates least conflict with parents and within themselves.

All three examples supporting the presence of this dynamic also related to other dynamics. In Case Three, the mother had called on at least one occasion in the past stating that she was going to harm the children if CYPFA did not respond immediately. On the second occasion the Social Worker stated that while the mother was saying that she wanted to get rid of the children, it was the Social Worker's assessment that all that was needed was for her to have a rest from the children. The Social Worker did not take into account the fact that the mother had stated very recently that she would harm the children if CYPFA did not react immediately. In making a decision about the best way to manage this case the Social Worker focused on the most favorable outcome – one which co-incidentally did not involve the children coming into care.

Case Four involved the Social Worker focusing on putting energy into a Housing New Zealand application rather than dealing with the safety needs of the children. "The Social Worker felt this would address concerns about the children's safety" (Case Four, Case Review, p. 16). One child was taken into care four times but: "... only limited action was taken to address (the mother's) inability to cope with her situation" (Case Four, Case Review, p. 18). The review team stated that:

> The Social Worker's actions seemed appropriate for the presenting problem, however once again there is no evidence of consideration being given to the causal problem of (the father's)

> violence, drug use and intimidation towards (the mother) or the possible effects of this on the children.
>
> (Case Four, Case Review, p. 18)

It would be interesting to note in each of these cases whether the Social Worker was driven by a commitment to practice in a manner consistent with a philosophy of minimum necessary intervention consistent with the safety of the child. This philosophy has been widely advocated within child protection but is at times sadly misguided when minimum necessary intervention is practised in the absence of maintaining the safety of the child. It seems logical to expect that one of the consequences of focusing solely on an approach of minimum necessary intervention will be that Social Workers will then seek to find the most positive explanation of a situation.

Minimisation

By definition minimisation refers to a process in which professionals disqualify external information in the face of what is considered to be superior knowledge. Morrison (1993) goes further to say that a professional system will use minimisation as a tactic to protect itself from further work. It is the opinion of the author that minimisation is one of the most common dynamics apparent in child protection. It is often evidenced by staff dismissing concerns held by others relating to children, treating a case with a degree of urgency several levels below that which is warranted and refuting claims held by other professionals.

The sample cases revealed evidence of varying degrees of minimisation. In Case One, despite concerns relating to failure to thrive, the mother leaving the child for periods and her "barely adequate parenting" (Case One, Case Review, p. 30) the care and protection issues involved in the first notification were not acted upon by way of any follow up.

Case Five contained a similar pattern of failing to act despite the existence of care and protection concerns. In this case information had been received from family members and the mother that the father was inclined to "over exert himself at times" (Case Five, Case Review, p. 8) when physically disciplining the child. This was said to involve occasions where the child was "booted up the bum'" by his father and that after a series of wrong-doings "severe punishment" from the father would result. These concerns were not recorded on the client file and were not acted on in the form of an investigation and assessment.

More commonly there was clear evidence that while the Social Worker took action, given the nature of the concerns being addressed the action was more often than not targeted at a lower level of intervention than was desirable. Case Three was closed after spending ten months trying to locate the mother and child. Initial allegations related to domestic violence, neglect and the mother's partner handling the baby roughly. The mother was eventually tracked down and came into the office for a short visit bringing the child with her. Concerns relating to domestic violence were dismissed upon the mother stating she had left her partner and that she didn't see him very much. Neglect issues were not investigated and the pattern of transience that developed during the investigation was negated on the basis that the mother identified an address at which she was living at the time she came into the office. On the basis of this meeting, and inquiries of Plunket, the GP and some family members, the case was closed.

Case Five involved the most note worthy example of minimisation. The Social Worker called at the home and found the child at home alone. As a result the Social Worker left a message for the mother to make contact with the office that day. The Social Worker subsequently noted on the file that: "I feel that (a community organisation) will follow this up and perhaps we need not be involved" (Case Five, Case Review, p. 25). This incident clearly warranted further action by the Social Worker. However, not only was the actual home alone incident not acted upon at the time it was discovered, the Social Worker also failed to see

that the case warranted any further action from CYPFA.

On two occasions evidence existed to suggest that Social Workers minimised the opinion and assessment of the community in relation to children for whom concerns existed. The first two notifications for Case One were received by Social Workers who knew the notifiers on the basis that they were clients of CYPFA. They believed that the information these notifiers provided them was the result of after-thoughts about the family rather being the primary reason for calling. This resulted in subsequent involvement, which did not focus on a full and informed investigation and assessment but rather a checking of key professionals to inquire as to the validity of the concerns.

In Case Five allegations were received from a member of the community that the children had been physically abused (whipped), had received bruises from the beatings, were being left home alone and that there was no food in the house. The Social Workers response to this was to make a decision to proceed with what was referred to as a "softly softly approach" (Case Five, Case Review, p. 9).

Categorisation of cases at intake was also noted to impact on the manner in which the case was followed up. All evidence of false categorisation related to a minimising of the seriousness of the concerns at the intake phase. The consequence of this was a response that did not match the degree of seriousness of concern in the case. Case One included a second notification which involved a request from two adults for assistance to leave violent partners, including help to find alternative accommodation. Despite the concerns relating to family violence and accommodation, the case was categorised as 'Problem Behavior'. The outcome of this notification did not include an investigation of the violence in the home as it impacted on the two children and adults. Some time later this case was again notified to CYPFA for the same concerns. The mother's violent partner eventually killed one of the children in the family.

In a similar scenario, Case Two involved a notification received by CYPFA that was categorised as relating to a 'Detrimental Environment'. The details of the notification related to an incident of abuse and should more accurately have been categorised as relating to abuse/neglect. Doing so would have resulted in the case being actioned quicker and with a different focus. In both cases, incorrect categorisation lead to a minimising of the seriousness of the child protection concerns.

Fragmentation

Case Four illustrates the manner in which families contribute selective information to an agency rarely painting the whole picture thus provoking a fragmented response within the professional network. The Social Worker had been trying to locate the child for some time. He was thought to be in the care of his stepfather. In explanation for the stepfather failing to 'produce the child' the Social Worker has recorded on file:

> ... (the stepfather) indicated that he had placed (the child) in hiding to protect him from the (his mother's) family and that (the child) was not attending school. He said that (the child) was receiving good care but that he was not prepared to disclose his whereabouts to NZCYPFA because he feared that information would be passed on to the (the mother's) family".
>
> (Case Four, Personal File, p. 30)

For a significant period of time the Social Worker attempted to locate the child by requesting the step-father provide information as to his whereabouts. As a result the stepfather was very selective about the information he supplied to the Social Worker. During one meeting, he stated that the whereabouts of the child was none of the Social Worker's business and he ordered them to leave the property. He is also reported to have said that the child was OK, that he was able to look after him and that there was no need for help from CYPFA. At this time the child is thought to have been killed by the stepfather.

In the same case, despite the fact that the mother and stepfather were living apart much of the time, the Social Worker also asked the mother about the whereabouts of her son. It is recorded on file that: "...she (the mother) also knew where (the child) was but would not tell the NZ Children and Young Persons Agency" (Case Four, Personal File, p. 75). In this respect, both parents volunteered minimal information to assist the Social Worker to locate the child.

Fragmentation can also occur within the relationships that professionals have with each other when working on mutual cases. One of the results of this, as evidenced in Case Three, is that different members of the professional community can end up holding discrete items of knowledge about cases. Despite the staff involved with Case Three feeling that they had a good working relationship with members of the community, it is noted on the file that: "It is surprising therefore that significant information held by these agencies was not accessed or co-ordinated in this case" (Case Three, Case Review, p. 30). This could be partly attributed to the fact that the organisations that held information about the family and children did not make it available to the Social Worker. It is, however, the author's opinion that it is more likely to have been due to the impact of the family failing to provide all those involved with all the information at any one point in time. Although some information was passed between organisations, a lack of clarity developed as to who had what knowledge, and therefore, organisations slipped into assuming that each knew what the other did about the case. Couple this with a family who displayed evidence of closure and resistance and a picture evolves of a professional network grappling to manage a dysfunctional family and thus mirroring some of what was happening in the family.

Cultural Relativism

It was interesting to note that from five sample cases, only two incidents of cultural relativism were apparent. Given the fact that three of the five cases

involved Maori children the author expected this dynamic to feature more significantly.

Cultural relativism serves to provide an infinitely elastic set of norms and values associated with family life and the care of children that can immobilise professionals of a different cultural or ethnic background. In Case Two it was thought that a Maori adoption had taken place and this contributed to attention being diverted from the care and protection issues that existed for the child. It is noted in the Case Review that:

> This seems to have had some effect on the depth of the investigation ... it seems that once this case was labelled a 'Maori Adoption', other standard investigative procedures were marginalised ... the above influences all served to detract from and predetermine the course of the investigation.
>
> (Case Two, Case Review No.2, p. 7)

In Case Five the review team was advised by at least five people that it was well known in the community that there was a history of inter-generational sexual abuse. The Social Worker had heard rumours, but considered it 'culturally inappropriate' to pry into this as there were no substantiated reports or allegations in respect of sexual abuse in relation to any of the children.

> It was never put into the equation ... that the widespread abuse of alcohol and neglect of children, as well as inter-marriage with violent and troubled families could be symptomatic of an intergenerational sexually abusive family system.
>
> (Case Five, Case Review, p. 31)

Such a response effectively resulted in the Social Worker being disempowered and the rumours relating to sexual abuse continuing in the absence of a comprehensive investigation.

Blurring Care and Control (Re-framing)

Morrison (1993) states that "... the way our behaviour accommodates to our covert needs as helpers, has a significant influence on our vulnerability to dangerous practice" (Morrison, 1993, p. 9). Case Three included a case note which described how at the conclusion to the first home visit the Social Worker supplied the mother with a card and her home phone number with instructions to: "...call anytime she needs help..." (Case Three SWis File, p. 5). This case note referred to an initial visit relating to an incident of domestic violence and involved a case that contained evidence of a history on the mother's part of threatening to harm the children if CYPFA did not respond immediately. The fact that the Social Worker provided the mother with her home phone number along with a suggestion that she could call anytime provided evidence of the Social Worker's behaviour accommodating to her covert need as a helper.

Case Five provided further evidence of the manner in which CYPFA workers lost a focus on their role as child protection workers and slipped into a helping role with the family. The review team report found that this case included elements of family violence; use and abuse of drugs and alcohol; historical concerns in relation to sexual abuse of the children and evidence of neglect. In response to this: "...the Social Worker's intervention was more of a supportive and admonishing nature designed to bring about change in an informal manner" (Case Five, Case Review, p. 31).

In the same case, but at a later date, the agreed upon Family Group Conference plan encompassed: "...monitoring rather than prevention" (Case Five, Case Review, p. 23). This was apparent despite issues having been identified in relation to excessive punishment/physical punishment of the child, domestic violence, children being left home alone, lack of food for the children, alcohol abuse and financial problems.

The impact of other professionals in the formation of recommendations and

decision making process was also apparent in Case One. Through the course of managing the second notification the Care and Protection Resource Panel recommended that the Social Worker refer the case to the Plunket Nurse and ask that she "monitor the situation" (Case One, Case Review, p. 30). The case was closed on the basis of this. However, a referral was not completed and the Plunket Nurse neither understood she was to have a monitoring role nor made any contact with the child and her mother. The Social Worker, with the support of the panel, decided that Plunket should be involved in assisting the family and that it was appropriate that this occur in lieu of an investigation and assessment being carried out. Aside from the fact that Plunket was never contacted to take on this role, it is questionable given the nature of the care and protection concerns, whether it was appropriate that the plan excluded CYPFA from having a role in managing the care and protection issues.

Hostage Theory

Case Five contained a scenario that clearly depicted the impact of Hostage Theory on the Social Worker's assessment process and overall management of the case. The Social Worker stated that she did not agree with some FGC recommendations however she did not feel able to voice her disagreement. The reasons for this, as documented on the file, were as follows:

- She thought the family should be given the opportunity to carry out their own decisions.
- She thought there might not be sufficient grounds for an Application for Declaration through the Family Court in any case.
- She thought she was the only person at the Family Group Conference who did not agree with the decisions.
- She was unsure whether there were current concerns as all the reports indicated that the children had been removed.
- She began to wonder about the reasons for doubting the wisdom of the family's decision, becoming concerned that she might have either

> become overly judgmental of the family or overly protective of (the child)
>
> (Case Five, Case Review, p. 20).

It is recorded in the case review that case notes relating to this Family Group Conference stated that: "It seems that the Family Group Conference did not provide a safe environment for either professionals or family members to express their views openly" (Case Five, Case Review, p. 20). It is little wonder that this was the case when one considers that those involved had either heard about or feared the consequences of a negative response from the father in the event he was challenged about his role with the family/children. Such was the degree to which the Social Worker was held captive by the family that the review team noted in their report that: "...one Social Worker, working alone with this particular family system did not have a significant chance of success" (Case Five, Case Review, p. 35). As Morrison (1993, p. 27) states, "Powerless professionals cannot either protect children or promote change in abusing families".

Knowledge Deficit

Parker (1994) found that in the deaths of two children, Social Workers allocated to the case had inadequate knowledge bases upon which to rely when they made decisions about the cases and that this factor significantly contributed to the children's deaths. Four of the five sample cases in this research contained evidence of Social Workers lacking adequate practice knowledge. Whether this was the result of Social Workers being new to CYPFA or having had a change in roles within the organisation the result was the same – staff lacked adequate practice knowledge to be able to effectively manage the case.

Case One highlighted the importance of re-training for staff when their role within the organisation changes. The Social Worker who managed the first notification for this child had been working in Adoptions and had: "...very little experience and no training for investigation and assessment work" (Case One, SWis File, p.

5). This significantly hampered her ability to conduct a well-informed investigation and assessment.

In Case Three the review team found that there was evidence in the way the case had been managed to indicate that: "Learning from attendance at training did not transfer into practice" (Case Three, Case Review, p. 23). Cases Three and Four highlighted specific knowledge gaps with both individual staff and the Site involved. In Case Three the case review report noted that "Most Social Workers interviewed were not clear either about the role of the Panel or the process of referral" (Case Three, Case Review, p. 17). Case Four contained evidence of a belief that has already been mentioned. The:

> ... office worked with this family in a context of a heavy emphasis on minimum NZCYPFA intervention through the use of an investigate, assess and refer model. This was based on a belief that this was the intention of the Act... "
>
> (Case Three, Case Review, p. 14)

What was missing from the office's understanding of how the Children Young Persons and their Families Act (1989) was to be implemented, was that while the emphasis was rightly placed on a model of minimum necessary intervention, this was never intended to be to the detriment of the child's safety. At the time the Children Young Persons and their Families Act (1989) was introduced CYPFA staff had been equipped with information relating to the principle associated with minimum intervention, however, as indicated in this case, that information was not well integrated into practice.

The case review report for Case Five yielded evidence of staff who did not have the necessary knowledge to be able to conduct thorough assessments and interpret what was happening in the case in a manner resulting in the care and protection issues being well managed. This was clearly stated in the case review:

> With hindsight, it is apparent that the Social Work staff did not

> have the requisite background of training and experience in child protection investigation and assessment to have made a difference in this case.
>
> (Case Five, Case Review, p. 35)

Burnout

The existence of Social Worker burnout can result in decreased effectiveness and ability to help families. Burnout can be apparent in casework when Social Workers are seen to forget details of the case, become immobilised by the work they have before them, lose their ability to plan and achieve tasks and, fail to turn up at work due to ill health.

Case Three presented a graphic example of the impact burnout had on staff managing the case. The child's death occurred at a time when staff morale was described as low. The review team noted that:

> Staff are barely coping and do not take a proactive approach in delivering quality services. The review team found the office climate was not conducive to the delivery of a professional social work service. Staff appeared exhausted and depressed. And, Social Workers stated they felt stressed in not being able to do their work properly.
>
> (Case Three, Case Review, p. 19)

Staff morale was considered to be low both at the time the child died and at the time the case review was completed. Given this, it is difficult to imagine how staff would have been able to provide a service which both succeeded in protecting children and assisting families to change. Morrison notes that:

> ... there are no quick fixes or standardised remedies for the complex emotional turbulence of child protection. What is clear however is that such processes are best understood as a triangular interaction involving agency, clients and workers.

(Morrison, 1996, p. 20)

This will be discussed further in relation to the organisational issues impacting on practice, but it is important to note here that while burnout is experienced by the worker, it is clearly part of a wider construct involving both the organisation and the families with whom staff work.

Response to Experience of Violence

Bibby (1994) notes that common psychological consequences of a violent incident include:

- a sense of isolation
- problems with decision making
- fear of further violence
- lack of confidence in handling potentially violent individuals.

Not surprisingly, and in keeping with the evidence which existed in this case of Hostage Theory, Case Five highlighted the impact that the father's behaviour had on the Social Worker. The Social Worker's report to the Care and Protection Co-ordinator refers to a perceived threat from the father: "Mr. ... is reputed to have little regard and respect of people, place and time, which has caused us to practice careful and discreet inquiries" (Case Five, Case Review, p. 12). The Social Worker reported that: "... I was frightened of (interviewing the father) because of what (the mother) had warned me of" (Case Five, Case Review, p. 12). She had been warned by the mother about a possibility that her personal safety could be endangered if she was to proceed with certain actions. As a result, although the Social Worker was not in agreement with what the family had come up with, she was not able to voice her disagreement with the FGC outcomes. It was only once she was removed from the situation, sometime after the child's death, that the Social Worker was able to state that she did not agree with what the family had recommended. The review team identified the following as contributing to the Social Worker's failure to voice non-agreement:

> It seems that the Family Group Conference did not provide a safe environment for either professionals or family members to express their views openly.
>
> (Case Five, Case Review, p. 20)

This appeared to be due to the fact that those involved had either heard about or feared the consequences of a negative response from the father in the event he was challenged about his role with the family/children.

Use of Legislation and Authority

Statutory Social Work activity can be seen as the functioning of the law in practice. Social Workers who do not recognise this do not appreciate their proper role and function and the full significance of their responsibilities. Parton and Parton (1989) discovered that Social Workers' lack of confidence, particularly when working with confronting parents, stems in large measure from uncertainty about the legal powers and authority that is vested in them by the statutes. The impact of this is often that workers focus on the needs and rights of the parents to the exclusion of those of the children, and that they become uncertain and anxious to protect themselves rather than influencing families and protecting children.

This is well evidenced in Case Five, where due to the Social Worker's concerns that interviewing the children would result in heightened risk for them, a decision was made not to intervene with a formal investigation. This decision was made against a background of concerns for the children including neglect, family violence and historical sexual abuse. This decision was discussed with a supervisor and rationalised by stating on the file that:

> It was decided that formal investigation not be undertaken. There were a number of reasons for this – among which are the safety of the children whom could be exposed to increased risk if interviewed tendency of father to be violent – toward anybody.

(Case Five, SWis File, p. 18)

While acknowledging the dilemma this kind of scenario presents to Social Workers, in this case a reasonable belief was held that the children were being or were likely to be harmed and that in itself provided grounds for an application for a warrant to secure the safety of the child. This would have placed the children in the custody of the Director General and allowed for an investigation to take place over a period of five days. The Social Worker and supervisor appeared to have had a degree of uncertainty about the power vested in them by the legislation and as a result their focus shifted to protecting themselves as opposed to influencing the family or taking action to protect the children. Critical though this may seem, statutory Social Work is largely driven by the legislation provided. A clear understanding and competent application of that legislation is fundamental to being able to protect children, work with families and avoid collusion.

**THE FAMILY-PROFESSIONAL SYSTEM**

The nature of the relationship between Social Workers and the families they work with is at the heart of this research. Reder, Duncan and Grey (1993) identify two extremes of family-professional interaction. The first relates to families who are observed to attract professional attention in an attempt to overcome dependency needs and experiences of deprivation. Other families are said to resent what they view as intrusion and persecution. In between these extremes are families who develop what is referred to as ambivalent relationships with professionals and both attract and repel attention. Translated, this can be understood to refer to families who are perceived as dependent, families who attempt to maintain control and in between families who fluctuate between the two.

How families react to the involvement of professionals poses a significant challenge for Social Workers. Added to this is the dilemma of adjusting responses to families whose reactions alter from time to time and having to react in a manner which is consistent with ensuring that an adequate response is

provided in the face of identified care and protection concerns. A family that fluctuates between reacting to the involvement of Social Workers by closing down then changing to allow contact, requires a Social Worker who is able to recognise and respond to these changes in behaviour. Failing to detect and respond to changes in behaviour may result in a family manipulating the Social Worker to a point of complete powerlessness.

The sample cases revealed evidence that significant care and control issues were apparent in the relationships Social Workers had with the families with whom they were working.

Not-exist Double Bind

Reder, Duncan and Grey (1993) describe this as a 'not existing' pattern of abuse. This involves a sequence of events whereby the Social Worker fails to get access to the child and is therefore unable to determine that s/he is safe. This is accompanied by a belief on the part of the Social Worker that the child is well regardless of the fact that s/he was not sighted.

In Case Five the Social Worker had been trying to get the step-father to make the child available both in order that the Social Worker could check that the child was all right and interview him regarding sexual abuse allegations. The family had resisted the Social Worker's request to produce the child. In doing so they repeatedly told the Social Worker that the child was or would be going to school and was safe. This is documented on the file:

> ... (the father) presented himself at the ... office and said he was moving to (a location) and that (the child) was not enrolled at school at present but he intended enrolling him in ...
>
> (Case Five, Case Review, p. 24)

The Social Worker accepted that this would occur. Shortly after this a home visit was made and as a result of still not being able to sight the child, the Social

Worker became even more concerned. Follow up revealed that the child was not at any schools in the areas that the father had indicated he was intending to enroll him. Had the Social Worker not asked about the child, the stepfather would not have been required to produce any evidence that the child existed.

It is noted in the case review that while this child was the focus of attention from the school and CYPFA: "In other ways he appears to have been the invisible child in the family" (Case Five, Case Review, p. 35). While the Social Worker was prepared to settle for the explanations the step-father offered as to where the child was, this effectively allowed the step-father to continue to behave as though the child did not exist. At the same time the Social Worker's anxieties were alleviated as she had asked and was told the child was fine. It was not until some time later that concerns arose because the child was never found to be where the step-father said he was. By the time the child was eventually located, he had been killed. Failure to insist that the child be sighted by the Social Worker had resulted in an opportunity for the child to be fatally harmed.

Disguised Compliance

At times where an increasingly controlling stance is taken by professionals towards families a seemingly co-operative response may result. The effect of doing so enables the family to neutralise the Social Worker's authority thus returning the situation to a point where the family consider themselves to be back in control.

Following the death of a child, the Social Worker in Case Three met with the mother to discuss the care of the dead child's sibling. The mother had agreed, prior to the child's death, that she would ensure that her violent partner was kept away from the home. As far as the Social Worker was aware the mother was successful in achieving this. After the death, the mother revealed that, despite the fact that she had said she would keep her violent ex-partner away, he had been around to the home frequently prior to the child dying. It was apparent that

the mother had sufficiently convinced the Social Worker that her partner was not in the home.

In the same case it was documented in the case review report that:

> (the mother) agreed to work with NZCYPFS to ensure the children's safety and to follow up ... speech development and to have ongoing support.
>
> (Case Three, Case Review, p. 12)

Despite this, when the Social Worker made the necessary arrangements the mother refused to accompany the Social Worker to pre-arranged appointments.

Flight

Flight is best described as the manner in which families move from one location to another, often with little or no warning and usually as a result of professionals attempting to become more involved. Flight is considered to be an attempt by families to maintain control in the relationship they have with professionals by establishing physical distance between themselves and those involved with the family.

Between May and September 1992 there were three case notes on the files of Case Two indicating a degree of transience within the family. This occurred around the time the Social Worker was trying to complete an investigation. Case notes stated: "It would be good to know where they are living. The address could not be found" (Case Two, Siblings SWis File, p. 21). During this time the mother was aware of an investigation being conducted and it appears she continued to move around without advising the Agency of her location.

In Case Four, CYPFA had placed two of four children in Foster Care subject to a Section 139 (CYPF Act 1989) Temporary Care Agreement. The case plan involved working towards placing the remaining two children in care. Before this

happened, the mother left with the children and returned to where her violent ex-husband was living. CYPFA was alerted to this.

> A phone call from (the child's) school alerted New Zealand Children and Young Persons Service to the fact that (the mother's) intention was to take the two younger children to (another location) forthwith. She was very distressed and angry.
>
> (Case Four, Personal File, p. 12)

Clearly, the threat of the remaining two children being removed, had resulted in the mother electing to leave at short notice in an attempt to maintain control of the children she still had in her care. While she alerted the school to what she was doing the Social Worker was not contacted. Flight is considered to be a variant of closure.

Closure

While flight refers to families closing the boundary between themselves and others by moving elsewhere, closure refers to families using a range of other tactics to close boundaries. Closure is commonly evidenced by the nature in which families retreat from contact with professionals through failing to attend appointments, not allowing Social Workers into the home and withdrawing children from usual activities like school. Closure may be intermittent in which reoccurrence coincides with increased involvement of professionals, or persistent in which the family shuns contact from the outside world. On occasions closure may be fatal in that a withdrawal from the outside world may occur in conjunction with escalating abuse or neglect of children. Reder, Duncan and Grey (1993) stated that they:

> ... understood closure to be primarily an issue about control with parents feeling that they were in precarious control of their lives and that outsiders were unwelcome intruders who would further undermine them.
>
> (Reder, Duncan and Grey, 1993, p. 99)

Cases Three and Four contained evidence of fatal closure. In Case Three a Special Education Service assessment was organised as part of a plan CYPFA had developed to assist the mother to cope with two children. On the day of the appointment the mother phoned to cancel the appointment and refused to go. Five days later one of the children was fatally harmed.

Case Four involved a family that had been identified by the Social Worker as becoming elusive. However, at the point this was acknowledged the Social Worker withdrew from further contact with the family. This is documented on the file in the following way:

> ... family became elusive. At this point a decision was made by the Social Worker to close the notification and leave it to the family to remake contact with the Agency as they wished.
>
> (Case Four, Case Review, p. 10)

Sometime later CYPFA again became involved with the family and as was the case during the first involvement, the Social Worker's persistent attempts to sight the child were unsuccessful. It is documented on the file that:

> ... (the Social Worker) has been unable to sight (the child) ...(the father) says that he has not allowed access to (the child) because he wants to keep him safe ...He still refuses to inform us of (the child's) exact whereabouts ... despite his vehement opposition and peripatetic lifestyle of late, which has defied social work involvement.
>
> (Case Four, Personal File, p. 23)

While taking further action to get access to the child it was revealed that the child had been killed sometime during the onset of a period of closure.

Only in retrospect is it possible to know that closure is about to become terminal. A significant dilemma exists for professionals working with a family receiving assistance who then withdraw from this due to a sense that they are losing control. Just as the act of withdrawing has the potential to lessen the degree of security and safety in the family for the children so too does any attempt by the Social Worker to regain involvement with the family as this is perceived to be even more controlling. Therein lies a bind for professionals in relation to issues of control within child protection.

Resistance

Morrison (1993) identifies four forms of resistance.

- hostile resistance – an overt form of resistance which is highly threatening and may sometimes involve the use of physical force.
- passive aggressive resistance – passive aggressive families are overtly co-operative but covertly defiant.
- passive hopelessness – parents present in the role of victims.
- challenging/chaotic resistance – typified by threats made to harm children unless requests are immediately satisfied.

(Morrison, 1996, p. 15)

Passive aggressive and challenging / chaotic resistance were evident in the sample cases.

Case Five involved a Social Worker developing plans to address what were assessed to be care and protection issues warranting further action. The family was noted to passively resist intervention by means of not attending counselling. The case review team noted that: "(the Social Worker) also sustained her actions in the face of passive non-compliance of the clients..." (Case Five, Case Review, p. 16).

In the same case, the stepfather and mother both resisted attempts by the Social Worker to implement a plan. As noted in the evidence referred to regarding closure:

> ... (the father) indicated that he had placed (the child) in hiding to protect him from (the mother's) family and that (the child) was not attending school. He said that (the child) was receiving good care but that he was not prepared to disclose his whereabouts to NZCYPFS because he feared that information would be passed on to the (mother's) family.
>
> (Case Five, Personal File, p. 30)

The father was overt in the way he made it clear that he would not convey the child's whereabouts but demonstrated resistance by refusing to produce the child for the Social Worker or to indicate where he was living. While this resembled closure, the evidence also points to overt resistance as a tactic used to avoid the Social Worker gaining access to the child. In the same case the mother exhibited a similar response when she was contacted to assist with locating the child. "She, (the mother) also knew where (the child) was but would not tell the NZ Children and Young Persons Service" (Case Five, Personal File, p. 75). The mother was co-operative in identifying that the child was alive and well but, as was the case with the step-father, she failed to assist in producing the child or in indicating where he was.

Challenging or chaotic resistance was evident in Case Three. The mother contacted the duty Social Worker demanding assistance immediately. When a promise could not be made that someone would be there that day she threatened that something would happen to her children if CYPFA was not interested. This pattern repeated itself on at least three separate occasions. Threats to harm children if agencies do not comply with what is demanded is considered a challenging or chaotic form of resistance.

Manipulative Behaviour

Hepworth (1993) notes that manipulative bahaviour is a means of deliberately influencing or controlling the behaviour of others to one's own advantage by using tactics like charm, persuasion, seduction, deceit, guilt induction and coercion as well as making glib promises to change. Clients who manipulate are said to do so more to gain control over the relationship and process than to exploit the worker.

A range of manipulative tactics may be used to gain control. In Case Five it was documented that:

> The family are well known to social service agencies in (an area) and there appears to have been a certain communal acceptance that they were a difficult family to work with or to bring about any substantial change. They are regarded as a 'closed shop' who would report each other to DSW while attempting to gain Special Needs Grants for themselves, but would not be prepared to substantiate any reports of abuse or neglect when asked to do so.
>
> (Case Five, Case Review, p. 3)

Seeking to gain unearned benefits, including use of manipulation, is evidenced by the way the family used disclosure of information about each other to entice payment of Special Needs Grants. In addition, the manner in which they continually focused on each other resulted in avoidance of them then engaging in the helping process.

Covert Warnings

These can be seen as the opposite to closure in that families may approach professionals and communicate what was, in retrospect, a disguised admission that abuse was escalating. Only in retrospect does it become possible to claim

that some parental behaviour has constituted a covert warning of impending escalation of maltreatment.

This research did not reveal any evidence of parents approaching CYPFA communicating in a way which could have been in retrospect, interpreted as a disguised admission that abuse was escalating. However, evidence existed to indicate that a number of incidents did occur which can, in retrospect, be seen to be indicators that abuse was escalating. Both incidents occurred in Case Three.

The first involved a notification which indicated that the father of the child, whom had a violent relationship with the mother, was seen in public: "swinging the child around by the hair" and had "picked a push-chair up and chucked it at the child" (Case Three, Sibling File, p. 30). A home visit was conducted and the father gave his version of events. Two months later, a further notification was received involving another incident of Domestic Violence. One child received marks on her face and the mother was removed from the house to the Refuge. There is little documented evidence of any follow up by CYPFA having taken place and approximately three weeks later the child who received injuries from this incident was killed by the father. Within two months of the child's death CYPFA was made aware of two new incidents of violence perpetrated by the father on the children.

In the second example, the child was placed in care as a result of the mother threatening to harm him – she then took him back two days later. Five months later she again demanded the same child be placed in care – this was done for a few days. Two weeks after that she again demanded the child be placed in care on the grounds that she could not cope with him and was likely to hurt him if he was not placed. Three days later she removed him from the placement. Some months later the mother gave the child and his sibling to her violent partner. Soon after this the partner killed the sibling. While the mother was not responsible for the death of the child, a pattern had emerged of her contacting CYPFA asking for the child to be placed, stating that she could not cope and that she would harm

the child if he were not placed. This ended with the child being given to her violent partner.

## INTERPROFESSIONAL COMMUNICATION AND SHARING OF KNOWLEDGE

Reder, Duncan and Grey (1993) found that interagency communication was flawed in the majority of cases they reviewed. Child death inquiries in England documented a legacy of poor information sharing and an inability on the part of those involved to ensure that children did not fall through the net. At the root of poor interagency working relationships is the problem of poor communication. The sample cases in this research revealed similar evidence to those that Reder, Duncan and Grey (1993) examined.

### Inter-professional Communication and Sharing of Knowledge

A dynamic which has an impact on the effectiveness of multi-disciplinary case management is the manner in which professionals communicate and share information. Absence of common understanding among professional groups and 'strained relationships' have the potential to compromise open and accurate information sharing.

Case One revealed evidence of the way in which strained relationships had an impact on the manner in which the case was managed. Comment is made on the paper file that in the area where the third notification was received "...there were long waiting lists for referrals to the ... Evidential Unit and this affected decisions regarding sexual abuse investigations." In addition it is noted that:

> ...relationships with the ... Police were extremely difficult at the time with little support or co-operation from the Police. There is no formal CAT team and child abuse work is seen to be a low priority for the Police.
>
> (Case One, Case Review, p. 29)

It was further stated that: "The absence of a functional joint Police and NZCYPFS

child abuse team seriously compromises a Social Worker's ability to provide effective services to children and families" (Case One, Case Review, p. 29).

In Case Five the interagency issues were linked to the Social Worker receiving what she interpreted to be mixed messages about what was happening for the children. While monitoring the case and checking back with the child's school, two teachers at the school provided the Social Worker with differing information. The frustration that this caused the Social Worker is evidenced on the file by her comment: "I hope (the teacher) will eventually discontinue conveying 'mixed messages' to me" (Case Five, SWis File, p. 18).

Effective communication is fundamental to the practice of child protection work. Considerable effort is needed to establish and build meaningful relationships between organisations involved in the child welfare sector. Once established, these relationships are relied on to function in a way which facilitates information flowing between the organisations as it should. Failing to have sound relationships based on a common language to be used to convey information relating to the care and protection of children, results in a lack of ability to work together and a lack of clarity as to the meaning attached to shared information.

Polarisation

Reder, Duncan and Grey (1993) identify polarisation as the result of points of views held between two individuals or groups progressively diverging over time. Although the communication between these groups may be adequate, information or ideas are rarely exchanged between them. Polarisation is evidenced in the sample cases by some workers making the child's protection their primary focus, while others giving primacy to the parents and their needs. In Case Two Social Workers were: "...predominantly influenced by the comment of other professionals which indicated that (the mother) was a good parent" (Case Two, Case Review, p. 3). This occurred despite one of the children being taken to the doctor with a broken arm and black eye. These injuries occurred within a

short space of time and the explanation given was that the child had had accidents (the child was a toddler at the time). Despite being influenced by the other professionals, the Social Worker held an opposing opinion with respect to the parent's ability to provide adequate care. It was apparent that the Social Worker's primary focus was the care and protection of the child whereas the other professionals were focused on the mother's ability to parent.

Case Four highlighted evidence of how polarisation can occur between CYPFA Social Workers from different Sites when jointly managing a case. The review team report highlights elements of the relationship that had developed between two Sites through the course of taking action to locate a missing child.

> During this final period the communication problems that characterised the case in the early stages escalated and undermined the effective management of the case. Both offices became more rigid in their perspectives of the 'rightness' of their own actions, and this was compounded by the fact that in their own ways they were both right ... this became a 'no-win' situation for both offices and, as a result, both offices did not communicate over important case work developments...
>
> (Case Four, Case Review, p. 30)

Both Sites interacted together in a way which became increasingly polarised in relation to what each thought was the best means of managing the case. Towards the final stages, it became clear that communication had ceased. As a result, the chances of being able to take action to address the divergence in opinion lessened to a point whereby the solution became one Site withdrawing from the case.

Exaggeration of Hierarchy

Only one example of this dynamic existed in the sample cases. In Case Two the Social Workers were noted to be: "...predominantly influenced by the comment of

other professionals which indicated that (the mother) was a good parent" (Case Two, Case Review, p. 3). While the occupation of the other professionals is not known, the fact that the Social Worker deferred to their opinion may be indicative of the Social Worker perceiving his/her opinion to be of lesser significance than that of others.

Exaggeration of hierarchy is characterised by professionals with lower perceived status deferring to the opinion of others who are perceived as hierarchically superior. In this case, deferment to the opinion of others occurred in the face of serious concerns for the care and well being of the children (one of the children had been taken to the Doctor with a broken arm and black eye). Regardless of the Social Worker holding a differing opinion to these professionals, in this case it was the opinion of the other professionals that often carried more weight in decision-making.

Systems Failure

The dynamic referred to as systems failure was developed to capture a large volume of evidence relating to breakdowns in the systems CYPFA uses to record and distribute information about clients. Such was the frequency with which this dynamic featured that it was considered important to include it in this research.

Four of the five sample cases contained evidence of occasions where the CYPFA information systems were incorrectly utilised by staff.

Frequently, use of the computer system was identified as a weakness. For example in Case One, transfer of information from one computer database (OLE) to another (CYPFis) resulted in some information not being established on the new social work database. This subsequently lead to Social Workers not having easy access to all relevant and recorded information. In 1995 the social work recording system called 'CYPFis' ceased use in preference for the current system known as 'SWis'. Change over between the two systems resulted in

some data being difficult to access at the point of conversion in one of the sample cases. In this case the third notification was received immediately prior to the change over and it appears that information from the central data base was more difficult to access hence a 'central search' was not conducted.

Paper files were not exempt from similar difficulties. In Case One a personal file was not established for the client. Paper based information was held on what was referred to as a miscellaneous file and as a consequence was largely inaccessible. Systems did not exist to facilitate the miscellaneous files being transferred to a client file. In Case Five, paper based miscellaneous files and information were misplaced. This information remained where it was stored while the rest of the files were transferred to another Site. As a result of this: "...some time later this office also created a record for (the child) under the name of... Incomplete records were transferred from one office to the other" (Case One, Case Review, p. 12).

Transfer of information from one Site to the next was also problematic in some of the sample cases. In Case Three it was noted by the review team that: " The transfer of files between the three offices involved was either not actioned or actioned after lengthy delays" (Case Three, Case Review, p. 19).

Case Four contained similar concerns.

> There have, however, been major difficulties in transfer of records from (an office). This has been caused partly from the duplication of records, with no tagging of records created in error..

and,

> This has been exacerbated by the temporary 'loss' of the miscellaneous file in ... and the fact that when a family file was created these papers were not included in it. In addition, many of

> the early records kept in the day book have not been copied and included in the paper files.

and,

> Case ownership and information confusions were important in the course of the case as they interfered with ... office making early sustained contact and early re-assessment of the care and protection issues for the children.
>
> (Case Four, Case Review, p. 17)

Problems associated with systems were not confined to the manner in which files were managed. One office was subject to a number of significant changes in personnel and office systems leading up to the child's death. "Those factors included changes to a number of systems, staff absences due to leave and transitional training, budget constraints and a change in management" (Case Three, Case Review, p. 3). These circumstances were thought to have significantly contributed to the effectiveness of the service provided.

A similar scenario was documented by the review team in Case Four, where, following a notification of physical abuse the father was contacted in order that the allegation could be investigated. It is noted on the file that: "Once (the child and father were) located there was no follow up due to staff absences and system changes" (Case Four, Case Review, p. 10).

Case Three also articulates the impact that changes in systems can have on service delivery. The review team noted that:

> ...small combination of factors in the ... office made it difficult for a small team to deliver a safe care and protection service. These factors included changes to a number of systems...
>
> (Case Three, Case Review, p. 3).

## DYNAMICS WHICH DID NOT FEATURE

A number of the dynamics could not be identified in the sample cases. These included:

- Transference/counter-transference.
- Functional/dysfunctional learning cycle.
- Systems abuse.
- Professionalism.
- Defensive social work.
- Agency defence mechanisms.
- Natural love.
- Destructive rescuing.
- Belief systems of the worker.
- Anxiety response.

In determining why evidence did not exist to support the presence of these dynamics, it is important to consider whether the design of the research was sufficient to facilitate detection of relevant evidence. As stated, a documentary analysis relies on the existing documentation to form the basis of available data. Put plainly, this means that the research is restricted to data recorded on files. Reid and Smith (1981) note that the limitations of case records for the measurement of intervention is well known. They cite incompleteness, inaccuracy, selectivity, and bias as typical problems. In addition they state that the nature of case recording often precludes any fine grained analysis of what practitioners do.

Despite this, evidence was identified on the files to support the existence of two thirds of the identified dynamics. That being the case, it is important to examine the nature of each of the remaining dynamics to ascertain why they have not featured.

Given the limitations of documentary analysis the issue of complexity is raised as a possible explanation for an absence of evidence relating to some dynamics. Transference/counter-transference and functional/dysfunctional learning cycles are both particularly complex dynamics that involve a number of different components. Rather than having what could be termed singular definitions, as in the case of minimisation, flight, resistance etc., both these dynamics are multifaceted and complex. As a result of this a possible explanation as to their absence from the sample cases could be that the research method was not sufficiently complex to enable their detection. It may be that a more sophisticated research method, perhaps one involving interviewing those involved with each case, may have revealed more detailed evidence supporting the existence of these two dynamics. At the same time, a more complex methodology may not have revealed any evidence of these dynamics as it may simply be that the dynamics did not feature in the case.

So what of the less complex dynamics that didn't feature? None of the remaining nine are considered complex in nature. In comparison to the dynamics as a group, each has a relatively simple definition that easily lends itself to being applied to a case. The only realistic explanation of their absence is that the evidence was simply not present in any of the sample cases. While using a more sophisticated methodology to complete the research may have revealed a wider range of evidence, the very fact that two thirds of the dynamics did feature in the sample cases indicates that a more sophisticated research method was not warranted.

**DYNAMICS THAT RELATED TO ONE ANOTHER**

In examining the evidence for each dynamic, it became clear that some of the dynamics could be linked through common evidence. Interestingly there appeared to be themes relating to the dynamics that were linked. The themes related closely to the work of Reder, Duncan and Grey (1993) and included the following:

1. The way professionals worked together - polarisation and exaggeration of hierarchy.
2. The way CYPFA managed information - information treated discretely and systems failure and fragmentation.
3. Case decision making - rule of optimism and concrete solutions.
4. Behaviour of the family towards the worker - disguised compliance and resistance and manipulative behaviour and closure.
5. Threats and intimidation towards CYPFA staff - response to experience of violence and hostage theory.

**THE WAY PROFESSIONALS WORKED TOGETHER**

A common link with respect to this category related to the manner in which Social Workers viewed the information provided by other professionals. In the face of clear evidence that care and protection issues existed, the Social Worker in Case Two viewed the opinion of another professional as carrying more weight than her own assessment of the case. The case review team found that the Social Workers were "...predominantly influenced by the comment of other professionals which indicated that (the mother) was a good parent" (Case Two, Case Review, p. 3).

While it is not clearly stated on any of the files, the impression gained is that this deferment of opinion was related to a professional whom the Social Worker appeared to consider as more knowledgeable than she and whose opinion was subsequently considered to carry greater weight.

It is the opinion of the author that such deferment to the opinion of professionals can be directly related to a number of factors. Morrison (1993, p. 4) states that "...societal responses to child abuse are ambivalent". Such ambivalence is said to result from the fickle response society has to situations where child protection workers are seen to fail in their duty to protect children. This kind of response generates in social work thinking what can be referred to as a 'damned if you do,

damned if you don't' philosophy. The impact of this is twofold. It can be seen to undermine the credibility of the child protection agency as well as impact on the Social Workers' confidence in their assessment and judgment. As a consequence Social Workers may, from time to time, react by deferring to the opinion of other professionals as opposed to assessing all available information with a view to developing their own assessment. It is the author's opinion that this occurs in part as a result of Social Workers' confidence having been undermined by the messages society conveys about the competence of the child protection system.

Alongside this, Social Workers are also faced with working in multidisciplinary teams and the dilemmas that this sometimes presents. Though often unspoken, a hierarchy exists within multidisciplinary teams as to an order of importance of opinion. Medical practitioners are often referred to as 'experts'; a status child protection workers rarely acquire nor have confidence in assuming. Once a professional has acquired the label 'expert' that person's status and opinion within the multidisciplinary environment takes on a new and enhanced meaning. In the face of this and the fact that the social work is not considered high in the professional hierarchy, it is sometimes the case that Social Workers will defer to the opinion of others.

**THE WAY CYPFA MANAGED INFORMATION**

This category captured some of the most disquieting evidence to come out of the sample cases. The evidence for systems failure, information treated discretely and fragmentation was littered with examples of poor information management, which then led to faulty decision making. This included:

1. Decisions being made with incomplete information. For example in Case One the Social Worker acknowledged to the review team that: "...if she had the historical information available her assessment would have been different" (Case One, Case Review, p. 16).

2. Difficulties in locating and accessing information. In Case Three "The review team had difficulty locating all the information and making sense of the information that was available." and "Significant information held by these agencies was not accessed or co-ordinated in this case" (Case Three, Case Review, p. 18).
3. Extreme difficulties with ensuring all the information about a child was on one file and failure to deal with duplicated files. Case Four revealed that:

> "There have, however, been major difficulties in transfer of records from ... This has been caused partly from the duplication of records, with no tagging of records created in error ... This has been exacerbated by the temporary 'loss' of the miscellaneous file in ... and the fact that when a family file was created these papers were not included in it. In addition, many of the early records kept in the day book have not been copied and included in the paper files.
>
> (Case Four, Case Review, p. 17)

4. Case transfers, which either didn't happen or occurred in a haphazard manner. " The transfer of files between the three offices involved was either not actioned or actioned after lengthy delays" (Case Three, Case Review, p. 13).

The result of this is a picture of disorganisation and dangerousness with regard to the management of information in relation to the children and families in the sample cases. This, coupled with the state that case files were in when received by the author (disordered, incomplete and contained evidence of poor case note recording), indicates that CYPFA has a significant problem with information management which can be seen to contribute to the circumstances surrounding the death of children known to the Agency.

**CASE DECISION MAKING**

This category included the rule of optimism and concrete solutions. As Social Workers applied the rule of optimism to their casework it was evident that in doing so the plans they subsequently developed were often based upon concrete solutions to problems. This is well demonstrated in Case Three in which Social Workers focused on putting energy into an Housing NZ application rather than focusing on strategies to address the safety of the children. As the file states: "The Social Workers felt this would address concerns about the children's safety" (Case Three, SWis File, p. 6), and:

> One child was taken into care four times but "... only limited action was taken to address (the mother's) inability to cope with her situation. We (the reviewers) question the usefulness of respite care under these circumstances ... continuous provision of respite care by (offices) was not useful as a permanent solution.
>
> (Case Three, Case Review, p. 16)

In this case the Social Worker was faced with managing a series of allegations relating to family violence and neglect of the children. Such allegations had been occurring for a long period of time. Despite this, the Social Worker persisted with a plan based on respite care for the mother and relocation into another home. The issues relating to family violence were not addressed in any other way.

In Case Four a similar scenario developed except this time the plan was formalised into a Family/Whanau Agreement. It is noted by the review team that

> The Whanau Agreements that were entered into were more focused on the provision of resources for transport than ensuring that there was a contractual case work relationship...
>
> (Case Four, Case Review, p. 16)

These Agreements were intended to deal with matters relating to family violence, sexual abuse and a father's inability to provide care for one of his children. Provision of resources to facilitate transport, in the absence of other components of the plan designed to meaningfully address the care and protection issues within the family, meant that little changed with respect to the environment the children were in and the quality of care they received. Any improvements in the situation were seen as justification to continue with the existing plan.

**BEHAVIOUR OF THE FAMILY TOWARD THE WORKER**

This category involved a collection of dynamics that referred to the tactics used by family members in influencing the Social Worker. Such tactics generally did not include overt threats or intimidation but were captured under the definition of the following dynamics – disguised compliance, resistance and closure.

Evidence which linked these dynamics together included an incident that occurred in Case Three when the mother agreed to work with CYPFA to ensure the children's safety. Despite this, the mother resisted getting involved with the plan and refused to accompany the Social Worker to a pre-arranged doctor's appointment and an appointment with the Special Education Service.

Perhaps the most powerful evidence in this category related to Case Five whereby the Social Worker had been trying to locate a child who had not been seen for some time. The review team noted in their report that:

> ... (the father) indicated that he had placed (the child) in hiding to protect him from (the mother's) family and that (the child) was not attending school. He said that (the child) was receiving good care but that he was not prepared to disclose his whereabouts to NZCYPFS because he feared that information would be passed on to the (mother's) family.
>
> (Case Five, Personal File, p. 30)

The father was co-operative with the Social Worker in attending meetings and alluding to the whereabouts and wellbeing of the child. However, at the same time, he made it clear that he would not reveal the child's whereabouts and demonstrated resistance by refusing to produce the child for the Social Worker or to indicate where he was living. From the Social Workers point of view, their relationship with the child was one which was defined by closure.

**THREATS AND INTIMIDATION TOWARDS CYPFA STAFF**

The most powerful evidence of this in the sample cases, existed in Case Five. The impact of reading and considering the situation the Social Worker found herself in, as a result of an over-powering sense of threat from the family, was remarkable. In addition, the review team failed to realise that hostage theory and other issues concerning the worker's experience of violence, were having a significant influence on how the case had been managed. The case file reveals a picture of a Social Worker cast adrift in the case with little sense of direction while trying to navigate through extremely unfriendly seas. This resulted in decisions being made that were based more on fear than good judgment.

Both hostage theory and the worker's experience of violence are clearly evident in the Social Worker stating that she did not agree with the FGC recommendations. She did not voice her agreement. The case file notes that: "It seems that the Family Group Conference did not provide a safe environment for either professionals or family members to express their views openly" (Case Five, Case Review, p. 20). This was due to the fact that those involved had either heard about or feared the consequences of a negative response from the father in the event of his being challenged about his role with the family/children. The child case review report noted that:

> ... one Social Worker, working alone with this particular family system did not have a significant chance of success.
>
> (Case Five, Case Review, p. 35).

## ARE THE FINDINGS ABLE TO BE GENERALISED?

It is important to consider the degree to which the findings of this research can be generalised across more than the identified sample cases. In presenting the findings for discussion it is recognised that each of the cases was known to the Agency at different times (1991 through to 1994) and that the most recent involvement with any of the identified cases dates back five years. Practice issues identified in the course of the case reviews may well have been addressed by the Agency as a direct result of the reviews. Since 1994 the Agency has taken steps to introduce practice tools (Risk Estimation) and training courses (Dangerous Dynamics) in order that some of the issues identified in the case reviews are addressed. As such those issues may well no longer be apparent in the current practice of Social Workers within CYPFA.

Conversely, the issues raised in this research have been triggered by an analysis of five cases and they may be able to be generalised across other cases with which the Agency has recently been involved. Without comparing recent cases where children known to the Agency have died as a result of non-accidental injury, it is difficult to ascertain to what degree the identified issues can be generalised across a range of cases known to the Agency.

## CONCLUSION

It is apparent that, to a varying degree, the sample cases have revealed evidence to suggest that a number of patterns are identifiable in relation to the dynamics which have featured in this research. An association has also been found between clusters of dynamics. Clusters formed around the way professionals worked with one another, the way CYPFA managed information, case decision making, the behavior of the family towards the worker and threats and intimidation towards CYPFA staff. This can be regarded as consistent with the definitions Reder, Duncan and Grey (1993) identified.

A number of possibilities have been explored as to why some dynamics were not found to feature in any of the cases. In addition, those dynamics for which a disproportionate volume of evidence was apparent have also been identified and considered.

On the basis of this information a number of recommendations will be made.

Chapter 6

# More Than A Death – Implications for practice

> When we regard a problem as simple, a single solution often seems appropriate. Once we begin to differentiate among different and distinct components of a problem, however, different and distinct solutions become a necessity. When we fail to make the proper distinctions we may unwittingly and despite the very best intentions replace one problem with another.
>
> (Eichler, 1988)

If the information that becomes available to the Agency as a result of case reviews following the death of a child is to be of value in preventing future deaths, it is the writer's view that solutions must be identified and implemented. In light of the findings of this research, it is important to consider a number of recommendations in order that these tragedies become 'more than a death'. Many of the recommendations that follow relate to the themes under which a number of the dynamics were assembled but some stand on their own.

## SUPERVISION

First and foremost is the importance of both supervision and the supervisor in the care and protection process. As Morrison (1993) states:

> Supervision is crucial to enable us to examine our focus, direction, goals and relationships with such families. None of us however experienced is immune from the effects of such powerful processes. Professionally dangerous systems are characterised by an absence of supervision for all involved.
>
> (Morrison, 1993, p. 25)

In reviewing files relating to the sample cases, the absence of supervisory involvement was evident. None of the cases revealed any evidence that a supervisor had had a role in adequately overseeing and managing the case. In addition, there was a distinct absence of evidence to suggest that a supervisor had been involved with supporting, guiding and managing the Social Worker.

That being the case, it is not surprising that a range of dangerous dynamics were apparent leading up to and at the time the children in the sample cases died. **Involvement of a supervisor in the management of both cases and Social Workers allocated to those cases is critical to safe and sound practice.**

Partly as a result of Case Reviews, CYPFA has recently developed and released a comprehensive supervision policy. The Professional Supervision policy (CYPFA, 1998) directs that all Social Workers are to receive, at a minimum, 1.5 hours of supervision per week. Alongside this, the Professional Quality Assurance (PQA) programme (CYPFS, 1997b) includes a quality performance indicator (QPI) relating to supervision. One requirement of this QPI includes an expectation that there will be evidence in the case files of supervisory involvement. This can occur in varying forms but most commonly involves supervisors documenting information on case files thus having what could be referred to as a transparent involvement with the case.

It is the opinion of the author that the introduction of a supervision policy and measuring supervisory involvement in case management as a requirement of quality assurance will significantly improve the degree to which supervisors are involved with case work and lessen the occurrence of dangerous dynamics. Again, to quote Tony Morrison "A supervisor's job is to provide a shoulder to cry on, a brain to pick and someone to kick your butt when it's needed" (Supervision Workshop, 1997). In essence Morrison is referring to support, guidance and direction as key roles for supervisors within child protection. In reflecting on the

sample cases it is not difficult to identify a number of occasions where a shoulder was needed, a brain should have been picked and direction should have been given.

**MANAGEMENT OF INFORMATION**

While effective supervision is a vital component of the care and protection process, as demonstrated in this research, the most significant aspect of that process is the manner in which information is managed. This relates to the recording, storage and transfer of information from one Site to the next and between workers. Failure to competently manage information seriously impaired the ability of CYPFA to manage the care and protection process in the sample cases. If CYPFA is to keep children safe and make well informed decisions then:

1. Information has to be recorded more professionally, case notes have to be able to be read, they have to make sense and they must not be left incomplete.
2. Files (and cases) must be transferred from one Site to the next with more efficiency. Children cannot afford to be left in limbo between offices and CYPFA cannot sustain a situation in which a client's file is fragmented with information scattered throughout the organisation.
3. Consistency has to be established with respect to whether CYPFA maintains individual client files or family files.

It is the opinion of the author that failure to manage information proficiently places CYPFA at indefensible risk. While Case Transfer policy exists (CYPFS, 1996) in relation to the transfer of files this clearly was not adhered to in at least three of the sample cases. In 1997, case note recording specifications were developed (CYPFS, 1997a) as a means of providing clear direction as to the requirements of acceptable case note recording.

**The author recommends the following as a means of addressing this area of concern:**

1. **Case note recording specifications to be incorporated into core training for all staff involved with case management.**
2. **Sites audit and revisit their filing systems with a view to ensuring that information is appropriately filed and managed within the Site.**
3. **The case transfer policy and procedure for dealing with case transfer problems be further endorsed by CYPFA. Encourage staff to take more assertive action in dealing with case transfer difficulties.**
4. **Provide direction with respect to whether CYPFA requires family OR individual client paper files to be established and that the Agency as a whole adopts whatever is directed.**

**INVESTIGATION AND ASSESSMENT**

Decision-making and evidence of a process in relation to investigation and assessment was a further area of concern in the sample cases. As the result of critiquing case reviews, in 1997 CYPFS acted to introduce a framework for the analysis of risk. While this then provided all care and protection staff with a consistent means of thinking about and analysing risk, it was never intended to replace the requirement that full and proper investigations and assessments be conducted.

It is the author's view that, as was the case with respect to risk analysis, in the absence of any clear process, framework or guidelines, staff will become reliant on a variety of means of conducting an investigation and assessment. Again, as in the case of risk, the variety ranges from working on a gut reaction, completing what can be referred to as ad hoc information gathering, to failing to investigate and assess at all. It is the author's opinion that failure on the part of Social Workers and supervisors to conduct adequate investigations and assessments is due in part to the lack of any CYPFA compulsory training in investigation and assessment. **It is strongly recommended that a training course focusing on**

**investigation and assessment skills and techniques is designed and implemented for Social Workers and supervisors and that this becomes a compulsory course within CYPFA.**

## INTERAGENCY WORKING RELATIONSHIPS

Interagency working relationships and the ability of Social Workers to work as part of a wider team are central elements in the effective management of cases. The sample cases documented evidence of Social Workers either working in isolation from the wider child welfare sector or of them having difficulties with relationships within that sector. Morrison (1993) states that:

> Clarity about roles, responsibilities and priorities, particularly in relation to our professional and legal duties to the child whose welfare in such cases must always remain our paramount concern. These principles of child protection work must be agreed at the top before they can be demanded from those at the front line.
>
> (Morrison, 1993, p. 25)

The Government initiative of Strengthening Families (1998) has gone some way to establishing that agencies involved with families at risk work together. Strengthening Families (1998) provides those involved in care and protection with a framework to use in establishing a collaborative approach to working with other agencies. This is of great benefit to developing working relationships amongst agencies, as an expectation relating to working together is set from the top.

For working relationships to be based on sound principles of collaboration and working together they will need to be developed and nurtured. Trust, openness and direction, as well as clarity about roles and responsibilities, will be essential principles of interagency relationships. As Morrison (1993) states:

> Effective teams develop strengths that are beyond the sum of the individual members and which can enable us to work skillfully, powerfully and compassionately with even the most difficult families, so that children are not failed by the system and parents get the help they really need. Powerless professionals cannot either protect children or promote change in abusing families.
>
> (Morrison, 1993, p. 25)

**It is recommended that CYPFA further endorses and promotes the Strengthening Families (1998) initiative as a sound practice framework. As well as this endorsement, there should be a continued expectation from CYPFA that staff will take a lead role in promoting and implementing the Strengthening Families (1998) initiative. In addition, staff should be provided access to training and information relating to how to develop and foster collaborative working relationships with colleagues within the child welfare sector. Such training should include reference to what can go wrong when working in collaboration with other professionals and what can be done to rectify such problems.**

## MANAGEMENT OF SIBLINGS IN THE WAKE OF A CHILDS DEATH

The sample cases highlighted a need to develop practice guidelines relating to the handling of cases where a child has died but siblings remain. Presently, CYPFA does not have any such guidelines, so there is variability in the way cases are managed following a death. While the requirements of current policy relating to child deaths includes completion of a range of reports, these do not relate to decision making and management of any remaining children. Therefore after a death, some Sites act to ensure the safety and well being of any remaining children whereas other Sites adopt what can be described as a wait and see type approach.

**The development of guidelines relating to management of cases after a child has died would provide Social Workers with direction as to what specifically needs to be taken into consideration with respect to the remaining siblings and how that is to be done.**

## DEVELOPMENT OF KNOWLEDGE BASE

A final recommendation relates to the fact that without adequate knowledge, those working in the child protection field are ill equipped to protect children, work with families and safeguard themselves. This research has focused in a unique manner on a select group of cases where children have died. While the framework of dynamics used is available to staff through the Dangerous Dynamics training course run through CYPFA Training Units, the course itself is not considered a core course for child protection staff.

'To be forewarned is to be forearmed' and it is the view of the author that if staff are to both detect and better manage the presence of dangerous dynamics in the relationships they have with the families with whom they are working, then they will require a comprehensive understanding of these dynamics. Given the impact that this set of dynamics has been seen to have on the sample cases. **It is recommended that the Dangerous Dynamics training course, which includes detection and management, becomes a core course within the CYPFA training calendar and that it is made mandatory for all Social Work and supervisory staff to attend.**

Chapter 7

# Summary and Conclusion

The purpose of this research was to take a fresh look at cases where children known to the Children Young Persons and their Families Agency had died. Motivation for doing so emerged from the author's personal experience of supervising a case in which a child died. This, coupled with an intense interest in the range of dangerous dynamics which can be apparent in the relationship a care and protection Social Worker has with clients and families, led to a desire to contribute to existing knowledge with a view to preventing future deaths.

While similar research has been completed in the United Kingdom and the United States, completion of this project is thought to herald a new development in care and protection knowledge in New Zealand. It is hoped that the outcome of this research will both significantly contribute to current knowledge in the field as well as form the basis of further training for Social Workers.

Central to completion of this research was the availability of case files and the case reviews for the five sample cases. Releasing this information raised a number of issues for CYPFA not least of which was the fact that the files are confidential and contained information that had not been made available to the public. In addition, the author held concerns about the impact reviewing five cases would have on both CYPFA in general but more specifically the staff involved. Significant potential for harm to both CYPFA and the staff who were allocated to each case was anticipated. It was the author's view that the benefits of making the information available outweighed the potential risk of harm to the Agency and the individuals involved.

A hypothesis was formed that in cases known to CYPFA where a child had died a series of dangerous dynamics were present in the relationship Social Workers had with the families. Through the course of this research this hypothesis was found to be correct in that 106 separate pieces of evidence were identified across all five cases involving 28 of the dynamics. This was a significant finding and is consistent with what Reder, Duncan and Grey (1993) found in their research.

As a result of this finding, and the fact that a number of related but separate issues were identified in the course of completing the research, a number of recommendations have been made. It is hoped that these recommendations will be utlised both to inform future case work decisions and contribute to future policy and planning within CYPFA. More specifically, the information contained within this document is intended to be made available to staff in the hope that it significantly contributes to preventing future deaths of children known to CYPFA.

Finally, as the Commissioner for Children has stated:

> To be a Social Worker with the Children Young Persons and their Families Service is a daunting task. It requires sensitivity and the ability to engender trust in seeking family co-operation during the investigation of allegations of abuse but it can also require courage and persistence in the face of the family's hostility and denial when seeking the safety of a child. A child focus is essential if these different qualities are to come to the fore at the appropriate times. Such a focus must be adopted and maintained by the individual Social Worker, those who train and supervise her and the child protection Agency as a whole.
>
> (CFC, 1995, p. 6)

In order that CYPFA is able to ensure that children are protected, families are encouraged to make changes and staff are cared for and supported through the dilemmas associated with statutory social work, attention must be paid to all

information that meaningfully contributes to existing knowledge and expertise. It is hoped that this research provides some of that information.

# Appendices

**Appendix A: DEFINITIONS OF DANGEROUS DYNAMICS**

INDEX:

CULTURAL RELATIVISM (Dingwall, Eeklaar and Murray, 1983)

This provides an infinitely elastic set of norms and standards in respect of family life and the care of children which immobilises professionals when dealing with families of a different culture or ethnic background.

NATURAL LOVE (Dingwall, Eeklaar and Murray, 1983)

This assumes that all parents love their children just because they are their parents. Once this is assumed as a fact of nature, it becomes very difficult to read evidence in a way which is inconsistent with this assumption. Any challenge amounts to an allegation that the parents do not share a common humanity with the rest of us.

RULE OF OPTIMISM (Reder, Duncan and Gray, 1983)

Enables professionals to find the most positive explanation of a situation, one which creates least conflict with parents and within themselves.

INTERPROFESSIONAL COMMUNICATION AND SHARING OF INFORMATION (Reder, Duncan and Gray, 1993)

A dynamic which has an impact on the effectiveness of multi-disciplinary case management; it is the manner in which professionals communicate and share information. Absence of common understanding among professional groups and 'strained relationships' have the potential to compromise open and accurate information sharing.

CLOSED PROFESSIONAL SYSTEM (Reder, Duncan and Gray, 1993)

A group of workers become united by a dominant view about a case and are less sensitive to conflicting information or observations.

POLARISATION (Reder, Duncan and Gray, 1993)

Can develop between groups of workers in which their opinions about a case diverge and they share less and less information with each other.

EXAGGERATION OF HIERARCHY (Reder, Duncan and Gray, 1993)

Workers presumed status in relation to each other can become magnified and professionals with lower perceived status defer to the opinion of others who are viewed as hierarchically superior.

ROLE CONFUSION (Reder, Duncan and Gray,1993)

Involves a lack of clarity about roles and can lead to inaction on a case with one worker believing that responsibility lies with someone else.

PERVASIVE BELIEF SYSTEMS (Reder, Duncan and Gray, 1993)

Beliefs held by society that influence decisions made about children. For example, a belief was once held that children are better off living with their natural parents. This had implications for decisions made in relation to the return of children to parents who had maltreated them.

INFORMATION TREATED DISCRETELY (Reder, Duncan and Gray, 1993)

Refers to circumstances in which events are considered in isolation from each other and no coherent overview emerges. Thus the significance of new complaints of maltreatment are not appreciated within the context of the family's history nor put together with other workers' current knowledge of the case.

CONCRETE SOLUTIONS (Reder, Duncan and Gray,1993)

Undue reliance is placed upon very practical measures as a means of dealing with or monitoring problems which are essentially emotional. Undue reliance on concrete solutions can lull professionals into a false sense of security because they believe that work is being done but fail to assess whether it has an effect on the emotional relationship problems contributing to the abuse.

SELECTIVE INTERPRETATIONS (Reder, Duncan and Gray, 1993)

Workers accommodate to conditions that later are recognised as appalling. This is comparable to Dingwall *et al's* (1983) 'Rule Of Optimism'. At other times they expressed excessive confidence following minor improvements. Frequently,

observations are not translated into their significance that protective action is required.

'NOT EXIST' DOUBLE BIND (Reder, Duncan and Gray, 1993)

Is indicated by professionals not seeing a child, despite having had access to the home but leaving believing that all is well with the child. Absence of external scrutiny can lead to parents continuing to behave as though a child does not exist and in its extreme form can result in a child dying of chronic neglect. The act of professionals visiting transforms the child into existing and results in parents offering reassurances of the child's whereabouts. In situations of this nature, children can go for some time before being sighted by professionals.

CLOSURE (Reder, Duncan and Gray, 1993)

Parents who have a precarious feeling of control over their own lives, when forced to engage in mostly involuntary relationships with the child protection system, may respond by distancing and closing in on themselves, either temporarily or completely in an attempt to regain control of the outside world by keeping it out.

COVERT WARNINGS (Reder, Duncan and Gray, 1993)

Can be seen as the opposite to closure, in that families may approach professionals and communicate what was, in retrospect, a disguised admission that abuse was escalating. Only in retrospect does it become possible to claim that some parental behaviour has constituted a covert warning of impending escalation of maltreatment.

DISGUISED COMPLIANCE (Reder, Duncan and Gray, 1993)

Parents neutralise professional's demands by offering an overt/verbal compliance whilst maintaining a covert agenda of delinquent and rebellious behaviour towards the child protection agencies.

FLIGHT (Reder, Duncan and Gray, 1993)

Parents move home, in some cases travelling to another part of the country in an effort to maintain control over their relationship with child protection agencies by running away from and thus fragmenting the professional network.

FRAGMENTATION (Reder, Duncan and Gray, 1993)

Families which exhibit closure and flight often induce a fragmented response in the professional network. As more and more agencies come to know about a family, the nature of the communication, collaboration and co-ordination can become increasingly fragmented. Families will often contribute selective information to an agency and will rarely paint the whole picture. Equally, agencies will hold some amount of discrete information which families may not have access to and which can only be passed along by the 'owning agency'.

PROFESSIONAL DANGEROUSNESS (Morrison, 1996)

Morrison defines Professional Dangerousness as ".... the process whereby professionals involved in child protection work can behave in a way which either colludes with or increases the dangerous dynamics of the abusing family" (Morrison, 1996, p.1). In examining Professional Dangerousness Morrison notes that we must look beyond structures, procedures and resources surrounding child protection work to include the societal context in which child protection systems operate. Ambivalent attitudes within society to 'child protection' can result in individual practitioners becoming confused as to what their mandate is to protect children and intervene in family life. Morrison states that society's classic defence mechanisms have been denial, minimisation and inaction all of which are found at the root of professional dangerousness, and which can result in the following:

1. Ignoring of clinical observations
2. Conflict avoidance or minimisation
3. Ambivalence or confusion or misunderstanding about roles
4. An absence of sensitivity and absolute standards for the care safety and development of children
5. An absence of awareness of personal and professional

behaviour and responsibility

6. Failure to maintain a focus on the child

A danger develops that the professional systems unwittingly copy, mirror and replicate the behaviour of abusing families.

MINIMISATION (Morrison, 1996)

A defence used as a means of claiming to have superior knowledge about a family in question and to invalidate external information. Minimisation is a professional rule system which operates to disqualify minimised external concerns in order to protect itself from further work.

REFRAMING (BLURRING CARE AND CONTROL) (Morrison, 1995a)

Process has its roots in ambivalence by members of the "helping professions" about the use of personal, therapeutic and especially statutory control. When statutory responsibility accommodates to our covert needs as helpers this has a significant influence on our vulnerability to dangerous practice.

ANXIETY RESPONSES (Morrison, 1995a)

Child protection work is one of the most acutely stressful areas of practice. Individual behaviour of professionals often manifests itself in classic anxiety responses - fight, flight or freeze.

1. Fight - can be seen in over involvement or enmeshment in a case. Agencies are driven by the need 'to do' in order to feel that things are getting better. Procedures may be followed but in a mechanistic way which fails to address the key protection issues. Enmeshment has been far the most serious factor in professional dangerousness.
2. Flight - this is the failure to act by denying that there is a problem or reframing it as something else. The more isolated the professional the more vulnerable she/he will be to flight responses.
3. Freeze - this is the failure to act or to complete important actions due

> to immobilisation, distraction or fear. The picture that can emerge is one of a group of frontline professionals watching rather than intervening in the development of increasingly dangerous situations.
>
> (Morrison, 1995a, p. 7)

ENMESHMENT (Morrison, 1996)

Characterised by the professionals doing more than 50% of the work because there is a lack of commitment by the family towards change.

PROFESSIONALISM (Morrison, 1996)

The relationship between client and professional is built on the principles of confidentiality and client self-determination. Being a professional is associated with the training, status and experience to act autonomously. In the field of child protection where there are often serious conflicts of interest within the same family, and where the sharing of information is so crucial among professionals, these aspects of 'professionalism' can become problematic and on occasions dangerous.

RESISTANCE (Morrison, 1995a)

In its varying forms, resistance plays a central role in disabling professionals from using their power in an appropriate and child protective fashion.

1. Hostile resistance - overt and openly intimidating.
2. Passive aggressive - overtly co-operative but covertly defiant
3. Passive hopelessness - parents present in role of victim.
4. Challenging/chaotic - typified by threats made to harm children if agencies do not comply in some manner.

PROFESSIONAL ACCOMMODATION SYNDROME (Morrison, 1996)

A model designed to understand the behaviour and response of organisations to staff under stress. Involves not only looking at the primary impact of dealing directly with abusing families but also the secondary impact on staff that comes from the organisational and managerial responses to these staff.

Morrison argues that when social workers are struggling with the stress and trauma of working in the field of care and protection, the response of their organisations is crucial to combating the difficulties workers experience. Failure of organisations to learn how to combat the alienating environment of child protection will result in defence mechanisms of denial and minimisation. Professional Accommodation Syndrome has the following components:

**Secrecy:** Many staff hesitate to speak about the impact of the work on them because they feel or know that the agency or colleagues covertly or overtly denies them permission to do so.

**Helplessness:** Staff who feel helpless in relation to their work, or in the face of stress arising from it, feel a sense of shame. They experience the agency's rejection and dislike of their helplessness, and receive the message that those in the helping professions are paid to be copers. The agency's belief system is that uncomplaining workers are OK. Myths exist that trained staff should act logically, rationally and objectively. Gender stereotyping in agencies sees women who express stress as "hysterical or victims" and men as "wimps or little boys". Features of race, disability or sexuality create yet other pejorative stereotypes.

**Entrapment and accommodation:** Staff are trapped in a dilemma in which telling the truth about their stress is seen as "unprofessional", whilst maintaining the denial is seen as coping and professional. In the face of this, staff are forced to accommodate by them deciding that the fault lies not with the agency's insensitivity, or with the nature of their work, but with themselves for feeling as they do, failing to cope, and generally not being sufficiently robust. The answer appears then to lie in suppressing their feelings, invalidating their experiences, and working harder.

**Delayed or unconvincing disclosure:** Conflict, training, illness or talking with colleagues may eventually trigger disclosure of the distress. Where conflict is the trigger this may be in the form of unpredictable behaviour such as atypical aggression, lateness, sickness or sudden resignation. If this behaviour is only understood at a superficial level, and not as a signal of more prolonged underlying

distress it may result in actual or perceived responses such as: "She should never have been a social worker/teacher/ nurse anyway" - "If you can't stand the heat get out of the kitchen". The difficulty for managers in the agency is that it is not until this point that any obvious signs of problems appear and the fact that the presenting behaviour may well be a problem in its own right. The surface behaviour however is like the tip of the iceberg below which there may lie a history of distress which has progressed through secrecy, helplessness and accommodation, whose diagnostic signs have been both subtle and ambiguous. If the worker does leave the agency, she/he may well take to the new job these unresolved experiences, which will, unbeknown to the new employer render this worker additionally vulnerable to stress. Some career patterns seem to be driven by a series of even more rapid cycles of delayed disclosure/flight.

**Retraction:** The delayed or confusing nature of the disclosure if followed by insensitive, ignoring or disbelieving responses in the agency, leaves the worker psychologically and professionally abandoned, fearing that she/he will now be written off as incompetent. In the face of this threat to their whole career the only solution appears to be retraction: "I'm fine now, it was just the time of the month" or "I'm fine now, it was nothing to do with work". Secrecy resumes and the entrapment deepens as a result of the experience of being punished for disclosing which of course confirms the original belief system about the agency.

HOSTAGE THEORY (Stanley and Goddard, 1993)

Hostage Theory analyses case failure from the point of view of the client/worker relationship, particularly the effect of an abusive caregiver on the worker's ability to intervene effectively. The theory is applied to family members and workers in care and protection cases where the abuser uses bullying or charm to minimise severity of the situation. The effect is family and worker are either paralysed into inaction or actively defend the abuser adopting their view of the situation.

Goddard and Stanley developed a model to depict hostage type responses in child protection workers.

Reasons for Hostage Behaviour:

- belief that the social worker/client is unidirectional

- false emphasis in social work theory and education on voluntary clients
- own unresolved childhood events
- personal history of physical abuse
- perceiving and identifying with the client as underdog
- professional pressure not to admit fear of client

Signs of Hostage Behaviour:

- avoiding clients or avoiding confrontation with them
- seeing only one of the caregivers
- early termination of case
- denial or minimising of the severity of the situation
- rationalisation of the abuser's behaviour or the child's injuries
- unfounded optimism about changes being achieved
- underestimating the level of violence in the family
- return of children to households where violence still exists
- denial of own feeling of being scared or threatened

TRANSFERENCE (Gil and Cavanagh–Johnson, 1993)

The process whereby the client transfers or projects feelings, perceptions or behaviours arising from a previous relationship onto the worker.

COUNTER-TRANSFERENCE (Gil and Cavanagh-Johnson, 1993)

Can be described as the feelings, perceptions or behaviours generated in the worker either by response to the client's transference or the workers own unresolved issues.

IATROGENIC HARM (SYSTEMS ABUSE) (Jones, 1991)

Jones notes that harm which emanates from child maltreatment can come from the maltreatment itself and from the professional's response to discovery of maltreatment.

Components of iatrogenic harm (systems abuse) include:

1. Over zealous professional intervention - may result in alienating

children and families with eventual negative outcomes.

2. Repeated interviewing or multiple interviews - child is subject to many interviews often involving separate professionals.
3. Repeated physical examinations - may be implemented to substantiate the occurrence of maltreatment.
4. Decline in living standards or family break-up - the splitting of families following the discovery of maltreatment has been defined as an example of systems abuse. Not all incidents whereby a child has been removed from a family can be described as systems abuse.
5. Defensive decision making - professionals not prepared to take risks in case plans for fear of negative repercussions. Can lead to investigations which in itself may create harm to children.
6. Attendance at Court - for example the manner in which children are expected to give evidence at Court and the fact that this is not always done in a way which is best for the child.
7. Withholding of treatment - the absence of treatment can be harmful. As an example, more specifically focused attention is often needed for children as opposed to just parental and family treatment.
8. Over-treatment - The relentless provision of treatment and social work services for a child and family where change is manifestly impossible.
9. Foster care - may in itself be abusive. Can include numerous changes of placement, foster care, drift and harm caused to children in foster placements by foster caregivers.

USE OF LEGISLATION AND AUTHORITY (Parton and Parton, 1989)

Social work activity is seen as the functioning of the law in practice and social workers who do not recognise this do not appreciate their proper role and functions and the full significance of their responsibilities.

Parton and Parton discovered the social worker's lack of confidence, particularly when working with confronting parents, stems in large measure from uncertainty

about the legal powers and authority that is vested in them by the statues. The impact of this is often that workers focus on needs and rights of parents to the exclusion of children, and that they become uncertain and anxious to protect themselves rather than influencing families and protecting children. What develops is collusion with families and a lack of clarity about protecting children.

AGENCY DEFENCE MECHANISMS (Valentine, 1994)

Four specific defence mechanisms may operate within social service departments in relation to work with child abuse :

1. The assigning of responsibility for the child's welfare to one worker
2. The detachment from, and denial of, the feelings that child abuse engenders
3. The responsibility without authority that many social workers experience
4. The regulation and control of child protection work as provided by legislative frameworks.

Anxiety is always a central issue and how that is experienced, expressed and defended against is a major factor in determining personal and institutional behaviour. To work creatively with anxiety it must be acknowledged and confronted. Failure to do so raises the likelihood of defensive cultures developing within child protection agencies which do not deal with the external and internal anxiety produced through the course of the work.

DEFENSIVE SOCIAL WORK (Harris, 1987)

The occurrence of definable practices by the practitioner which are deliberately chosen to protect the professional worker at the possible expense of the well being of the client. Three varieties exist :

1. Positive defensive social work - adherence to elaborate and detailed procedures as a means of minimising the likelihood of scrutiny in the face of disaster with a client.
2. Negative defensive social work - adoption of hard and fast rules that are applied across a range of cases despite indicators to the contrary.

3. Suppressing information - production of records which effectively "cover the social worker's back" sometimes at the expense of having accurate casenotes.

A common factor in all defensive practices is that they are attempts to avoid incurring blame for tragic occurrences that might have been avoided.

KNOWLEDGE DEFICIT (Parker, 1994)

Knowledge deficits on the part of the social worker can occur in the following areas :

1. Knowledge of the natural history of child abuse and neglect.
2. Knowledge of the traps commonly encountered in families where child abuse and neglect is either occurring or suspected.

Parker found that fundamental deficiencies in knowledge and training on the part of social workers can contribute to ongoing maltreatment and death of children.

BURNOUT (Hansen, Diamond and Ludwig, 1989)

The existence of social worker burnout can result in decreased effectiveness and ability to help families because of the stresses of the job, the needs of families and the worker's limited ability to help.

DESTRUCTIVE RESCUING (Wiltshire, 1995)

Involves seeking to ensure that the child will never be hurt again without taking into account the context of the injury and the long term implications of a child being permanently separated from birth family. Workers operating in rescue mode are likely to operate in a prescriptive fashion and resort to informing parents of the perceived problems and then suggest/demand that they address the problem.

The following may exist :

1. over use of authority
2. avoidance of honesty
3. reframing the agency's involvement in more acceptable terms
4. lack of clarity

5. focus on individual tasks rather than a combination
6. lack of case plan
7. lack of goal oriented work
8. absence of a clear framework for decision making
9. lack of sound assessment skills.

RESPONSE TO EXPERIENCES OF VIOLENCE (Bibby, 1994)

When violence occurs social workers tend to blame themselves and each other. Common psychological consequences of a violent incident include:

1. a sense of isolation
2. problems with decision making
3. fear of further violence
4. lack of confidence in handling potentially violent individuals.

Such consequences have a significant impact on casework practice and the worker's ability to protect children.

MANIPULATIVE BEHAVIOUR (Hepworth, 1993)

Manipulative behaviour is a means of deliberately influencing or controlling the behaviour of others to one's own advantage by using charm, persuasion, seduction, deceit, guilt induction and coercion as well as making glib promises to change and exploiting a worker's vulnerability.

Clients who manipulate do so more to gain control over the relationship and process than to exploit the therapist.

Manipulative tactics can include the following:

1. Attempting to gain control of treatment (e.g. attempting to specify family members to be included in treatment, specifying causes of the problem, prescribing what should be done to remedy the problem).
2. Avoiding engaging in the helping process (e.g. diversionary tactics, inattention, silence)

3. Attempting to gratify needs in the helping relationship (e.g. assuming a helpless stance, persistently seeking excessive advice and direction, calling between appointments)
4. Seeking to avoid adverse consequences of infractions (e.g. lying about committing an offence, feigning remorse, splitting hairs to convince others they did not break a rule).
5. Seeking to gain unearned benefits or favours (e.g. frequent and unreasonable changes of appointment, exploiting potential areas of the worker's vulnerability, use of manipulation.)

## Appendix B: EVIDENCE FROM SAMPLE CASES

| Evidence collated from all sample cases. | | |
|---|---|---|
| **Dangerous Dynamic** | **Evidence** | **Reference** |
| **Transference/counter transference** | | |
| **Inter-professional communication and sharing of knowledge** | ❑ Comment is made on the paper file about the fact that in the Area where the third notification was received, *"…there were long waiting lists for referrals to the … Evidential Unit and this affected decisions regarding sexual abuse investigations."*. In addition it is noted that *"…relationships with the … Police were extremely difficult at the time with little support or co-operation from the Police. There is no formal CAT team and child abuse work is seen to be a low priority for the Police"*. It was stated that *"The absence of a functional joint Police and NZCYPFS child abuse team seriously compromises social workers ability to provide effective services to children and families."*<br>❑ Through the course of monitoring the case and checking back with the child's school, two teachers at the school provided the social worker with differing information. The frustration that this caused the Social Worker is evidenced on the file by her comment *"I hope (the teacher) will eventually discontinue conveying 'mixed messages' to me."* | 1 PF Case Review page 29<br><br>5 SWis File page 18 |
| **Use of Legislation and Authority** | ❑ As a result of the social worker holding concerns that interviewing the children would result in heightened risk for them, a decision was made not to intervene with a formal investigation. This decision was made against a background of concerns for the children including neglect, family violence and historical sexual abuse. The decision was discussed with a supervisor and was rationalised by stating on the file that *"It was decided that formal investigation not be undertaken a number of reasons for this - among which are the safety of the children whom could be exposed to increased risk if interviewed tendency of father to be violent - toward anybody."* | 5 SWis File page 18 |
| **Functional /dysfunctional Learning cycles** | | |
| **Systems Abuse (Iatrogenic Harm)** | | |

| Closed Professional Systems | | |
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| **Polarization** | ❑ Social Workers were *"…predominantly influenced by the comment of other professionals which indicated that (the mother) was a good parent."* This occurred despite the fact that one of the children had been taken to the Doctor with a broken arm and black eye. These injuries occurred within a short space of time and the explanation given was that the child had had accidents (the child was a toddler at the time). The Social Worker held an opposing opinion with respect to the parent's ability to provide adequate care.<br>❑ "During this final period the communication problems that characterised the case in the early stages escalated and undermined the effective management of the case. both offices became more rigid in their perspectives of the 'rightness' of their own actions, and this was compounded by the fact that in their own ways they were both right.' And "This became a 'no-win' situation for both offices and, as a result, both offices did not communicate over important case work developments…" | 2 Case Review page 3<br><br>4 Case Review page 30 |
| **Exaggeration of Hierarchy** | ❑ Social Workers were *"…predominantly influenced by the comment of other professionals which indicated that (the mother) was a good parent."* This occurred despite the fact that one of the children had been taken to the Doctor with a broken arm and black eye. These injuries occurred within a short space of time and the explanation given was that the child had had accidents (the child was a toddler at the time). Regardless of the fact that the Social worker held a differing opinion to these professionals, it was their view that carried more weight in decision-making from time to time throughout the case. | 2 Case Review page 3 |
| **Role Confusion** | ❑ The Social worker allocated to the case at the time the first notification was received was working both in adoptions and care and protection. The notifier for the case was an adoption | 1 PF Case Review page 19 |

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| | service client. Failure to clearly distinguish between the two roles resulted in a loss of clarity associated with the care and protection aspect of the case - especially as that related to investigation and assessment. | |
| | ❑ Through the course of managing the second notification, the Care and Protection Resource Panel recommended that the social worker refer the case to the Plunket Nurse and ask that she *"monitor"* the situation. The case was closed on the basis of this. However, a referral was not completed and the Plunket Nurse neither understood she was to have a monitoring role nor made any contact with the child and her mother. The fact that the social worker thought Plunket could have a *"monitoring role"* in lieu of an investigation and assessment being carried out was indicative of role confusion on the part of both the social worker and the Plunket Nurse. | 1 PF Case Review page 30 |
| | ❑ At the conclusion to the first home visit the social worker supplied the mother with a card and her home phone number with instructions to *"…call anytime she needs help…"*. Social Workers are advised not to provide clients with details relating to their home. In this scenario, the Social Worker indicated to the client that she was available to be contacted at any time thus blurring the role between being a professional and, separate to that, a member of the community. | 3 SWis File page 5 |
| | ❑ Following a notification relating to inappropriate sexualised bahaviour, the Service failed to follow up on the basis that the Police were also involved with the case and they had taken on a supportive role with the family. *"The police in this case were being actively supportive of the family. This raises the issue of NZCYPFS' responsibility in cases where, although they are given information about the possible abuse of young children, the Police are already playing an actively supportive role. It appears that in this instance NZCYPFS chose not to pursue the issues, in the belief that the police had responsibility to act."* The notification was received as an allegation that required investigation. This was not conducted on the basis of the Polices' involvement and the fact that they had adopted a supportive role with the family. | 4 Case Review page 16 |

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| | ❑ "Reliance was placed on the Public Health Nurse's strong relationship with the mother to monitor the children's welfare and safety.' This occurred against a backdrop that involved a lack of comprehensive care and protection investigation and assessment. The social worker saw her role as limited to that of providing help with budgeting advice and provision of a Special Needs Grant in an emergency situation. Under these circumstances it was clearly not the role of the Public Health Nurse to monitor the children's welfare and safety. Doing so clearly fell within the realm of a statutory social workers role.<br>❑ Through the course of monitoring the case, the social worker became concerned that there were a number of oganisations involved with the family and at times there was a double up of roles. She noted that *"At times there has been doubling up, and therefore I have discontinued weekly visits."* A lack of clarity regarding the various roles of those involved with the case resulted in the one worker responsible for maintaining statutory vigilance with-drawing for the sake of avoiding doubling up of input. As a consequence, none of those involved were focused on the children in the family from a safety/risk perspective. | 5 Case Review page 4<br>5 SWis File page 18 |
| **Professionalism** | | |
| **Pervasive Belief System** | ❑ Child was seen by the Duty Social Worker at the time the notification was documented. It was noted by the Social Worker that *"… although small she (the child) is well covered…"*. The notification related to issues of neglect in that the child was said to not be receiving adequate meals and was not adequately clothed. A belief appeared to exist on the part of the social worker that 'well covered children' are healthy well cared for children. This lead to the focus of the case being on contacting the Plunket Nurse to ascertain their involvement as opposed to completing a thorough investigation and assessment of the concerns which related to neglect. | 1 PF Intake Form |
| **Information Treated Discretely** | ❑ Client files on the computer database were duplicated and held in separate offices. The offices that established the second and third notifications did not have access to the initial | 1 PF Case Review page 6 |

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| | notification at the time they were considering how to proceed with an investigation. This resulted in the second two notifications being considered in isolation to the first and as a result no coherent over-view of the case was established. | |
| | ❑ Child who died had an older sibling. The Children Young Persons and their Families Service (CYPFS) knew this child. Information on the older child's file was not considered when the Service received notifications for the child who died. The result of this was that incidents which had been documented on the older child's file did not contribute to the over all picture of what was happening for the family - three incidents of abuse or neglect, two incidents of Domestic Violence and transience were not taken into consideration. | 1 Siblings SWis file page 19 |
| | ❑ Information concerning previous notifications about the family was not documented on this child's file and there was no evidence of that information being taken into consideration during involvement with this child. | 3 SWis File page 5 |
| | ❑ Information relating to the family was not held in one place at any one point in time. *"Transfer of computer and paper based files between offices was either not actioned at all or actioned subsequent to the child's death"*. This meant that information was not collated to form a complete picture at any point throughout the Services involvement with the case. | 3 PF Case Review page 14 |
| | ❑ Social Worker made an assessment on the basis of no historical information. Social Worker acknowledged to the review team that *"…if she had the historical information available her assessment would have been different."* Given an awareness of all the historical knowledge, new allegations of physical abuse would/should have been treated more seriously than they were. | 1 PF Case Review page 16 |
| | ❑ The office responsible for managing the case leading up to the child's death were not aware that the child had an older sibling who was known to two other CYPFS offices. *"It is significant that (an office) did not know of the existence of (a sibling) or her file until well after (the child's) death. The Review Team only learned of the existence of (the sibling's) file from informal information received from a member of the community"*. This meant that information relating | 3 PF Case Review page 19 |

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| | to the older sibling in the family did not contribute to knowledge applied to making decisions about the younger children | |
| | ❑ *"Critical information was not accessed and resulted in assessments which did not address the critical issues."* As result of this the child abuse assessments and decisions made about the case were based on information which did not reflect everything the Service knew about the case. | 3 Case Review page 8 |
| | ❑ *"Transfer of computer and paper based files between offices was either not actioned at all or actioned subsequent to (the child's) death."* And, " *(an office) does not appear to have had knowledge of historical information from (another) office who did not appear to have knowledge of (a third offices) involvement."* Transfer of the paper file was not requested or actioned until 2 months after the child's death. This resulted in decisions about the case being made lacking the full picture that all relevant information about the case would have provided. | 3 Case Review page 15 |
| | ❑ *"The review team had difficulty locating all the information and making sense of the information that was available."* and *"Significant information held by these agency's was not accessed or co-ordinated in this case."* This resulted in decisions made about the case being based on incomplete information. | 3 Case Review page 18 |
| | ❑ The social worker did not "*… know of the existence of (an older sibling) or her file until well after (the child's) death."* This case is notable for the fact that the social worker was not aware of the existence of an older sibling or the fact that that child had a file with the Service. Without this knowledge it was impossible for the social worker to get an accurate picture of what was happening in the family for the child she was allocated to work with. | 3 Case Review page 19 |
| | ❑ *"Notifications received in November 1992 were viewed as isolated incidents and were not seen in the context of the Notifications of 1991 and the FGC's".* This resulted in key decisions not being placed in the context of what had been happening for the children in this family over a period of | 5 Case Review page 36 |

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| | time.<br>❑ Through the course of following up a notification involving care concerns, the social worker was advised by the Health Social Worker that the child's sibling had been seen by Hospital staff to have her ear twisted, to be sworn at and smacked and was admitted to hospital with a closed black eye. This was not recorded on that child's file and was not followed up with an investigation of any nature. At the time the child was in the care of a family member. When asked if this family member may have hit the child causing the black eye the mother thought that that was possible. Furthermore, when it was discovered that the same family member also had the care of this child, the information about the older siblings black eye etc was not considered in the context of this child's care.<br>❑ Two separate files existed for the child. One had correct spelling of her name the other incorrect. Notifications listed under the incorrect spelling were not considered when a different office recorded subsequent notifications. This resulted in information being held by two separate offices and it was not until the Case Review that all information gathered about the child and her family was considered.<br>❑ Information relating to the family was not held in one place at any one point in time. *"Transfer of computer and paper based files between offices was either not actioned at all or actioned subsequent to the child's death"*. This meant that information was not collated to form a complete picture. | 3 SWis File page 8<br><br>1 Case Review page 6<br><br>3 PF Case Review page 14 |
| **Defensive Social Work** | | |
| **Concrete Solutions** | ❑ First notification was closed at the point at which the mother was located and thought to be in a stable environment. The Social Workers case note reads *"Mother was advised during interview on May 14 that there would be no further action from DSW now that her permanent address was known…"*. The fact that the family had been located was seen as a significant reason for then being able to close the investigation. This was despite concerns having been expressed about her ability to protect and care for the children.<br>❑ Following a notification whereby the mother threatened to harm | 2 Sibling SWis file page 25<br><br>3 SWis File |

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| | the child if he was not removed from her care, the social work follow-up focused on a referral to the Housing Corp and medical checks for the children. Issues relating to threatening to harm the child and Domestic Violence were not directly addressed with the mother by the Social Worker. | page 6 |
| | ❑ After a history of threatening to harm the children if the Service did not take them into care, of moving from home to home, of being in a violent relationship and of not managing the eldest child well, the mother was involved in another fight with the children's violent father. The Services response to this was to work with the mother on the basis that *"(the mother) agreed to work with the NZCYPS to ensure the children's safety, to follow up (the child's) speech development and to have on going support."* Such a plan focused on concrete solutions to issues that had existed for a long period of time and were more to do with relationships, child safety and parenting than speech development and provision of ongoing support. | 3 PF Case Review page 11 |
| | ❑ Social workers focused on putting energy into an Housing NZ application rather than focusing on strategies to address the safety of the children. *"The Social Workers felt this would address concerns about the children's safety"*. One child was taken into care four times but *"… only limited action was taken to address (the mothers) inability to cope with her situation." "We (the reviewers) question the usefulness of respite care under these circumstances."* And, *"Continuous provision of respite care by (offices) was not useful as a permanent solution."* | 3 PF Case Review page 16 |
| | ❑ The first notification included an incident of domestic violence in which it was known that holes had been punched in walls, and there were concerns relating to historical incidents of sexual abuse involving the mother and the children. *"The emphasis of this intervention was on the provision of material assistance for the family."* | 4 Case Review page 10 |
| | ❑ *"The Whanau Agreements that were entered into were more focused on the provision of resources for transport than ensuring that there was a contractual casework relationship … "*. These | 4 Case Review page 15 |

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| | Agreements were intended to deal with maters relating to family violence, sexual abuse and a father's inability to provide care for one of his children. Provision of resources to facilitate transport, in the absence of other components of the plan designed to meaningfully address the care and protection issues within the family, meant that little changed with respect to the environment the children were in and the quality of care they received.<br>❑ In response to the fact that the father was only leaving the mother $50 per week to care for the children the social worker assisted the mother to get access to an ATM card. Upon discovering this, the father assaulted the mother in a supermarket and broke her collarbone. While the strategy assisted in addressing the issue relating to the mother's access to money, it did not address those issues relating to family violence and it unfortunately inadvertently perpetuated a further incident of violence. | 5 Case Review page 5 |
| **Minimization** | ❑ The first two notifications for this case were received by social workers who knew the notifiers on the basis that they were clients of the Service. They believed that the information these notifiers provided them was the result of *"after thoughts"* about the family rather being the primary reason for calling. This resulted in subsequent involvement, which did not focus on a full and informed investigation and assessment but rather a checking of key professionals to inquire as to the validity of the concerns. This is evidenced by a failure to fulfill the requirements of an investigation as per Service Policy.<br>❑ The second notification for this case involved a request from the two adults for assistance to leave violent partners including help with finding alternative accommodation. The outcome of this interview did not include an investigation of the violence in the home as it impacted on the two children and adults. The case was categorised as *"Problem Behavior"*.<br>❑ Despite concerns relating to failure to thrive, mother leaving the child for periods and her *"barely adequate parenting"* the care and protection issues involved in the first notification | 1 PF Case Review page 17<br>1 PF Case Review page 21<br>1 PF Case Review page 30 |

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| | were not acted upon by way of any follow up. | |
| | ❑ Case was closed after spending ten months trying to locate the mother and child. Initial allegations related to Domestic Violence, Neglect and partner roughly handling the baby. Mother was eventually tracked down and came into the office for a short visit- the child was with her. Concerns relating to Domestic Violence were dismissed upon the mother stating she had left her partner and that she doesn't see him very much. Neglect issues were not investigated and the pattern of transience, which developed during the investigation, was negated on the basis that the mother identified an address she at which she was living at the time she came into the office. On the basis of this meeting, and inquiries of Plunket, the GP and some Family members, the case was closed. | 3 Siblings SWis file page 25 |
| | ❑ Mother of children contacted the Service while living in an emergency house. She was described as stressed and asked for time out from both children. *"She wanted a social worker to visit and threatened something would happen to her children if CYPFS was not interested"*. Only the older child was placed in care - the baby remained with her until she went to the care of her father who was later arrested for the child's murder. | 3 PF Case Review page 9 |
| | ❑ A notification received by the Service was categorised as relating to a Detrimental Environment. This was despite the fact that the details of the notification related to an incident of abuse and should have been categorised as relating to abuse/neglect. Doing so would have resulted in the case being actioned in quicker and with a different focus. This may have prevented the risk for the child being minimised. | 2 Case Review no.2 page 6 |
| | ❑ Information had been received from family members and the mother that the father was inclined to *"over exert himself at times"* when physically disciplining the child; that the child was *"booted up the bum'"* by his father; that after a series of wrong doings *"severe punishment"* from the father would result. These concerns were not recorded on the client file and were not acted on in the form an investigation and assessment. | 5 Case Review page 8 |
| | ❑ Allegations from a member of the community that the children had been physically abused (whipped), had received bruises from | 5 Case Review page |

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| | the beatings, were being left home alone and that there was no food in the house were met by the Service with a decision to proceed with what was referred to as a *"softly softly approach"*. | 9 |
| | ❑ *"The need to be culturally sensitive to this whanau's recent bereavement may also have led to minimising of the importance of the historical physical abuse and the need for a detailed formal investigation."* | 5 Case Review page 14 |
| | ❑ Social worker called to the home and found the child at home alone. As a result the social worker left a message for the mother to make contact with the office that day. The social worker subsequently noted on the file that *"I feel that (a community organisation) will follow this up and perhaps we need not be involved."* | 5 Case Review page 25 |
| **Fragmentation** | ❑ In total nine notifications were received by four different offices within the Service for the family. The last notification referred specifically to the child that was killed. Through the course of investigating the ninth notification there is no evidence that the previous 8 were taken into consideration. | 3 PF Case Review page 14 |
| | ❑ Despite the fact that staff felt they had a good working relationship with members of the community, it is noted on the file that *"It is surprising therefore that significant information held by these agencies was not accessed or co-ordinated in this case"*. This could be partly attributed to the fact that the organisations that held information about the family and children did not make that available to the Service. | 3 PF Case Review page 19 |
| | ❑ Failure to record information, failure to open a notification about the children being left home alone and failure to contain all information on the same file (deal with duplicated files) resulted in all the information never being considered as one picture and as such hampered a full assessment being completed. | 5 Case Review page 30 |
| | ❑ The Social Worker had been trying to locate the child for some time. He was thought to be in the care of his stepfather. In explanation for the stepfather failing to 'produce the child' the social worker has recorded on file *"… (the stepfather) indicated that he had placed (the child) in hiding to protect* | 4 PF page 30 |

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| | *him from the (his mothers) family and that (the child) was not attending school. He said that (the child) was receiving good care but that he was not prepared to disclose his whereabouts to NZCYPFS because he feared that information would be passed on to the (the mothers) family."* The stepfather was very selective as to the information he supplied the social worker as to the whereabouts of the child. During a meeting, he stated that the whereabouts of the child was none of the social workers business and he ordered them to leave the property. He is also reported to have said that the child was OK and that he was able to look after him and that there was no need for help from the Service. It was around this time that the child is thought to have been killed by the stepfather.<br>❑ In the same case, despite the fact that the mother and stepfather were living apart much of the time, the social worker also asked her about the whereabouts of her son. It is recorded on file that "…she (the mother) also knew where (the child) was but would not tell the NZ Children and Young Persons Service." | 4 PF page 75 |
| **Agency Defense Mechanism** | | |
| **Cultural Relativism** | ❑ The fact that it was thought that a Maori Adoption had taken place served to detract attention from the care and protection issues that existed for the child. *"This seems to have had some effect on the depth of the investigation."* And *"It seems that once this case was labeled a 'Maori Adoption', other standard investigative procedures were marginalised … the above influences all served to detract from and predetermine the course of the investigation."*<br>❑ *"The review team were advised by at least 5 people that it was well known in the community that there was a history of inter-generational sexual abuse."* The social worker, had heard rumors, but considered it 'culturally inappropriate' to pry into this as there were no reports or allegations in respect of this in relation to any of the children." *It was never put into the equation … that the widespread abuse of alcohol and neglect* | 2 Case Review no.2 page 7<br>5 Case Review page 31 |

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| | *of children, as well as inter-marriage with violent and troubled families could be symptomatic of an intergenerational sexually abusive family system."* | |
| **Natural Love** | | |
| **Rule of Optimism** | ❑ Mother had called on at least one occasion in the past stating that she was going to harm the children if the Service did not respond immediately. On the second occasion the social worker stated that while the mother was saying that she wanted to get rid of the children, it was the social workers assessment that all that was needed was for her to have a rest from the children. The social worker did not take into account the fact that the mother very recently had stated that she would harm the children if the Service did not react immediately. The mother was thought by the social worker to be in need of a rest from the children.<br>❑ Social workers focused on putting energy into an Housing NZ application rather than focusing on the safety of the children. *"The Social Workers felt this would address concerns about the children's safety"*. One child was taken into care four times but *"… only limited action was taken to address (the mothers) inability to cope with her situation."*<br>❑ *"The social workers actions seemed appropriate for the presenting problem, however once again there is no evidence of consideration being given to the causal problem of (the fathers) violence, drug use and intimidation towards (the mother) or the possible effects of this on the children."* The social worker managed a plan that was based around securing access for the mother to an ATM card in order that she could manage her money without interference from the father. While this addressed one aspect of the problem the plan went no further to deal with the issues relating to violence, drug and alcohol use etc. | 3 SWis File page 26<br><br>4 PF Case Review page 16<br><br>5 Case Review page 5 |
| **Enmeshment** | ❑ Referrals to SES and the GP were not actioned due to the fact that the mother refused to comply. This was despite the social worker making the referral arranging the appointments and then providing transport for the GP visit. Mother initially indicated she would comply but at the point of leaving for the | 5 SWis File page 7 |

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| | visit queried the value of going and refused. Initiative and efforts to get the children both medical and special education assistance were at the insistence and instigation of the social worker with minimal co-operation from the mother.<br>❑ *"… (the mother) is rather a shy person and I have found it necessary to be sensitive to her feelings, making sure to allow her time to make her own informed decisions. She is very proud and responds positively to patient guidance."* This was noted within the context of the social worker having had *"… very little to do with the children."* Throughout the course of her involvement with the case. The care and protection issues for the children related to violence and allegations of harm by the stepfather to the children.<br>❑ Despite his central role in parenting the children and being identified as violent towards both the mother and the children, the social worker did not talk to the father until some time after a Whanau Agreement was negotiated. The social worker has noted on the file *that "Hopefully it won't be too long before (the father) and I can discuss (the child)"*. Given this, the father did not become engaged in working on the plan and as a result the mother and social worker assumed primary responsibility for the plan working. In this sense the social worker became enmeshed with the family as opposed to working with them on resolving the care and protection issues apparent in the home. | 5 Case Review page 8<br><br>5 SWis File page 18 |
| **Selective Interpretation** | ❑ Intake social worker was aware that the household the child lived in at the time the notification was established was one in which family violence was apparent. It was noted in the case file that *"…describes her house as being violent at times. She told me that she was getting out and taking (a child) and (another child) with her. I reminded (the mother) that 10 years ago she was telling me that she was getting out."* Despite identifying the child's current environment as containing significant violence, and having a stated knowledge that there had been problems for a while, the seriousness of the situation was not focused on in the subsequent investigation and assessment. | 1 SWis File page 5 |

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| | ❑ Reports from Health professionals indicated that the mother was providing good care for her child and that there were no care or protection concerns. This is contrasted with the fact that significant concerns had been identified through the course of the investigation in relation to drug taking, disciplining, and handling of the child, Domestic Violence and transience. It is noted in the Child Case Review report that *"Unfortunately it would appear that some of these obvious concerns were not identified, and were somewhat clouded by glowing reports from Health professionals."* The social worker focused on information and opinion received from the Health professionals to the detriment of translating the evidence relating to care and protection concerns into an approach to the case that was clearly investigative. | 2 PF page 7b |
| | ❑ Mother had called on at least one occasion in the past stating that she was going to harm the children if the Service did not respond immediately. On the second occasion the social worker stated that while the mother was saying that she wanted to get rid of the children, it was the social workers assessment that all that was needed was for her to have a rest from the children. The social worker did not take into account the fact that the mother very recently had stated that she would harm the children if the Service did not react immediately - at that time the mother was also thought to be in need of a rest from the children. | 3 Sibling SWis File page 26 |
| | ❑ *"… prior knowledge of the case appeared to have narrowed or predetermined the focus of the second investigation, e.g. (the mother) had already been assessed to be a 'good mother' who wanted the best for her child."* Prior knowledge contributed to the social worker focusing on the case in a way that was reliant on the fact that the social worker had confidence that the mother had made changes in the past. | 2 Case Review page 6 |
| | ❑ Two Family Group Conferences were held. At the second the family decided that the child was not in need of care and protection. At the time, the concerns the Service had for the child related to neglect, violence in the home, the children being left home alone and historical sexual abuse. The social | 5 SWis File page 18 |

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| | worker accepted the FGC recommendations and documented the following "… *the whanau felt that (the child) is not subjected to unnecessary physical discipline and that the disciplinary methods employed by his parents are undesirable but controlled."* This was largely the result of the fact that the whanau thought that things had improved. This is evidenced in the case note by the following "*(the father) attended the FGC and it was agreed that he no longer exposed the children to risk of physical abuse the family supported his explanations as to his methods of discipline as being reasonable and that (the father) did have control of his anger."* Four months earlier the same social worker and supervisor made a decision not to undertake a formal investigation for a number of reasons. Those reasons were documented as "… *the safety of the children whom could be exposed to increased risk if interviewed. Tendency of the father to be violent - toward anybody."*<br>❑ " *From comments made to us by workers in (the office) where they are working with numbers of families perceived to be severely dysfunctional, it appears to us that there is an element of "accommodation" present in their acceptance of the dysfunction within this family."* This case related to a family, who was transient, there were allegations of sexual abuse, neglect and violence existed in the home. As stated, the review team believed the fact that the office was working with a number of similar cases. The impact this had was for the social workers to accommodate to conditions that were later recognised as unsatisfactory. | 4 Case Review page 32 |
| **Knowledge Deficit** | ❑ Social worker who managed the first notification was working in Adoptions and had "…*very little experience and no training for investigation and assessment work."* This significantly hampered her ability to conduct a well informed investigation and assessment.<br>❑ Social workers are required to carry out a number of statutory functions. Consultation with the Care and Protection Resource Panel is one such function. The Case Review for this case noted that *"Most Social Workers interviewed were not clear either about the role of the Panel or the process of referral."* | 1 SWis File page 5<br><br>3 PF Case Review page 17 |

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| | ❑ The Case Review found that there was evidence in the way the case had been managed to indicate that "Learning from attendance at training did not transfer into practice."<br>❑ *"With hindsight, it is apparent that the Social Work staff did not have the requisite background of training and experience in child protection investigation and assessment to have made a difference in this case."*<br>❑ *" … office worked with this family in a context of a heavy emphasis on minimum NZCYPFS intervention through the use of an investigate, assess and refer model. This was based on a belief that this was the intention of the Act… "*. What was missing from the offices understanding of how the Act was to be implemented, was that while the emphasis was rightly placed on a model of minimal intervention this should not have been at the detriment of ensuring the safety of the child. The Service had been equipped with information relating to this, however, as indicated in this case, that information was not well integrated into practice. | 3 Case Review page 23<br>5 Case Review page 35<br><br>4 Case Review page 14 |
| **Burnout** | ❑ The child's death occurred at a time where the staff morale was described as low. *"Staff are barely coping and do not take a proactive approach in delivering quality services."*<br>❑ *"The review team found the office climate was not conducive to the delivery of a professional social work service. Staff appeared exhausted and depressed."* And *"Social workers stated they felt stressed in not being able to do their work properly."* Staff moral was considered to be low both at the time the child died and at the time the Case Review was completed. | 3 PF Case Review page 3<br>3 PF Case Review page 19 |
| **Destructive Rescuing** | | |
| **Belief System of the Worker** | | |
| **Response to Experience of Violence** | ❑ The Social Workers report to the Care and Protection Co-ordinator refers to a perceived threat from the father *"Mr. … is reputed to have little regard and respect of people, place and time, which has caused us to practice careful and discreet inquiries."* The Social Worker reported that *"… I was frightened of (interviewing the father) because of what (the mother) had* | 5 Case Review page 12 |

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| | *warned me of".* She had been warned by the mother about a possibility that her personal safety could be endangered if she was to proceed with certain actions. | |
| **Not Exist Double Bind** | ❑ *" … (the father) presented himself at the … office and said he was moving to Cambridge and that (the child) was not enrolled at school at present but he intended enrolling him in … ."* The Social Worker accepted that this would occur. Shortly after this a home visit was made and as a result the worker became concerned about the whereabouts of the child. Follow up revealed that the child was not enrolled at any schools in the areas the father had indicated he was intending to enroll him. Had it not been for the fact that the Social Worker asked about the child, the stepfather would not have been required to produce any evidence that the child existed.<br>❑ It is noted on the file that while this child was the focus of attention from the school and the Service, *"In other ways he appears to have been the invisible child in the family."* | 4 Case Review page 24<br><br>4 Case Review page 35 |
| **Reframing -Blurring Care and Control** | ❑ At the conclusion to the first home visit the social worker supplied the mother with a card and her home phone number with instructions to *"…call anytime she needs help…"*. This was in response to an initial visit relating to an incident of Domestic Violence with a history of threatening to harm the children if the Service did not respond immediately.<br>❑ Through the course of managing the second notification the Care and Protection Resource Panel recommended that the social worker refer the case to the Plunket Nurse and ask that she "monitor" the situation. The case was closed on the basis of this. However, a referral was not completed and the Plunket Nurse neither understood she was to have a monitoring role nor made any contact with the child and her mother. The social worker thought Plunket should be involved in assisting the family in lieu of an investigation and assessment being carried out.<br>❑ Despite issues relating to excessive punishment/physical punishment of the child, domestic violence, children being left home alone, lack of food for the children, alcohol abuse and financial problems, the plan following two Family Group | 3 SWis File page 5<br><br>1 PF Case Review page 30<br><br>5 Case Review page 23 |

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| | Conference's focused *"… on monitoring rather than prevention."*<br>❑ The review team report found that in a case where the family were known to be violent, where there was use and abuse of drugs and alcohol, where historical concerns relating to sexual abuse of the children and where evidence of neglect was apparent that *"The Social Workers intervention was more of a supportive and admonishing nature designed to bring about change in an informal manner."* | 5 Case Review page 31 |
| **Disguised Compliance** | ❑ Following the death of a child, the social worker met with the mother to discuss the care of a sibling. The mother revealed that, despite the fact that she had said she would keep her violent ex partner away, he had been around to the home a lot prior to the child dying.<br>❑ *"(the mother) agreed to work with NZCYPFS to ensure the children's safety and to follow up … speech development and to have on going support."* Despite this the mother refused to accompany the social worker to a pre arranged Dr.'s appointment and an appointment with the Special Education Service. | 3 PF Case Review page 14<br><br>3 Case Review page 12 |
| **Flight** | ❑ Between May and September 1992 there were three case notes on file indicating transience which may have been a result of the Service initiating an investigation. Case notes stated *"It would be good to know where they are living"*, *"The address could not be found"*. During this time the mother was aware of an investigation being conducted and it appears she continued to move around without advising the Service of her location.<br>❑ The Service placed two of four children in Foster Care subject to a Section 139 Temporary Care Agreement. The plan was to also to place the remaining two children in care. Before this could be achieved, the mother left with them and returned to where her violent ex-husband was living. The Service was alerted to this by one of the children's school *"A phone call from (the child's) school alerted New Zealand Children and Young Persons Service to the fact that (the mother's) intention was to take the two younger children to (another location) forthwith. She was very distressed and angry"*. | 2 Sibling SWis File page 21<br><br>4 PF page 12 |

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| **Resistance** | ❑ SES assessment was organised as part of a plan the Service had to assist the mother cope with two children. On the day of the appointment she phoned, cancelled and refused to go. Five days later the child was killed.<br>❑ *"She (the Social Worker) also sustained her actions in the face of passive non-compliance of the clients…".* While plans were developed to addressed what the Social Worker assessed to be the care and protection issues warranting a plan, the family passively resisted intervention by means of not attending counseling.<br>❑ *"… (the father) indicated that he had placed (the child) in hiding to protect him from (the mothers) family and that (the child) was not attending school. He said that (the child) was receiving good care but that he was not prepared to disclose his whereabouts to NZCYPFS because he feared that information would be passed on to the (mothers) family."* The father was overt in the way he made it clear that he would not convey the child's whereabouts but demonstrated resistance by virtue of the fact that he would not produce the child for the Social worker of indicate where he was living.<br>❑ *" she (the mother) also knew where (the child) was but not tell the NZ Children and Young Persons Service."* The mother was also co-operative in identifying that the child was alive and well but also failed to assist in producing the child or indicating where he was.<br>❑ Mother contacted the Duty social worker demanding assistance immediately. When a promise could not be made that someone would be there that day she threatened that something would happen to her children if the Service was not interested. This pattern repeated itself on at least 3 separate occasions. Resistance comprises four categories - threats to harm children are defined as 'challenging and / or chaotic'. | 3 Sibling SWis File page 24<br><br>5 Case Review page 15<br><br>6 PF page 30<br><br>4 PF page 75<br><br>3 PF Case Review page 12 |
| **Manipulative Behavior** | ❑ Through the course of trying to locate a child who had not been able to be sighted for some time, despite demands from the Social Worker to the family to present the child, it is recorded that the mother said *"She was also stating that she had been speaking to him (the child) and he was well."* | 4 Case Review page 25 |

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| | ❑ *"The family are well known to social service agency's in (an area) and there appears to have been a certain communal acceptance that they were a difficult family tom work with or to bring about any substantial change. They are regarded as a "closed shop" who would report each other to DSW while attempting to gain Special Needs Grants for themselves, but would not be prepared to substantiate any reports of abuse or neglect when asked to do so."* | 5 Case Review page 3 |
| **Hostage Theory** | ❑ The social worker stated that she did not agree with the FGC recommendations. She did not voice her agreement. The reasons for this were as follows:<br>1. That she thought the family should be given the opportunity to carry out their own decisions.<br>2. That she thought there might not be sufficient grounds for an Application for Declaration through the Family Court in any case.<br>3. That she thought she was the only person at the Family Group Conference who did not agree with the decisions.<br>4. That she was unsure whether there were current concerns as all the reports indicated that the children had been removed.<br>5. That she began to wonder about the reasons for doubting the wisdom of the families decision, becoming concerned that she might have either *become "overly judgmental of the family"* or *"overly protective of (the child)".*<br>*"It seems that the Family Group Conference did not provide a safe environment for either professionals or family members to express their views openly."* This was due to the fact that those involved had either heard about or feared the consequences of a negative response from the father in the event he was challenged about his role with the family/children.<br>❑ *"… one social worker, working alone working alone with this particular family system did not have a significant chance of success. That fact that she is Maori with Iwi links to the whanau may in this case have increased the tension between the DSW and the family as the family were questioning hr Maori status at the meeting."* | 5 Case Review page 20<br><br>5 Case Review page 35 |
| **Covert Warnings** | ❑ A notification was received that the father of the child, whom | 3 Sibling |

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| | had had a violent relationship with the mother, was seen in public *"swinging the child around by the hair"* and had *"picked a push-chair up and chucked it at the child"*. A home visit was conducted and the father gave his version of events. Two months later, a further notification was received involving another incident of Domestic Violence. One child received marks on her face and the mother was removed from the house to the Refuge. There is little documented evidence of follow up by the Service and approximately 3 weeks later the child who received injuries from this incident was killed by the father. Within two months of the child's death the Service was made aware of two incidents of violence perpetrated by the father on the children.<br>❑ A child was placed in care as a result of the mother threatening to harm him - she then took him back 2 days later. Five months later she again demanded the same child be placed in care - this was done for a few days. Two weeks later she again demanded the child be placed in care on the grounds that she could not cope with him and was likely to hurt him if he did not go into care. Three days later she removed him from the placement. Some months later the mother gave the child and his sibling to her violent partner. Soon after this the partner killed the sibling. | File pages 30 and 32<br><br>3 Case Review pages 10 and 11 |
| **Closure** | ❑ SES assessment was organised as part of a plan the Service had to assist the mother cope with two children. On the day of the appointment she phoned and cancelled and refused to go. Five days later the child was killed.<br>❑ *"… family became elusive. At this point a decision was made by the social worker to close the notification and leave it to the family to remake contact with the Service as they wished."*<br>❑ Social worker reported that she had *"… been unable to sight (the child) and (the father) had been resisting her request to present him."*<br>❑ *"… (the social worker) has been unable to sight (the child) …(the father) says that he has not allowed access to (the child) because he wants to keep him safe …He still refuses to inform us of (the child's) exact whereabouts … despite his* | 3 PF Case Review page 12<br><br>4 Case Review page 10<br>5 Case Review page 25<br>4 PF page 23 |

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| | *vehement opposition and peripatetic lifestyle of late, which has defied social work involvement."* | |
| **Systems Failure** | ❑ Transfer of information from one computer database (OLE) to another (CYPFis) resulted in some information not being established on the new social work database. This resulted in social workers not having easy access to all relevant and recorded information. | 1 PF Case Review page 6 |
| | ❑ The social work recording system called 'CYPFis' ceased use in preference for the current system known as 'SWis'. Change over between the two systems resulted in some data being difficult to access at the point of conversion. In this case the third notification was received immediately prior to the change over and it appears that information from the central data base was more difficult to access hence a 'central search' was not conducted. | 1 PF Case Review page 6 |
| | ❑ A personal file was not established for this client. Paper based information was held on what was referred to as a Miscellaneous file and in this form that information was largely inaccessible. Systems did not exist to facilitate the information on paper miscellaneous files being transferred to a client file. | 1 PF Case Review page 19 |
| | ❑ An office was subject to a number of significant changes in personnel and systems leading up to the child's death. "Those factors included changes to a number of systems, staff absences due to leave and transitional training, budget constraints and a change in management." | 3 F Case Review page 3 |
| | ❑ Following a notification of physical abuse the father was contacted in order that the allegation could be investigated. "Once located there was no follow up due to staff absences and system changes." | 4 PF Case Review page 10 |
| | ❑ " The transfer of files between the three offices involved was either not actioned or actioned after lengthy delays." | 3 PF Case Review page 19 |
| | ❑ " …small combination of factors in the … office made it difficult for a small team to deliver a safe care and protection service. These factors included changes to a number of systems…" | 3 Case Review page 3 |
| | ❑ Paper based miscellaneous files and information was misplaced | 5 |

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| | in … (office). This information remained there when the rest of the files were transferred to another Site. "…some time later this office also created a record for … under the name of …. Incomplete records were transferred from one office to the other." | Case Review page 12 |
| | ❑ "There have, however, been major difficulties in transfer of records from … . This has been caused partly from the duplication of records, with no tagging of records created in error…." And, "This has been exacerbated by the temporary 'loss' of the Miscellaneous File in … and the fact that when a family file was created these papers were not included in it. In addition, many of the early records kept in the day book have not been copied and included in the paper files." | 4 Case Review page 17 |
| | ❑ "Case owner ship and information confusions were important in the course of the case as they interfered with … office making early sustained contact and early re-assessment of the care and protection issues for the children." | 4 Case Review page 17 |
| | ❑ Information on miscellaneous files was not transferred to client files at the time further notifications were received. In the form of a miscellaneous file the information was largely inaccessible and did not contribute to decision making in the case as a whole. | 1 PF Case Review page 14 |
| **Anxiety Response** | | |

**Appendix C: ETHICS PROPOSAL**

# MASSEY UNIVERSITY
# APPLICATION TO HUMAN ETHICS COMMITTEE

**NAME:** Paula Attrill

**STATUS OF APPLICANT:** MSW Student.

**DEPARTMANT:** Social Policy and Social Work.

**EMPLOYMENT:** Practice Manager, Children Young Persons and their Families Service – Taranaki Site.

**PROJECT STATUS:** Masters Thesis.

**FUNDING SOURCE:** Self and Employer.

**SUPERVISORS:** Mike Garland – Lecturer – Social Policy and Social Work.
Mary-Ann Baskerville – Senior Lecturer – Social Policy and Social Work.

**TITLE OF RESEARCH PROJECT:**

***AN EXAMINATION OF THE INFLUENCE DANGEROUS DYNAMICS HAVE IN CASES KNOWN TO THE CHILDREN YOUNG PERSONS AND THEIR FAMILIES SERVICE WHERE A CHILD HAS DIED.***

**ATTACHMENTS:** Children Young Persons and their Families Service Deed of Confidentiality.

**SIGNIATURES:**

Researcher: ----------
PAULA ATTRILL

Supervisors: ----------
MIKE GARLAND

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MARY-ANN BASKERVILIE

**DATE:** ----------

# 1 DESCRIPTION:

## 1.1 Justification:

The presence of dangerous dynamics in the relationship a social worker has with the families with whom they work potentially heightens the degree of risk apparent for the child. At times such risk is raised to fatal proportions.

This research proposal seeks to examine 'whether or not a set of definable dangerous dynamics were apparent leading up to and at the time of the death of children known to the Children Young Persons and their Families Service (CYPFS).

These circumstances coupled with the fact that the death of a child is one of the most feared and catastrophic events faced by care and protection social workers, have led to this attempt to contribute to existing knowledge and research in the area. It is hoped that the outcome of this project will lead to the development of knowledge and training which in turn will assist staff of the CYPF Service to be better equipped to anticipate and prevent further deaths of the children and young people with whom they work.

## 1.2 Objective:

To examine whether a set of definable dangerous dynamics were present leading up to and at the time of the deaths of four children known to the Children Young Persons and their Families Service.

## 1.3 Procedures for recruiting participants and obtaining Informed Consent:

This research will be an archival study of 4 files hand chosen by the researcher in consultation with the CYPF Service. Both paper and computer files will be accessed for the cases selected.

1.4 **Procedure in which research participants will be involved:**

No participants directly involved due to the fact that this an archival study with the Children Young Persons and their Families Service regarded as the participant.

**1.5 Procedure for handling information and material produced in the course of the research including raw data and final research report(s):**

Access to files will be via requesting paper files be transferred into the office from which the researcher works and through remote access being approved to computer files located in other Sites. The files will be reviewed to ascertain whether or not there is evidence to suggest that dangerous dynamics were present in the case leading up to and at the time the child died. No information will be physically removed from the files, and when not in use they will be stored either in a lockable filing cabinet in work office or lockable drawer in home office desk. The final research report will be published in the form of a thesis, a copy of which will be made available to the CYPF Service.

## 2 ETHICAL CONCERNS:

### 2.1 Access To Participants:

Case information relates directly to the children, young people and their families with whom the Service was involved leading up to and at the time the child/young person died. For the purposes of this research, the Children Young Persons and their Families Service will be viewed as the participant.

### 2.2 Informed Consent:

Please refer to the *Deed of Confidentiality* attached.

**2.3 Anonymity and Confidentiality:**

All identifying information will be omitted from the thesis in order that the identity of those involved, both clients and workers, is protected as far as practicably possible.

**2.4 Potential Harm to Participants**:

The Deed of Confidentiality and accompanying documentation specifies that the CYPFS reserves the right to view the penultimate copy of this research document. This agreement is designed to protect against potential harm to the participant.

**2.5 Potential Harm to Researcher(s):**

All cases will be chosen with a view to avoiding any which the researcher may have had involvement with through the course of employment with the CYPFS. Doing so essentially decreases the potential for harm to the researcher given her dual role as researcher and employee of the 'Participant'. Care will be taken through the course of conducting this research to focus on the issues and not the individuals involved with each case.

2.6 **Potential Harm to the University**:

None foreseen.

2.7 **Participant's right to decline to take part:**

Please refer to the *Deed of Confidentiality* attached.

**2.8 Uses of the Information:**

Information included in this thesis is intended to be used primarily for the purposes of meeting the requirements of a completed thesis but also to form the basis of a training tool for CYPFS staff. It will require significant re-working to be able to be used in the latter capacity but the intention is to make the information

available to staff in a form which lends itself to facilitating increased knowledge in this field. It is anticipated that any publications would focus on methodology and concepts rather than on specific cases.

### 2.9 Conflict of Interest:

Provision has been made in the agreement with the CYPF Service that any conflicts of interest that may arise, will be brought to the attention of the Chief Social Worker.

### 2.10 Other Ethical Concerns:

None

## 3 LEGAL CONCERNS:

### 3.1 Legislation:

3.1.1. Intellectual Property Legislation e.g. Copyright Act 1994 – none

3.1.2. Human rights Act 1993 – none

3.1.3. Privacy Act 1993 –

3.1.4. Health and Safety in Employment Act 1992 – none

3.1.5. Accident Rehabilitation Compensation Insurance Act 1992 – none

3.1.6. Employment Contract Act 1991 – none

### 3.2 Other Legal Concerns:

None.

## 4 CULTURAL CONCERNS:

Child death statistics reveal that Maori children who are fatally harmed proportionately outnumber non-Maori (Patterns and Reflections: 1997). In completing this research it will be important to ensure the sample group accurately reflects cultural diversity.

## 5 OTHER ETHICAL BODIES RELEVANT TO THIS RESEARCH:

### 5.1 Ethics Committee:

Children Young Persons and their Families Service Ethics Committee (See Code of Confidentiality attached).

### 5.2 Professional Codes:

CYPFS Code of Conduct

NZASW (Member) Code of Conduct

## 6.0 OTHER RELEVANT ISSUES:

None.

### REFERENCE:

Kinley, Liz. Patterns and Reflections. Children Young Persons and their Families Service. 1997.

**Appendix D: MASSEY UNIVERSITY ETHICS COMMITTEE APPROVAL**

MASSEY
UNIVERSITY

A L B A N Y

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

SCHOOL OF POLICY STUDIES & SOCIAL WORK

11 June 1998

Paula Attrill
7F Tasman Street
New Plymouth

Dear Paula

thank you for the letter from the Departmental Solicitor concerning your thesis. The information is particularly helpful and clarifies a number of important areas. The Ethics of the Project are approved.

Should you wish to use the material for teaching or training purposes, further ethical approval will be needed.

Best wishes for your research.

Yours sincerely

Mike O'B

**Mike O'Brien**
**Acting Chairperson**

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