Knowledge Production for Decision Making in Child Protection Social Work

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The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

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Needless to say any deficiencies in this work are entirely my responsibility.

...practice is an untidy, unpredictable business. The best that social work can do is to be wise about this uncertainty and complexity.

- David Howe, *A Brief Introduction to Social Work Theory,* 2009, Basingstoke: Palgrave Macmillan, p. 193

The sources of anxiety did not, of course, relate exclusively to our core sample clients. They could be found in much of the total volume of work. They seemed to lie in the quantity and variety of work expected in a social services department, in the seriousness of the events surrounding our core sample and other clients, in the feelings of impossibility and helplessness engendered by some of their demands, in the apparent unpredictability of events and, finally, in the sense of a hostile environment which placed high and idealized expectations on a department which had to deal with so many and varied unpleasant happenings.

- Mattinson & Sinclair, *Mate and Stalemate,* 1979, Oxford: Blackwell, p. 294

Only in books the flat and final happens,
Only in dreams we meet and interlock,
The hand impervious to nervous shock,
The future proofed against our vain suspense;

- Philip Larkin: *"Observation"* from *Collected Poems,* 2003, The Marvell Press and Faber & Faber

ABSTRACT

This study contributes to an understanding of how social workers produce knowledge and make decisions in child protection work. Since the early 1970s there have been a significant number of tragedies where children have died as a result of abuse and perceived errors by social workers and other professionals have been implicated. Child abuse is an extremely complex, uncertain and stressful area of work and eliminating all errors is impossible.

This study undertook a detailed examination of some of the daily routines and activities of a number of social workers across two sites: a local authority child protection team and a more specialist team undertaking family assessments. Treating the sites as case studies qualitative observations and in-depth interviews were carried out in an attempt to understand how social workers made decisions in day-to-day work and to develop concepts for further research.

The study found that decisions are not single events but the result of complex processes embedded in the social activities and practices that make up the work. The social workers drew on a range of sources of information all of which were fallible and then constructed knowledge for decision making through a series of social, cultural and cognitive processes. The nature of the work favoured experiential or naturalistic rather than analytic reasoning. Key practice areas such as home visiting, office duty and supervision were explored to understand how practitioners reasoned in these contexts which, despite their importance, are not well researched. An ecological model of knowledge is suggested which could help in understanding how decisions are made in practice.

It is suggested that social workers' decision making and knowledge are so embedded in the contexts and routines of practice that they can only be understood through close examination of local practices and this is a fruitful area for future research.

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CHAPTER 1 INTRODUCTION

1.1 The research question

This study was designed to answer the question: how do social workers form judgements and make decisions about child protection within everyday working contexts where those contexts may be marked by significant degrees of stress, complexity and uncertainty?

1.2 The background to the problem

On a day when I am writing up one of the chapters of this thesis the news is dominated by two terrible events. The Serious Case Review has been published on the death of 4 year old Daniel Pelka in Coventry, murdered by his mother and her partner despite the involvement of the police, the school and health and social care professionals. The police visited the family 30 times in six years to deal with domestic violence incidents but did not pass on any concerns about the children. Daniel's school did not refer on concerns despite Daniel reportedly appearing at school with bruises, being seriously underweight and so hungry he was stealing food from other children's lunch boxes. Many of the apparent failings by professionals in assessing Daniel's situation were described as "sadly familiar" from previous child abuse deaths.

On the other side of the world a 34 year old former US navy reservist called Aaron Alexis shot and killed 13 people at the high security Washington Navy Yard a few miles from the White House. Alexis worked as an IT technician at the military facility. Despite tight security and a ban on firearms at the yard (it was a week after the anniversary of 9/11) Alexis was able to carry out the killings with a semi-automatic rifle and a shotgun. It emerged he had a string of convictions for gun-related offences, including shooting out someone's car tyres in an "anger-fuelled blackout", and had been discharged from the navy after being arrested over a shooting incident. Less than four years previously 13 people had been shot dead at another US military facility in Fort Hood, Texas, by an army officer.

How can such appalling things happen despite all the procedures that have been put in place to prevent them following previous tragedies? Why did those who were charged with safety and security miss such apparently obvious risk factors? Why did they make the vital decisions that they did and not make others that might have prevented these deaths?

In 1974 a public inquiry was published into the tragic death of a young girl, Maria Colwell, at the hands of her step-father. For the first time in the modern era the actions of social workers in attempting to protect or safeguard vulnerable children were exposed to public scrutiny (although the terms "child protection" and "child safeguarding" had not been coined and the physical maltreatment of children was known as "baby battering"). As a consequence of this case, whose importance in the development of social work in the UK cannot be overestimated, the modern panoply of procedures for the protection of abused children came into being, social work became the subject of, often mercilessly critical, public and media attention and "public inquiries became the primary vehicle for bringing about change in policy and practice in the UK" (Parton, 2006, p.32). 40 years later, after over 30 public inquiries and a much larger number of statutory reviews into child deaths, social work practice in protecting children remains contested and the quality of social workers' decisions in child protection work remains a matter of public and political concern.

A study of how social workers make decisions about the cases they deal with might be done in different ways. In researching such a question attention might focus on, for example, the changing nature of policy and procedure or on the well-documented but rare and extreme instances where children have died and the circumstances surrounding their deaths have been the subject of public inquiries or Serious Case Reviews. What is presented here is a study of how a small number of social workers made and accounted for decisions and carried out their work in their day-to-day practice. This is an under-researched area in social work. The author of one such work observed that "the locations, activities, relationships and meanings which constitute everyday work are not abundantly documented in welfare literature" (Pithouse, 1998, p.1). Parton (1996), discussing a digest of Dept of Health research, commented on the lack of studies involving "participant observation or in-depth interviews with social workers that attempted to explore how they made sense of the work and, crucially, how they made judgements about cases" (p.8). Without such research, he argues, the nature of actual practice cannot be fully understood. More recently Ferguson (2004) has argued that much analysis of child protection has focused largely on procedural and organisational issues: "(i)t is possible to read most child protection texts today without realizing that most of the real action goes on at doorsteps and in people's homes" (p.213). Taylor (2013) and Helm (2011) have both commented on the lack of research into how social workers make decisions in practice while Forrester et al. (2008, p.50) note the "general lack of attention to directly observing and improving the skills (social workers) use in practice".

The decision to focus this study on the details of everyday practice, on the experiences and accounts of social workers and their managers, arose initially from my own experiences as a social worker and so, at this point, a personal note might be permitted.

I am standing with a colleague in the corridor of a block of flats somewhere in North London. It is a late afternoon in winter and outside it is dark and raining. We've come to speak to a family whose children, so neighbours allege, are constantly crying and distressed. We knock on the door. No answer. We knock again. Still no answer. Are they out? Are they in but keeping very quiet? There's no way of knowing. Secretly relieved, we go downstairs and drive back to our warm, safe, well-lit office. I wonder why I remember this moment so vividly rather than some of the other, more obviously dramatic, moments from my career as a social worker and I think it is because it exemplifies the anxieties and tensions of day-to-day practice and particularly of visiting families in their own homes which is a significant theme of this study.

Years later I am sitting in the waiting area of a health centre in northern England waiting for one of the social workers in the team I am studying to come down and take me upstairs to observe them at work. I cannot go up myself because I have not been given the codes to open the doors so I have to ring when I arrive and wait to be admitted. This is always a nervous moment. Sometimes I am kept waiting for what seems like ages. I start thinking something's gone wrong, there's been a problem and they don't want to see me anymore. All the hard work I did to gain access counts for nothing. Then one of the social workers comes down, smiling apologetically, and takes me up. She makes a joke about how hard it is to get into this place. The first time I came someone said how lucky I was to be "approved" to enter.

Is it possible to know what social work *practices* are like if we don't know what it feels like to stand on a half-lit corridor of a shabby block of flats knocking on a stranger's door to ask them questions of excruciating intimacy about how well they look after their children? Families' homes, of course, are intensely private and intimate places but so too are social work teams and the places they inhabit. Perhaps it is as difficult to know what goes on in them as it is to know what really goes in families. Both erect barriers between themselves and the outside world and in both cases there is, as Ferguson (2011) argues, a distinct sense of the liminal as thresholds are crossed. Mattinson & Sinclair (1979), in the conclusion to their study of a social work team, argued that to keep the demands of the work manageable everyone who could be excluded was kept out and only those whose problems were so serious and pressing that they

could not be excluded (which, they argued, were those least amenable to treatment) were granted access to services.

This study attempts to understand something about the nature of social work practice, to get an inside view, to try and work out how social workers go about their business of forming judgements and making decisions about their cases by paying close attention to what they actually *do* on a day-to-day basis. Ferguson (2004) distinguishes between the “liquid” and “solid” worlds of social work: this study focuses primarily on the “liquid” world – that fleeting, hard-to-capture world of practice – rather than the “solid” world of official policy and procedure, and on what we might learn from that perspective about social work decision making. When the professionals involved saw Daniel Pelka and Maria Colwell, without the benefit of hindsight, what did they see? What did they think? Did these children seem in any way different from all the other children they worked with, who did not die? Munro (2005) has argued that to really understand why decisions were made as they were, researchers should try to find out what situations looked like at the time, from the point of view of the individuals involved and the complex organisational systems they inhabited. Gray & Schubert (2013) suggest that the voice of practitioners is often absent from inquiries and reviews. Practitioner perspectives form an important part of this thesis.

1.3 The structure of the thesis

Chapters 2 and 3 review the literature relevant to this study.

In chapter 2 the complex nature of child abuse as a social problem is discussed and some historical material is presented exploring changes in social work with children and families since the 1970s against a background of wider change in a globalised and increasingly post-welfarist world. Lessons to be learned from the public inquiries and case reviews into child deaths in the last decades are set alongside key research studies into social work practice. Where inquiries and reviews have focused largely on procedural and bureaucratic issues studies of practice reveal a world of great complexity, uncertainty and localised practices where social workers struggle to makes sense of ambiguous cases. It is suggested that decision making processes are deeply enmeshed in these everyday practices.

In chapter 3 the focus is on theories and models of decision making and knowledge for social work. Intuitive or naturalistic models of decision making are compared to more analytical or orderly models and their respective strengths and limitations discussed. Studies of decision making in social work are reviewed. A picture emerges of social workers making rapid,

heuristic decisions in fluid, dynamic and often contested situations. There are considerable strengths to such decision processes but also some limitations which might be addressed by introducing more analytical modes of reasoning and these are discussed. The types of knowledge that social workers use are considered and the emphasis on experiential and tacit knowledge in social work is discussed. The importance of studying the contexts in which knowledge is produced and decisions made is suggested.

Chapter 4 is a brief chapter in which the key concepts emerging from reviewing the literature are elucidated and synthesised and a clear set of research questions flowing from this conceptual framework is set out.

Chapter 5 focuses on the methodological design of the study and the choice of methods used to gather, code and analyse the empirical data. Yin's (2009) concept of construct validity is employed as a model for ensuring that the research process in this thesis is clearly and transparently set out. The chapter seeks to balance the methodological theories behind the design and execution of the study and this researcher's actual experiences of what can be an unruly business. Issues of case selection, sampling, gaining access, ethics and the gathering and analysis of qualitative data through observations and semi-structured interviews are discussed.

Chapters 6-9 set out the empirical findings organised into four themes.

Chapter 6 draws on both observational and interview data to examine the daily activities of the social workers and the nature of their work. Some of the activities and routines of the work such as the processing of new referrals, team meetings and home visits are represented. The nature of the families the social workers worked with are also examined – suggesting that the vast majority of these families consisted of networks of relationships encompassing former partners and extended networks of relations and friends which the social workers often struggled to make sense of. Competing versions of events were often presented to the social workers and "truth" could be impossible to find.

Chapter 7 attempts to present a detailed picture of the social workers' daily work with their cases and is largely based on interview data. Home visiting, assessments and work with other professionals are key themes and what emerges is a picture of great complexity and uncertainty, very different from more official and orderly versions of the work and one where decisions had to be made quickly on the basis of incomplete and contested information.

Chapter 8 focuses on supervision and management and uses interview data to construct the perspectives of both supervisors and supervisees. Supervision is a crucial site for discussing, reflecting on and making sense of the work and is often seen as suited to more analytical and orderly forms of reasoning. In this study what also emerges is a picture of supervision as a complex social encounter, artfully managed by skilled social actors with a variety of unofficial as well as official functions. Its function as a routine or ritual through which social order was accomplished and knowledge constructed and reconstructed for decision making is highlighted.

Chapter 9 examines the knowledge social workers used to make decisions. The sources from which their knowledge was drawn is discussed. All of these sources were fallible and needed to be carefully evaluated before being used to build pictures or frames for decision making. Social work has a diverse knowledge base and experiential or tacit knowledge emerged as that which participants most highly valued for making sense of uncertain situations lacking definitive answers. Values, beliefs and moral judgements all played a part in workers' decisions and the emphasis on professional values could be seen as a recognition of the need to negotiate multiple versions of reality or as a professional ideology based on uninterrogated assumptions.

Chapter 10 attempts to take the analysis further and identifies three cross-cutting thematic categories for suggesting substantive theories. It is argued that the picture of system complexity that emerges reflects the complexity and intractability of child abuse as a social problem. Knowledge is constructed and decisions made as a result of complex social processes such as supervision and home visits which can be analysed as social encounters and as locally varied practices enacted by situated social actors. A theory of the ecology of knowledge is drawn upon to suggest a model for how social workers produce knowledge from fallible sources and reconstruct it for practical decision making. Finally it is suggested that developing and testing theories of social work *practices* might be a fruitful avenue for future research.

In conclusion chapter 11 reflects on the strengths and limitations of the study and what it may contribute to knowledge about how social workers make decisions. The methodology and methods of the study are considered and suggestions made about taking a realist approach to future research as this takes account of complexity and context. On the basis of the findings recommendations for future policy and practice are made.

1.4 Key to the anonymisation of participants

In the following chapters all participants have been anonymised. There are a total of 16 participants:

1 senior manager (SM1)

3 team managers (TM1-3)

2 senior social workers/assistant team managers (SSW1-2)

9 social workers (SW1-9)

1 social work assistant (SWA1)

All but one of the participants were female. I have referred to all of them as “she” so the one male cannot be identified.

1.5 Notes on the text

Every effort has been made to maintain confidentiality by disguising all names and places in the text. The link to the Ofsted report on the local authority has been anonymised.

Throughout this text I have used the word “client” to refer to family members receiving social work services. There is some considerable debate about the terms used to describe those in receipt (willingly or not) of social work interventions (including a debate about whether we should bother to have such a debate). In the UK the term “service user” is the one most widely used and in our individualised post-welfarist world the terms “customer” and “consumer” are increasingly heard. But all these terms can be criticised for the assumptions that lie behind them (McLaughlin, 2009). In using “client” I have opted for brevity and for the term most widely recognised by those outside the social work profession. The New Shorter Oxford English Dictionary gives a number of definitions of “client” including “a person using the services of any professional”. This definition is used in this study as it does not suggest any inequality in the relationship.

Reference is made in places to Initial and Core Assessments. These terms have ceased to be official terms since the redrafting of the guidelines governing the inter agency protection and safeguarding of children, known as “Working Together”, in April 2013 (Dept for Education, 2013). A single continuing assessment is now required. These guidelines were not in place when the fieldwork was done and I have not changed the references to the old assessments in the text. It is inevitable that specific references to policy and legislation will date relatively

quickly. Hopefully the issues at the heart of this study will remain relevant for somewhat longer.

CHAPTER 2 LITERATURE REVIEW I: Social work, child abuse and protecting children

2.1 Overview

This chapter begins with an historical overview of developments in social work with children and families over the past 40 years. The rationale for this is twofold: it helps explain many of the issues and dilemmas that preoccupy social workers and shape their working environment and it provides some understanding of the socially constructed nature of child abuse and the difficulty (perhaps the impossibility) of defining abusive behaviours in ways that meet with universal agreement. This lack of universal agreement has profound consequences for the nature of child protection social work.

The chapter then looks at studies analysing the public inquiries and Serious Case Reviews undertaken when children have died which have been such a pervasive feature of the development of social work and social policy during this period. Indeed, the chapter begins with the public inquiry into the death of Maria Colwell which, while now several decades old, can be seen to embody many of the issues, dilemmas and debates that continue to this day. These studies provide valuable insight into the ways social workers have made decisions and the working situations that have shaped those decisions. Inquiry reports have tended to focus more on recommending bureaucratic and procedural changes rather than examining the complex demands of the work which make errors so possible and so the chapter then looks at research studies of social work practice which attempt to uncover the ways in which social workers really go about their work and make decisions about their clients. In practice a mix of official and unofficial discourses are present and this chapter shows how such studies have revealed the nature of this mix.

The conceptual contribution of this chapter to the thesis is:

(i) To understand the “wicked” nature of child abuse as a social problem, a problem that does not permit easy or linear solutions

(ii) to examine the importance of the complex and socially constructed historical, cultural and professional contexts which profoundly shape decision making in social work

(iii) to examine the complex nature of the social work practice within which decisions are made and the errors and dilemmas that can occur in working with families where children are deemed to be at risk

(iv) To examine the interplay between official discourses and unofficial versions of social work and the local complexities of practice as enacted by situated actors

The conceptual framework is further developed in the next chapter and then summarised in Chapter 4 in which the research question is set out.

2.2 Social Work and Child Protection: a brief history

While it is not the remit of this chapter to give an account of the historical development of social work in the UK it would be difficult to understand the preoccupations of the social workers in the study (and those of the researcher) without some discussion of the way social work with children and families has developed since the early 1970s. In the following section some of the key events and themes are discussed which provide a context for modern-day social work as practised by the workers in this study.

A historical account emphasises the degree to which definitions of child abuse are socially constructed and change over time, helping to create the element of uncertainty that pervades child protection social work. It also shows what a "contingent activity" social work is – shaped by shifting discourses and policy imperatives (Harris, 2008, p.663) . Gordon (1989) argues that without some historical perspective the problem takes on a timeless quality that is somehow above changing social policies and community values whereas recent history suggests that the ways child abuse has been defined and the ways the state has sought to control it have changed regularly.

Corby et al. (2012) identify a "first era" of child protection from 1974 to 1990 beginning with the public inquiry into the death of Maria Colwell: an event whose importance in the development of social work in the UK cannot be overestimated. Maria was fostered by her uncle and aunt following the breakdown of her parents' marriage. A Care Order was made due to concerns about Maria's mother and Maria remained in care for over four years. When her mother remarried and asked for Maria to be returned to her the local authority agreed although Maria by this stage had only intermittent contact with her mother. She was killed by her stepfather, two months before her eighth birthday. The government decided to hold a public inquiry into her death which was held amidst intense public and media attention which became a "moral panic" (Parton, 1985; Hendrick, 2003). For the first time the private and

largely uncontested world of social work was held up to public scrutiny and social workers vilified for their mistakes, although the inquiry itself (Dept of Health & Social Security, 1974) blamed the "system" as much as the individual workers. As a result of this inquiry's uncovering of shortcomings in the systems for protecting children new procedures for investigating abuse and ensuring agencies worked together were created: in effect the modern system of child protection procedures was set up. It also, Corby et al. (2012) argue, created a template both for public inquiries and for the kind of public and media responses accompanying them. Writing about another public inquiry many years later, that into the death of Victoria Climbie, Cooper (2005) argued that these inquiries became a genre, reporting on practice in particular ways that usually focused on the quality of the bureaucratic procedures but, uniquely, the Colwell inquiry report was not unanimous. One of the three panel members dissented from some of the majority findings and wrote a minority report in which she argued that the picture of practice painted in the majority report was simplistic and failed to take account of the emotional complexities of the case. Far from a situation where there was evidently "good" on one side and "bad" on the other – in which case the errors of the social workers seemed scarcely credible – she argued that Maria was a confused and unhappy child, caught up in a bitter family feud and manipulated by angry family members. The minority report describes the social workers' visits to the different family members, where they would be faced with rooms full of furious relatives denouncing each other. The author does not suggest that terrible mistakes were not made, but that they were made against an extremely confusing and complex background which made it very hard to know what was "really" happening: circumstances that Munro later argued make mistakes unavoidable and uncertainty ineradicable (Munro, 1996; 2011)

This is a moment of some significance: the tension between a view of social work as a technical, bureaucratic activity in which official procedures will prevent tragic errors or as a much more uncertain and complex activity where situations are usually highly ambiguous and contested. This tension runs through much of this study. The portrait of home visits here is of chaotic, stressful, even frightening, situations, yet ones where important information must be gathered. The home visit was then and is now a critical feature of social work practice which, again, figures significantly in this study.

Following the Colwell Inquiry, the introduction of new procedures and a new Children Act in 1975 social work became more "focused and intrusive" (Corby et al., 2012, p. 37) in its

investigation and management of child abuse and this became central to the work of Social Services Departments having previously been of low priority.

Over the next 10 years there were 29 public inquiries into child deaths (Corby et al., 1998) and these inquiries became major, perhaps the major, driver of changes in social work policy and practice (Parton, 2006; 2009). We live, Manthorpe & Stanley (2004) suggest, in “the age of the inquiry” and not just in social care.

Parton (2006) argues that there were significant rises in legal interventions during this period yet Dingwall et al. (1983), studying welfare professionals in practice, suggested that an institutional device they called The Rule of Optimism enabled them to take a flexible view of what constituted abuse to prevent their actions becoming too intrusive into families’ private affairs. This “Rule” was highlighted by another significant inquiry, that into the death of a 4 year old girl, Jasmine Beckford, who like Maria was returned home after being taken into care and was murdered by her father (London Borough of Brent, 1985). This inquiry was extremely critical of the social workers, arguing they had been too gullible and naive in trusting the parents’ stories and recommending that social workers use their statutory powers much more authoritatively. There should, the report argued, be a much greater emphasis on assessing families for risk (Corby et al., 2012) and intervening early to protect children. Procedures were further tightened and the term “child protection” began to be used for the first time to describe social work with children.

There were another 12 public inquiries between 1985-89 (Corby et al., 1998). Figures suggest that during this period there were very large rises in the numbers of children removed from their families using statutory powers (Parton, 2006).

In the late 1980s sexual abuse began to be highlighted as a social problem for the first time. During a short period of time in 1987 over 100 children in Middlesborough were removed from their families and local paediatricians using a particular diagnostic test, found they had been sexually abused (Corby et al., 2012). Another public and media outcry followed and another public inquiry held: this one concerned with professionals over- rather than under-reacting (Parton, 2006). The inquiry concluded that professionals needed to be much more careful in their interventions so as to find the right balance between family privacy and state intervention:

(Cleveland) touched a range of sensitivities which were rarely evident in earlier concerns about physical abuse and neglect: it reached the most intimate, hidden and private elements of family life.....no longer could child abuse be seen as only associated with the marginalised and disreputable sections of society. It seemed to permeate 'normal' families. (Parton, 2006, p. 34-35)

The Cleveland Report played a part in reframing the new Children Act, giving families and children more rights and increasing limits on the powers of professionals. This new Act was passed in 1989 and remains the single most important piece of legislation in social work with children and families – so much so that Corby et al. (2012) date their "second era" of child protection work from 1991, the date of the Act's implementation.

The 1989 Act brought together a number of disparate pieces of legislation. It covered both children "in need" and children at risk of significant harm so that now both child protection and child welfare were covered in the same law. Distinguishing between the two became a major preoccupation of social workers and new referrals would quickly be separated out into these two categories (Spratt, 2000). Of course a child at risk might well also be a child in need as defined by the Act and the significant harm that was the legal test of risk was not precisely defined thus adding further to the complexity of what became a very quickly made choice with considerable room for error (Munro, 1996).

In 1995 a digest of government-funded research was published by the Dept of Health (Dept of Health, 1995) suggesting that large numbers of families were being drawn into the child protection system. For the families this was seen as a traumatising and stigmatising process yet the vast majority of the families were then filtered out without any statutory intervention or without receiving a social work service despite often great material need. Social work had, Corby et al. (2012) argue, become too procedural, too bureaucratic and too intrusive. The digest argued that definitions of abuse and thresholds for intervention were socially constructed and changed over time and now needed to be refocused.

The election of a Labour government in 1997 saw a policy shift to a wider definition of "safeguarding" children rather than a narrower focus on child protection (Parton, 2009), a shift that Parton (2006) characterised as "safeguarding of all children and childhood itself" (p.152) and criticised by some as a dangerous distraction from protecting children at risk (Munro & Calder, 2005). This government also set up a public inquiry into the death of Victoria Climbie which had profound consequences for policy, legislation and practice. Such inquiries had become much less common since the early 1990s (Corby, Doig & Roberts) having been

largely replaced by reviews under the procedures governing professional agencies working together in child protection (Dept for Ed., 2013). Again there was a powerful public focus on the failings of social workers and other professionals resulting in a raft of bureaucratic changes to child protection systems. The coming together of these two very different strands “meant that the role of the state would become broader, more interventionist and regulatory, all at the same time” (Parton, 2006, p. 139).

Most recently the death of Peter Connelly in 2007 highlighted social workers’ failures to protect a child despite having frequent contact with his family because of numerous concerns about unexplained injuries in his short life (Corby et al., 2012). A social work “task force” was set up which recommended changes in the ways social workers were trained and recruited (Socialworktaskforce, 2009). The newly elected government of 2010 commissioned a review of child protection whose author recommended abolishing or loosening many of the procedures introduced by the previous government, and in particular changing the rigid timescales governing assessments (Munro, 2010; 2011). This report was being published at the time this study was carried out. These assessments and their timescales were a major preoccupation of many of the social work participants.

The changes in social work have not taken place isolated from wider political and social changes. Ferguson (2004; 2013) and Parton (2006) have drawn on the sociologies of Giddens (Giddens, 1990; 1991), Beck(1992), Castells (1996) and others to argue that the Colwell inquiry came at a time of significant social change. Ferguson (2004) suggests that the Colwell inquiry marked a transition from “simple” to “reflexive” modernity” that has changed perceptions of risk and professional expertise. Parton (2006) argues that the era of “organised” modernity exemplified by the 1948 Children Act which created social work as a state-sponsored profession came to an end at the time of the Colwell inquiry to be replaced by a period of “late” modernity. The consensus of opinion about welfare services, he argues, fragmented and there was a shift away from public to more private, individualised responsibility in which a focus on child welfare was replaced by one on child protection and confidence in welfare workers being able to protect and support people was undermined (McDonald, 2006). The balance between family privacy and state intervention becomes a changing and contested boundary. In an era of increased diversity and individuality social workers find themselves uncertain judges of varied forms of family living (Morgan, 1996; Williams, 2004; Morgan, 2013) trying to balance liberal sensibilities, a professional

commitment to “anti oppressive practice” and the necessity, sometimes, of using legal powers to protect children (Ferguson, 2004).

Parton (2004) has compared the cases of Maria Colwell and Victoria Climbie to exemplify the social issues that have emerged in late modernity – globalisation, individualisation, transformations of intimate and family relationships, a society increasingly characterised by diversity and insecurity (Giddens, 1991; 1992; Beck & Beck-Gernsheim, 1995) – which have profoundly changed the nature of UK society and the nature of social work. Whereas Maria and her family were well known within a stable local community Victoria and the adults who abused her were profoundly not known: their background and culture was a mystery to professionals, they spoke a different language, the relationship of the adults to Victoria was not understood, even Victoria’s real name was not known..

The concept that has most deeply permeated social work, and is a central aspect of recent social changes is that of “risk” (Beck, 1992; Parton, 1998). It is not the remit here to examine risk as an overarching grand theory of late modernity but it is unarguable that child protection as a version of social work activity has become centrally concerned with recognising and assessing risk.

Social workers have become much more tightly managed and made accountable, partly in response to the inquiries and reviews that have taken place where risks have not been correctly assessed and partly because of government imperatives for services to be more efficient and offer better value for money in an era of increased privatisation of services dominated by neo-liberal economics (McDonald, 2006; Harris & White, 2009). This has transformed their relationship with the state from one of relatively autonomous bureau-professionals (Harris, 1998) to one marked by much more direction. The degree to which the discretion of the social worker as “street level bureaucrat” (Lipsky, 1980), afforded considerable flexibility in their face-to-face work with clients, still exists is a matter of some debate (Evans & Harris, 2004). Kemshall (2010) argues that the ways risk practices are carried out will always vary because social workers are “situated actors” (p.1248) whose work, however officially prescribed, is embedded in their values, beliefs and the “situated rationalities” (p. 1257) they work within locally yet social workers’ practices have become increasingly shaped by bureaucratic demands (Broadhurst et al., 2010b).

2.2.1 Child protection or child welfare

The term “child protection” has come into common use but it has a particular history. The term was first popularised by the inquiry into the death of Jasmine Beckford and stood for a version of social work that was much more concerned than had previously been the case with the assessment of risk and the use of legal powers to protect children from harm. The Area Review Committees set up after the Colwell inquiry to monitor child abuse procedures were renamed Area Child Protection Committees (Corby et al., 2012). A number of writers have examined how different countries have designed systems for dealing with child abuse and have suggested they can be categorised as having a child protection or a child welfare orientation and the orientation is often linked to wider orientations in those countries’ welfare systems. This categorisation and its relationship to national welfare systems is most easily summarised in tabular form:

Child Protection orientation	Child Welfare orientation
Protecting children from dangerous family members	Providing a range of social and psychological support services for families in need
Legal, forensic, investigatory responses	Responses focusing on prevention by assessing and meeting need
Child protection services separate from family support services	Child protection services integrated into family support services
A tendency to adversarial relations between families and professionals	A tendency to work in partnerships between professionals and families
An emphasis on children’s rights	An emphasis on family unity
Residual and selective welfare provision focused on the investigation of high- risk families	Widely available welfare provision focused on supporting families to function well and care safely for their children
State-citizen relationship one of individual rights and responsibilities	State-citizen relationship one of social solidarity
Abusers should be punished	Abusers should be helped and rehabilitated

Table 1 Child protection and child welfare oriented systems

drawn from (Hill et al., 2002; Schene, 2005; Gilbert et al., 2011; Connolly & Morris, 2012)

Broadly speaking child protection-oriented systems are found in countries with liberal or neo-liberal welfare systems and child welfare-oriented systems are found in countries with social democratic and redistributive welfare systems (Alcock, 2008; Gilbert et al., 2011)

These are ideal types and within any country responses to families may differ depending on whether they are seen as low or high risk (Schene, 2005). In addition every country has its own particular set of cultural and political discourses around welfare and so responses will be more complex than these broad categories suggest. For example the UK has a more child protection-oriented system than Denmark which has a system much more oriented to a social democratic, family welfare model yet Denmark has a much higher rate of out-of-home placements for children than does the UK (Gilbert et al., 2011). Spratt (2001; 2003) argues that the UK straddles both orientations and identifies a basic tension between the philosophy of the 1989 Children Act and the more child protection-oriented practices by social workers.

When the Labour government was elected in 1997 child protection came to be seen as a part of a wider more welfare-oriented category called "safeguarding". Area Child Protection Committees were duly renamed as Safeguarding Boards. As has been suggested this reclassification caused some problems for professionals focused on child protection work (Munro & Calder, 2005).

In the UK child protection-oriented and child welfare-oriented agencies work alongside each other and this can add significantly to the difficulties social workers have in deciding whether or not a case requires an investigatory or a family-support response. For the social workers in this study elements of both approaches could exist in their work with any family and this added to the complex nature of their practice.

2.2.2 Defining child abuse

Devaney & Spratt (2009) define child abuse as a "wicked" problem. Whereas "tame" problems have universally agreed definitions and solutions "wicked" problems do not because their complexity does not permit simple, straightforward or linear solutions. Their complexities are intractable and imposing apparent linear solutions simply creates problems elsewhere.

It is a consistent theme running through most definitions of child abuse that it is not an objective category involving a straightforwardly identifiable range of signs and symptoms. Some definitions have argued that it is a medical syndrome caused by parental illness but as definitions of abusive behaviour have widened such medical explanations have been found inadequate and since the 1970s a more social-constructionist model has been dominant (Dept of Health, 1995; Hendrick, 2003; Munro, 2008; Corby et al., 2012). Of course this is not to say that child abuse does not exist outside of socially constructed discourses about it but that the definitions of what is and is not abusive involve beliefs and values in the community which

change over time. Any definition of abuse must involve moral judgements and beliefs about what is harmful and what rights children and adults ought to have (Munro, 2008). There may not be universal agreement about some behaviours, an obvious example being the debates about the rights and wrongs of parents hitting their children. There may be behaviours that are sanctioned in some countries and cultures but not in others. The overview of the 1995 digest of Dept of Health research studies (Dept of Health, 1995) argued that "society continually reconstructs definitions of maltreatment which sanction intervention" (p.15) and suggests that any definition must take account of the very wide range of behaviours that occur "ordinarily" (p.11) in families – many of which, in different circumstances, are associated with mistreatment. As Munro (2008) argues, most if not all parents are imperfect and all will behave in potentially abusive ways from time to time.

In its *Working Together* guidance for agencies involved in safeguarding children the definition provided by the government ran to approximately 500 words in which the conditional word "may" appeared 17 times (DCSF, 2010) indicating that many acts associated with abuse are open to interpretation and judgement. The NICE guidance on child maltreatment (NICE, 2009) offers a list of factors for "considering" or "suspecting" maltreatment: different levels of probability. The legal definition is provided by the 1989 Children Act. A court may only make an order if a child is suffering or is likely to suffer "significant harm". The *Working Together* guidance states that "there are no absolute criteria on which to rely when judging what constitutes significant harm" (DCSF 2010, p.36). This leaves practitioners the task of distinguishing between two imprecisely worded terms – harm and *significant* harm – which may apply to the present and/or to a prediction of the future. This is clearly a difficult task. Corby et al. (2012) differentiate between operational and legal/bureaucratic definitions, arguing that a range of studies show considerable disagreements between professionals in defining abuse in practice.

The way the labels attached to these behaviours have changed over time gives an indication of how the phenomenon has been continually reconstructed: child cruelty, the battered baby syndrome, non-accidental injury, child maltreatment......the labels become more generalised as the behaviours classified as abusive have grown to include, first, physical abuse, then physical neglect, emotional abuse and neglect and sexual abuse. A suggested answer is to try and define abusive behaviours as tightly and as specifically as possible but Munro (2008) argues that this approach is problematic as many behaviours that may be considered abusive in some situations are not in others and this is particularly a problem with emotional forms of

abuse where harm occurs over time as a result of a sequence of events none of which in themselves might be labelled as abuse. Corby et al. (2012) conclude that “the only safe definition is that it is a judgement reached by a group of professionals on the examination of the circumstances of a child, normally (in the UK) at a child protection conference” (p.86). In other words, abuse can only be defined on a case-by-case basis, taking the circumstances of that particular case into account and the definition can only be reached at an inter professional meeting convened for that very purpose. The range of behaviours that could be considered abuse continues to grow: children trafficked into the UK, children in forced marriages, peer bullying, children forced into prostitution, the growth of child pornography on the internet: new issues arise all the time and suggest an ever widening remit for social workers. Inevitably, culturally specific factors determine what this society chooses to classify as abuse and which behaviours it seeks to control (Corby et al., 2012).

It is probable that the definition cited above from the UK government’s guidance (DCSF, 2010) is, with all its “may”s, as specific a definition as currently exists. Imprecision, ambiguity, uncertainty lie at the very heart of these definitional issues: child abuse remains a wicked problem. This might, if a purely academic topic was under discussion, be seen as no more than an interesting intellectual puzzle but child abuse really happens and the struggles of social workers to define what they see and then decide on an appropriate course of action are matters of great public concern.

2.2.3 Summary: an era of change and uncertainty

Since 1974 the activities of social workers have been transformed. From a low profile, private, largely uncontroversial profession carrying out its business well away from public attention it has become one whose work is regularly subjected to public scrutiny because of apparent failures to protect children (or, at times, of intervening too intrusively into families’ private lives). It is clear that the nature of professional discourses about child abuse, how it is defined, how thresholds for intervention are set and what interventions are preferred are social constructions that change over time in response to a mix of imperatives that include political and public considerations as well as professional expertise.

The aim of this opening section has been to emphasise the shifting context of uncertainty within which social workers practise and make decisions. It is not only that child abuse is intrinsically hard to define precisely, leaving practitioners with difficulties in deciding what is and is not abusive, but that policy and practice have changed regularly. Many of the social

workers in this study were well aware of the way social work has changed even if some of those changes took place before they entered the profession. They were aware too of the contested and uncertain nature of the work they had chosen to pursue: the changes and uncertainties around how abuse is defined and recognised, when to intervene, the lack of consensus on many professional issues. They were acutely conscious that they would be disliked and mistrusted by their clients and by the public and that they might make mistakes in their work and those mistakes might have very serious consequences. These issues formed a constant, taken-for-granted context to their daily work, framing many of the dilemmas and choices they faced as well as providing a wider set of discourses within which their work and their professional identities were sited.

2.3 Learning lessons from Inquiries and Reviews

The death of a child as a result of violence from parents or carers in the UK is an extremely rare event. Brandon et al. (2012) state that knowing the precise numbers is difficult as the different data sources such as evidence from Serious Case Reviews, the Office of National Statistics, the Home Office and Child Death Panels are all slightly at variance with each other. The annual number, they estimate, is probably between 50-55 with a further 30-35 where mistreatment was a contributory factor.

Hill (1990), discussing public inquiries, has argued that caution should be exercised in drawing generalised lessons from rare and specific cases. He asks whether such cases, where something has gone very badly wrong, are in any way typical of everyday practice. If, as has been suggested, changes in social work since the 1970s have been driven by such inquiries then it is examples of very unusual events and possibly untypical poor practice rather than examples of good practice or more routine work that have been the major agents of change. Sanders et al. (1999), reviewing Welsh Serious Case Reviews, argue that where poor practice can be identified it is very difficult to make a link between such practice and a fatality. Neither do we know, they argue, whether practice in cases where a death occurred was any different from practice in other cases. Another reason for caution is the adversarial nature of such inquiries and their tendency to blame individuals (Stanley & Manthorpe, 2004). The problem of hindsight bias is also an issue: when an outcome has occurred and is known then it may be assumed people acted wrongly whereas they often acted in accordance with what was known at the time (Munro, 2005a; 1996)

Nonetheless, a body of public inquiries, and analyses of these inquiries, exists as do a larger number of Serious Case Reviews (SCRs) which must be carried out locally when a child dies in circumstances where abuse is suspected. They can also be undertaken when a child is seriously injured in such circumstances. SCRs are designed primarily to ensure lessons are learned rather than individuals blamed and the guidance suggests that such reviews can also be carried out to highlight examples of good practice (Dept for Education, 2013). Somewhere between 80 and 90 SCRs are completed annually and since 1998 detailed biennial reviews have been commissioned by central government. In addition there have been a number of Ofsted evaluations of SCRs. However rare such tragedies are these inquiries and reviews, and the various analyses of them that have been carried out, constitute a significant body of knowledge for learning more about how social workers and other professionals have managed and made decisions about cases. Stanley & Manthorpe (2004) argue that overviews of inquiries and reviews are more useful than individual reports in terms of learning lessons as they often identify similar issues across a range of reports and it is the similarity in the themes identified that is perhaps the most striking feature of the various overviews.

Reder and colleagues undertook analyses of public inquiries (Reder et al., 1993) and “Part 8” reviews (as SCRs were then known) (Reder & Duncan, 1999). These works may be slightly dated now but remain influential (they were among the very few texts cited by participants in this study as influencing their practice). Many of the problems they identified were highlighted in much later inquiries such as that into the death of Victoria Climbie (Laming, 2003). They found in both texts a pattern in many of the families marked by dependency on professionals, disguised compliance where they pretended to cooperate, a period of “closure” where professionals were excluded and a pattern of flight that made them hard for agencies to locate. There was a pattern of professionals feeling assured that conditions were safer and cooperation more genuine than it really was. Accurate assessments were clearly important to ensure risks were properly assessed but they found a number of problems regularly arising: a tendency to treat incidents of abuse in a family in isolation so patterns of abusive incidents occurring over time were not identified, forming fixed beliefs and making selective interpretations about families so that information that contradicted the prevailing belief was ignored or was evaluated in such a way that signs of increased risk were misinterpreted. They found that the background to these errors was often one of poorly supported and supervised professionals struggling with the emotional demands and complexities of the work and they questioned the usefulness of inquiries that focused on identifying individual errors rather than

taking a more systemic perspective. Such systemic problems, they argue, compromise "the thinking components of assessment" (Reder & Duncan, 1999, p.101): the processes whereby professionals make sense of the complex and often ambiguous information involved in cases of suspected abuse. Another, almost universal, finding from inquiries was of poor inter-professional communication and information sharing. They argue that many inquiries have tended to see such communication as a mechanical transfer of information which can be improved by better bureaucratic procedures whereas it is a highly complex transaction that can be easily undermined by conflicts and disagreements between different professionals (Reder et al., 1993; Reder & Duncan, 2003)

Many of the issues identified by Reder and colleagues are also found in the biennial reviews of SCRs. A theme running through these reviews is of the complexity of the families and the effect these families had on the professionals. Families where children were being neglected posed particular problems because complex patterns of behaviour over time had to be assessed rather than identifiable incidents (Rose & Barnes, 2008). But these were the families most likely to overwhelm professionals with the sheer weight and complexity of their problems, reducing professionals to a state of helplessness where they often took a "start again" perspective: writing off the catalogue of concerns that had been raised over time and making a fresh start as if the families' problems could be disposed of like material debts, a process that prevented a clear analysis of their problems (Brandon et al., 2008). Such families were described as "complex, confusing and often overwhelming for practitioners" (Brandon et al., 2008, p.11). The reviewers found that these families avoided the social workers and the social workers avoided them. It was not just individual workers who did this: there was a "systemic failure to engage with parents' fundamental problems" (Brandon et al. 2008, p.11) involving prematurely closed cases, lost files, lost information and the allocation of different workers (often the least experienced) in quick succession. As well as avoiding the social workers these families were often hostile and unco-operative and the social workers were left "frozen (and) paralysed by their own fears and anxieties" (Brandon et al., 2008, p. 90). Like Reder and colleagues they found that such stress and anxiety impaired clear thinking: the social workers came to mirror the chaos and conflict in the families and became themselves unable to identify the risks of harm to the children (Brandon et al., 2009)

Identifying risks through clear assessment where information was comprehensively gathered *and* made sense of was not straightforward. The families featuring in the SCRs exhibited a range of risk factors and it was the complex and dynamic interaction of these factors rather

than single, static factors, which posed the greatest risks to children (Sinclair & Bullock, 2002). Examining one cohort of cases Brandon et al. (2012) identified 3 key risk factors: domestic abuse, mental ill-health and substance (drug or alcohol) misuse. They found that all 3 factors co-existed in 22% of the families, 2 factors in 35% and none of them in only 14% of the cohort. It was the combination of factors that was "particularly 'toxic'" (p.38) for children's safety. At the same time many families had some factors which protected the children and these relative strengths needed to be taken into account. Their "ecological-transactional-developmental model" (Brandon et al., 2008, p.56) attempts to bring together a range of intra- and extra-familial factors into a model for evaluating the way risk factors interact dynamically. In contrast, they argue, the actual assessments they saw were largely descriptive accumulations of information that had not been subject to sense-making analysis. These assessments were of static factors (Brandon et al., 2008) which arguably makes them more prone to the fixed beliefs identified by Reder et al. (1993; 1999).

Like Reder and colleagues these reviews consistently identify poor inter-professional working. The range of risk factors found in the families meant that co-ordinated responses from different professional agencies were very important but were often bedevilled by poor communication, conflict and a hesitancy to challenge other professionals' opinions (Rose & Barnes, 2008). Families with complex and enduring problems often had large numbers of professionals involved with them, all of whom had expertise in some areas of the families' lives but not all so bringing them together to pool knowledge should, ideally, have been essential yet in practice many professionals were excluded or marginalised and key areas of expertise left unrepresented (Brandon et al., 2005). Munro (1999), in her analysis of inquiry reports, also identified a common theme of professionals failing to communicate so that they all had only a partial view of a case which made accurate assessment of risk very difficult. Rose & Barnes (2008) suggest that there is some evidence that face-to-face communication between professionals can alleviate some of the communication difficulties but Corby, Young & Coleman, in discussing the Victoria Climbie case, argue that professionals work in complex bureaucracies where information often travels slowly down long chains of indirect communications (Corby et al., 2009). Face to face communication may be hard to achieve at times and even then may be no panacea (White & Featherstone, 2005).

These reviews also found evidence of poorly supervised, overburdened, inadequately supported professionals working within team cultures where practice was driven by bureaucratic procedures and a "lack of critical thought...and professionalism" (Brandon et al.,

2012, p.80). They comment that a social worker carrying 70 cases is likely to make mistakes in how they should be prioritised (Brandon et al., 2008).

The “Rule of Optimism” (Dingwall et al., 1983) is frequently cited as a problematic factor. It was, as was discussed above, highlighted in the Jasmine Beckford inquiry. Rose & Barnes (2008) and Brandon et al. (2012) suggest it describes an unrealistic optimism about families’ abilities to change resulting in premature case closures and a tolerance of unacceptably poor child care. Neither of these sources cites Dingwall et al. as originators of the term but they gave it a precise meaning which may differ from the way it is used here and in the Beckford inquiry. This will be discussed in more detail later.

Brandon et al. (2008) argue that SCRs should pay more attention to systemic issues and identify what practitioners knew at the time rather than what became known after the event. Munro (1996; 1999) analysed 45 inquiry reports and linked the errors she found to biases associated with intuitive thinking (Kahneman, 2011). She suggests, following a close analysis of the reports, that there are unavoidable errors that are bound to occur because of the nature of child abuse, the complexity of the work with families, fallibilities in prediction and the heuristic short cuts and simplifications inherent in intuitive reasoning. Social workers were forced to make decisions quickly based on incomplete or contested information and in 40% of the reports the social workers were not criticised because they made what seemed to be the right decision at the time based on the available information. However, she argues, there are avoidable mistakes and these often occur when quickly made decisions become fixed beliefs and are not revisited in situations such as supervision where there is time for a more analytical consideration of the options and the meaning of the information. Other avoidable mistakes involved the kinds of lapses in professionalism and critical thought identified by Brandon et al. (2012) when workers fail to undertake assessments thoroughly, fail to gather information that is technically available (for example, information held by other professionals who are not consulted), fail to pass on information to other professionals that should be communicated. Like others in this section she argues that some agency environments are more likely to correct errors through providing social workers with emotional and cognitive support through supervision and stable and supportive team cultures.

2.3.1 Summary

Child deaths are highly unusual events and making generalised recommendations from the way such cases were managed should be done cautiously. However a number of themes

emerge regularly from analyses of these cases. A picture emerges of families with complex, interacting problems who are often unwilling to co-operate with social workers. These families are very demanding to work with and the social workers sometimes come to mirror their problems and are unable to think clearly about the risks to the children. In some cases professionals are reduced to a frozen helplessness. This work is complex and uncertain and errors are inevitable which makes it important that professionals work within team cultures where decisions can be revisited and rethought – otherwise practitioners can develop fixed beliefs which are impervious to new information. Many of these families were involved with a range of different professionals but cooperation between these professionals was often lacking. Assessments of such families need to make sense of the way risk factors interact dynamically but in many cases assessments often consisted of collecting descriptive information which was not properly analysed. Many of the errors and problems identified with professionals' practices took place against a context of overburdened and unsupportive teams where there was an emphasis on following procedures and a lack of critical thinking and adequate supervision. Inquiries and reviews should therefore take a more systemic view of practice that goes beyond simply apportioning blame to individuals.

Another issue that has been identified is the tendency for inquiries and reviews to focus on the procedural and bureaucratic aspects of the work and to recommend that changing procedures will bring about improvements in practice. It is not suggested that such procedural changes are not useful but in themselves they are not sufficient because they do not address the emotional and cognitive complexities of the work and the need to provide working environments where practitioners can think clearly and critically about their practice. Writing about the Victoria Climbie report (Laming, 2003), Cooper (2005) argues that, like many inquiry reports, its accounts of practice are "thin" (p.7) and leave much of the emotional content of the work untold. Recommendations for future practice are "terse (and) lifeless" (p.5). Reder & Duncan (2003) argue that reports often describe problems with inter professional communication as largely administrative, ignoring the complexities and conflicts that characterise much inter professional working and which are deeply seated in professional cultures (Hudson, 2002). An exception was the minority report to the inquiry into the death of Maria Colwell which emphasised the complexity of the work and the difficulty of making decisions based on contested and uncertain information.

Munro (1996; E. Munro, 2005; E Munro, 2005) emphasises that reviews of practice errors should focus on what situations looked like at the time rather than in hindsight and on what

Gambrill (2005, p.349) calls "local rationality". Only then can an understanding be gained of decision making embedded in daily practice. This widens the scope of analysis to consider systemic as well as individual error which is considered more fully later. Munro points out (2005a) that the Colwell inquiry focused on system error, as a result of which new procedures were created, but that subsequent inquiries focused primarily on individual mistakes.

2.4 Researches into everyday practice

Buckley (2003) concludes her study of child protection practice in Ireland by arguing that:

> *The 'official' version tends to be stripped of the contextual and occupational realities of day to day work in a way that conceals the very nature of the job. (Buckley, 2003, p.202)*

Once we begin to examine empirical studies of social workers engaging in their practice we enter a very different world from that of the public inquiry. Where the latter focus on Ferguson's (2004) "solid" world of official procedures and often produces those thin and lifeless versions of practice that Cooper commented on above, the former highlight the ways in which official definitions and activities are inseparably enmeshed with unofficial, unwritten rules and strategies which the official versions pay very little attention to but which are enormously important to the way real people go about their actual work. Such studies are of course not confined to social work. There is a tradition of workplace studies which attempt to uncover the complexities behind the routine: "the unacknowledged, the hidden, the insider knowledge, the unwritten but pervasive rules governing jobs" (Smith, 2001, p.221). So perhaps what can be expected of such studies is rich, detailed and contextualised data, qualities that are often missing from official accounts and which may provide insights into how social workers make decisions in day-to-day practice.

Dingwall et al. (1983) conducted a large study that involved observations, interviews and file analysis across a range of sites – social work offices, health clinics, hospitals – and the activities of social workers, health visitors, GPs, paediatricians and nurses. They wanted to know how front-line workers recognise abuse and what decisions they make following recognition.

Child abuse, they argue, is not an objective category and is often difficult to mark out from non-abuse. "The core dispute is over the point at which intervention may be justified." (p.3) They argue that child abuse is defined by making moral judgements about a set of signs and behaviours so as to mark these out as deviant and define them as a social problem. They suggest therefore that the making of moral judgements is intrinsic to identifying child abuse

and that the identification and management of abuse cannot be separated from the social processes within health & welfare agencies which shape those judgements. Therefore any study needs to be rooted in the everyday, routine, mundane practices of welfare agencies to see how abuse is defined and managed *in practice* (exactly the dimension, they argue, that inquiries omit). This approach draws on sociological theories of deviance which pose two key questions: "First, how are some *behaviours*, and not others, defined as deviant? Second, given those definitions, why and how are some *persons* and not others processed as deviant, and with what consequences?" (Downes, 1999, p.233 author's italics)

They found that in most cases signs and symptoms suggestive of abuse were not seen as automatic indicators but were viewed with reference to the social circumstances and behaviour of the family. Only in a minority of cases did a diagnosis of abuse follow automatically from the presence of certain signs. So in most cases the injury itself was not enough: it had to be interpreted in the light of the child's circumstances and these circumstances were evaluated by reference to the moral character of the parents. If they were compliant with the professionals, and if their inter-personal relationships and ways of living were deemed socially acceptable, then it was much more likely that their behaviour would be judged as non-abusive and any behaviours that might be defined as abusive were minimised or ignored by the professionals: "moral character is, then, central to decision-making in child abuse and neglect, as with any other type of deviance" (p.80). Social evidence was a more significant determinant of whether a case would be defined as abusive than clinical evidence.

Dingwall et al. identified a Rule of Optimism operating in welfare agencies that was made up of two elements. One was cultural relativism: that in many families cultural practices existed which sanctioned acts that might otherwise be considered abusive and the acts therefore should be judged according to the cultural standards that applied in that family. The other was a belief in "natural love": children and parents love each other and so a very high standard of evidence is required before taking the drastic step of removing the child and breaking the bond. That high standard of evidence is often not available because of the uncertainties around defining and recognising abuse. This Rule ensures that the state will not take action unless the evidence of abuse is very high and this limits the powers of state agencies so that the relationship between family privacy and state intervention does not sway too far towards intervention. It also enables the professionals to construct their clients as morally worthy and amenable to intervention – thus meeting the ideals that brought them into the work – and to

take a flexible view of cases that allows them to manage these cases with a significant degree of discretion.

The Rule of Optimism is one of the most enduring substantive theories within social work. A quick Google search carried out at the time of writing revealed numerous blogs and online comments from a range of welfare professionals reflecting on whether, and how, the rule operates in their work. The theory has a curious history. It was cited by the inquiry into the death of Jasmine Beckford as an explanation for the naivety and gullibility of the workers in uncritically believing the accounts of Jasmine's parents and consequently received much publicity. But the panel crucially misinterpreted the theory. Dingwall, in a response to the Inquiry's findings, argued that the Rule is an *institutional* device to limit the state's powers of surveillance and interference into families' lives. In the inquiry's version "the 'rule of optimism' ....becomes a psychological property of individuals rather than a practical reflection of a political philosophy.....the product of a fundamental conflict of values about the relationship between families and the state....it is not that social workers do not *know* about their authority but rather that its exercise is inconsistent with the nature of their role (in a liberal state)" (Dingwall, 1986, pp.501, 506 author's italics). This is not to say that social workers do not err on the side of over-optimism sometimes (Dingwall believed that they did) but that the rule is more than an individual shortcoming that can be overcome by better training. Changing its grip on welfare cultures would requires a fundamental redrawing of the role of social work, rendering it far more coercive and socially divisive: if we don't "we must frankly acknowledge...that some children will die to preserve the freedom of others" (Dingwall, 1986, p.503). It is hard to imagine a more chilling encapsulation of state social work's eternal dilemma.

Did the reconfiguring of social work as child protection work mean that the rule no longer operated? Dingwall et al.'s research was carried out in 1979 but in a postscript to a later edition of their book (Dingwall *et al.*, 1995) they argued that the rise of legalism and proceduralism had made interventions more *defensible* while the Rule remained in operation. Buckley (2003) and Parton, Thorpe & Wattam (Parton et al., 1997) argued that they found evidence of the rule operating in their studies. Parton et al. noted how social workers paid great attention to whether or not parents dressed and acted "appropriately", sometimes paying more attention to this than to the child. However Parton (1998) subsequently argued that a focus on risk had become the key concept around which social work was organised. The rule is mentioned in several of the reviews of SCRs though the originator of the term is not

credited. It is as if it has become a sort of common-sense idea. It is used in these reviews to describe the unrealistic optimism of social workers failing to see the real risks in families but Dingwall's more complex and institutional definition is omitted: the misinterpretation made by the Beckford inquiry has become the accepted definition.

Buckley (Buckley, 2000; 2003) carried out a study in Ireland in the late 1990s, following 200 referrals made over a six month period. She interviewed front-line workers and observed them in meetings and conferences. Her starting point was her awareness that the perspectives of policy makers and managers differed sharply from those of practitioners and service users with the former seeing child protection work as essentially straightforward and the latter much more aware of its difficulties, dilemmas and contradictions. She was particularly interested in applying the theories developed by Dingwall et al. and exploring what mix of official and unofficial discourses applied to the ways social workers made decisions about child abuse cases in practice. Ireland, following its own well-publicised inquiries, had, like the U.K., developed a much more procedural and risk-focused approach to investigating abuse. The workers Buckley studied found the official procedures were very rigid and their underpinning philosophy that abuse could be clearly identified did not fit with the reality of large numbers of ambiguous referrals. In order to make sense of the volume of referrals and their often unclear nature and render the workload manageable the workers employed a range of unofficial strategies to screen out a large number of cases often judging them on unofficial criteria about the manner of the referral, the referrer's reliability and the family's reputation. Sometimes situations Buckley thought quite risky were not acted upon because the referral lacked clear details or the referrer was seen as someone untrustworthy (this could be a professional as well as a member of the public). In addition there were a number of well-known local families who were known to live in poverty or to belong to travelling communities who were not investigated because it was expected that they would provide a poor level of care. She identified a number of factors that made it more or less likely that cases would be investigated but the investigation would often turn on "situated moral reasoning" (2003, p.43) about the parents and the family rather than more clinical evidence of injury or abuse. Factors noted as likely to lessen social workers' concerns included suspect motivation of the referrer, children looking physically well, the mother behaving in a compliant way and the presence of good material circumstances (2003, p. 78). As Dingwall et al. found, social rather than clinical evidence was relied upon to make decisions.

Buckley felt she clearly identified the rule of optimism in action as one of the unofficial mechanisms workers used to filter out as many referrals as possible in order to make the work manageable and avoid over-intrusive practice. What also stood out was that many referrals did not fit the prescriptive categories of the official guidance because they were too vague or ambiguous and there was no easy line to draw between abusive and non-abusive situations. Official guidance was therefore of limited use to front-line practitioners who had to use a range of unofficial methods to interpret referrals more flexibly. Buckley noted (2000) that the workers acted quite flexibly and used considerable discretion, using the rule of optimism's key devices of cultural relativism and natural love but had no sense that they were doing so and frequently complained about how rigidly they were forced to practice.

The range of practitioners' unofficial strategies was the focus of a study by Pithouse (1998): an ethnographic study involving observations and interviews carried out in the 1980s and updated in the 1990s.

Pithouse was not specifically studying how social workers managed child abuse cases although the workers he studied were working with children and families. His concern was the daily experiences of social workers and how these were shared and rendered meaningful and visible. Social work, Pithouse argued, is an "invisible" trade because much of it takes place in private settings and its outcomes are often ambiguous and uncertain. It must be rendered visible through social workers accounting for what they do. He recognised the need for workers to make sense of the unpredictability and uncertainty of the work by acting with flexibility and discretion. Sense-making and accounting were done through the ordinary everyday activities and routines of the social workers which had a very important social function in establishing and sustaining a network of shared meanings from which the team and its members drew their sense of professional competence and identity. To sustain these meanings a considerable degree of agreement had to be negotiated and this was done through an "assumption of collegial competence" (p.55) where everyone is considered equally competent and should not be criticised. Some criticism in supervision with managers was acceptable but even here it had to be done in a way that maintained the workers' view of themselves as both competent and self-regulating.

Team harmony and morale were especially important because of the social workers' sense of themselves as a stigmatised and "dirty" profession disliked by the public and other professionals. Watson (1995) has defined dirty work as "an occupational activity which plays a

necessary role in a society but which is regarded in some respects as morally doubtful" (p.213) and suggests that this creates considerable peer pressure to conform to a particular work culture. Buckley (2003) drew on this idea when discussing the social workers in her study as child protection might well be seen as "dirty" by this definition. A parallel might be to the police whose "canteen culture" (Waddington, 1999) has been the subject of much popular and academic debate. Loftus (Loftus, 2008; 2010) has identified ways in which the traditional police culture "articulated principally by white, heterosexual, male officers" (Loftus, 2008, p.757) has shown a remarkable ability to endure despite many social and occupational changes because the pressures of the work have not changed and so an insular culture from which members can draw sustenance is as necessary as ever.

The workers in Pithouse's study were acutely aware of the "dirty" nature of compulsorily taking children into care or "sectioning" people under mental health legislation and how criticised they are, by other professionals as well as the public, for undertaking such distressing tasks. The team thus became a haven where security and identity were fostered. Official guidelines and procedures were distant and abstract and so loyalty was primarily to the team and its culture. Personal knowledge of the work grounded in experience was seen as much more important than official guidance or abstract theory.

Pithouse drew on the work of interactionist sociologists, notably Goffman (1961) and Becker (1991) to explore the idea of social workers' "moral careers". Goffman defines this as "the regular sequence of changes that career entails in the person's self and in his (sic) framework of imagery for judging himself and others" (1961, p.119). For the social workers in Pithouse's study moments of stress and crisis – taking a child into care, managing an aggressive client, dealing with a stressful home visit – were rites of passage, vital moments in their moral careers. If they could show they could cope with this kind of stress they would meet the team's shared definition of competence which was constructed around the ability to handle the stress and unpredictability so intrinsic to the work.

Another study with an ethnographic focus was conducted by Scourfield (2003). He was particularly interested in how social workers think about their clients in gendered ways. For the purposes of this thesis the significance of this study is the way it suggests that there is a considerable difference between the way ideas are constructed through official discourses and the way they are then constructed in social workers' practice. A key discourse in social work is the importance of anti-discriminatory practice (N. Thompson, 2012) within which

issues of gender are particularly important given that most social work is done by women to largely female clients and is constructed around issues about child care and family life which have powerfully gendered discourses (Milner, 2001). The avoidance by social workers of male family members has long been a matter of debate (O'Hagan, 1997) and has been seen as a key issue in some highly publicised child deaths. Scourfield shows the gulf between the abstract rhetoric and the daily reality of working with women who may be aggressive and demanding, and experiencing many social problems such as drug and alcohol misuse and failing to care for their children to an acceptable standard.

Scourfield (2003) argues that social workers experience a constant tension between individual, psychological approaches and structural, sociological ones. However much the social workers understood that a range of social oppressions impacted on these women's lives they were seen primarily in individual and moral terms: they *should* be better parents, they *should* leave violent partners and put their children's needs first. Men were seen in much more complex and nuanced ways than might have been supposed from the abstract rhetoric: some were seen as a threat, some as simply useless, some as no different from or better than women even when they had behaved reprehensibly. Scourfield argues that much abstract or official rhetoric is reconstructed in this way because it has quite vague or generalised meanings that could be interpreted in many ways. From his study Scourfield cites phrases like "child centredness" and "putting the child's needs first" as examples. Atkinson (1995) in his study of haematologists argues that such "spoken performances...... constitute a liturgical order" (p.59), a form of "everyday ceremony" (p.59) through which the work is done and knowledge constructed. If such "official" or "correct" discourses are actually ceremonial forms of behaviour then they may give very little clue to how the day-to-day work is actually done as opposed to how it is spoken about.

Spratt (2000; 2001), looking at the processes involved in decision making, studied how senior social workers distinguished between child protection and child welfare cases. As noted earlier making this distinction between children in need and children at risk of significant harm was not straightforward and could easily lead to error. Spratt (2000) found when combining a number of what he saw as the more ambiguous cases into vignettes that there was considerable disagreement between social workers making these decisions in as many as 90% of the cases. Brandon et al. (2008a) found in their analysis of Serious Case Reviews that of the 161 cases which they reviewed almost as many had been seen as being below the threshold for statutory intervention (45%) as above it. "Child protection" they concluded

"(does) not come labelled as such" (p.319). Because of the difficulty of applying general guidelines to specific and often ambiguous cases the senior workers used a range of unofficial, discretionary approaches but they were constrained in their degree of discretion by the employing agency's preferred range of choices. This had the effect of making them classify cases as child protection cases if there was ambiguity so many cases were drawn into the child protection system but then filtered out – as many as 70% according to Spratt – a process that stigmatised families, wasted resources and blunted the operation of skilled professional judgement. With only limited resources available and an increasingly narrow child protection focus those case classified as child welfare or child in need were, Spratt argued, really being classified as *not* child protection and therefore not sufficiently in need of a service increasingly geared to minimal child protection interventions.

Platt (Platt, 2006a; 2006b) also looked at the classification of ambiguous or borderline cases, interviewing social workers across two local authorities. As with Spratt, Platt found that social workers had great difficulty applying prescriptive criteria to ambiguous referrals and they used a very limited range of criteria in order to process large numbers of cases many of which were not easily classifiable. These criteria focused on specific incidents and so cases involving neglect and non-physical abuse were much less likely to be picked up. This ran counter to research (Dept of Health, 1995) that emphasised the need to improve identification of cases of neglect, which were seen as having the worst developmental outcomes for children. But Platt felt that the social workers had little choice but to make decisions based on limited criteria in order to keep their workloads manageable. Platt suggested that once a case was identified as child protection the social workers made little effort to try and find shared understandings with the parents or to explore the wider pressures in their lives. Interventions were focused on finding out more about the specific incident that had led to the classification and no more.

Spratt and Platt's studies suggest a distinct move towards a much more limited child protection-focused service with the agency's requirements curtailing workers' room for flexibility and discretion. But the problem of deciding upon the nature of complex and ambiguous cases using prescriptive and rigid guidelines remained and so to make their work more manageable and to meet the agency's requirements on timescales for processing the work the social workers resorted to a limited set of criteria that suggested quick decision making based on heuristic short cuts prone to error (see chapter 3). Many cases did not

receive a service and those that did received only brief interventions focused on specific instances of abuse.

This question of how social workers' activities were changing in the face of increasingly intrusive and rigid systems for managing their performance was the focus of a large ethnographic study across several local authorities carried out by Broadhurst et al. (Broadhurst et al., 2010a; Broadhurst et al., 2010b)

This study took place at a time when the already rigid agency requirements noted by Platt above had been further tightened following the Victoria Climbie inquiry with the introduction of a national computerised assessment system known as the Integrated Children's System (Shaw et al., 2009; White et al., 2010). Broadhurst et al. paint a picture of workers under considerable agency-induced stress trying to manage very large numbers of initial referrals that had to be dealt with swiftly. There were strict timescales for initial decisions and then for initial assessments and this meant that very rapid decisions had to be made which were facilitated by using very a limited and routinised range of responses which were designed to keep thresholds for intervention high. The researchers noted that, for example, all referrals made by family members were treated as malicious and therefore unreliable and that all referrals on teenaged children were "NFAd" (a term the participants in this study routinely used meaning "no further action"). Making rapid decisions on the incomplete information that often accompanies referrals and then, as the researchers noted, trying to close the cases that they did open as quickly as possible creates obvious room for serious errors to be made (Munro, 1996). Social workers were expected to complete Initial Assessments on all families who could not be NFAd and there was an inflexible 7 day deadline for these assessments which took no account of the difficulties in arranging to see families, missed appointments or time taken off for illness or leave. An assessment involves establishing some kind of relationship with families who may be suspicious and reluctant to cooperate and especially with the children. There was a heavy emphasis on "seeing" the child, a consequence of some of the highly publicised child deaths where children were not seen by the social workers, but "seeing" a child and forming some sort of meaningful relationship with that child are quite different matters (Jasmine Beckford's social worker "saw" Jasmine shortly before her death but not in a way that might have enabled her to see that Jasmine was suffering dreadful injuries and in a notorious incident cited in another inquiry the social worker was shown the child through a glass door panel). The assessment form was complex and time-consuming to complete and was organised into a series of boxes that made it almost impossible for the

assessor to create a coherent narrative. Social workers filled the form in skimpily, leaving out whole sections and "becom(ing) experts with the copy-and-paste function" (Broadhurst et al., 2010b, p. 364). Munro (1996; 1999; 2008) noted that errors in child protection work are unavoidable and so decisions should always be seen as provisional and revisited yet the computer systems the workers used did not allow changes to be made to these hastily half-completed forms (and it should be noted that these computer systems followed prescriptions from central government so were found across local authorities nationally).

The researchers concluded that rigid timescales meant rushed, inadequate work and created alarming potential for error – and this was systemic error because it was organisational changes that had created these conditions. These errors can remain "latent" for years until a particular set of circumstances precipitate a disaster which usually manifests in an individual's error (Reason, 2000; E. Munro, 2005). As Platt (2006a; 2006b) had noted, in the face of increasingly intrusive agency requirements professional discretion was becoming increasingly limited to a set of defensive strategies designed to make the workload and the agency's rigid requirements manageable.

This is a bleak picture but the researchers found (Broadhurst et al., 2010a) that practitioner discretion still operated where it could, particularly when the very rigid requirements for processing initial referrals and assessments were completed. They found that workers moved between different forms of reasoning, sometimes abiding by the instrumental logics of the formal procedures but doing all they could to vary them to meet the individual requirements of complex cases and to follow the informal rules and cultures existing within their team. Because the official rules are generalised and inflexible they do not account for the complexities and ambiguities of individual cases and so must be jettisoned or adapted to make the work meaningful. The social workers in this study described numerous ways in which each case offered rich possibilities for more flexible and informal negotiations and management of risk. Indeed, the researchers argue that without the development of relationships between workers and clients the official procedures would be impossible to implement because it is only through those relationships that the official requirements can be negotiated with families.

2.4.1 Summary

The studies discussed in this section are all entirely or primarily qualitative and some are quite small in scale. Any generalisations must therefore be made with caution. Some are also quite

old but seem to speak to themes that have an enduring currency within the profession. However the methods of qualitative enquiry are ideal for examining the perspectives of the actors involved and, as with the analyses of inquiries and reviews, some common themes emerge. Research into social work practice reveals the hidden rules and informal strategies and cultures which lie behind the official versions of the work as they do for many occupations. Since the Maria Colwell inquiry social work has become increasingly tightly managed and proceduralised and this has led to increasingly rigid and prescriptive official versions of the work which are at odds with the reality of practice as it is perceived by the social workers in these studies: rigid prescriptions based on generalised knowledge cannot account for the complexity and ambiguity of the majority of referrals and to make sense of the work and make it manageable the social workers employed a range of unofficial strategies to make decisions. The ways in which social workers see families and make sense of the work to themselves and others contain subtle sets of unwritten rules shaped by professional cultures and localised conditions and these have a profound effect on the ways decisions are made. Yet several of the studies found that social workers had very little sense of themselves working in these ways. As the work has become more prescriptive these unofficial ways of working have increasingly become defensive strategies, workarounds, to ameliorate or subvert the official rules, deadlines and information systems. Some of these strategies are designed to maintain a flexible and relationship-based version of the work within which social workers can engage with the complexities of individual families but others are short-cut ways of working which could lead to major mistakes being made. Broadhurst et al. suggest that “the bureaucratic bias that characterises government responses to public inquiries and serious case reviews continues to leave the *relational/social* aspects of practice under-emphasised, under-theorised and, indeed, under threat” (2010a, p.1060 Author’s italics).

2.5 Conclusion

This chapter has suggested a number of concepts which have informed the formulation of the research question and the design of the empirical research. Central to this chapter is a discussion of the nature of child abuse as a social phenomenon and the way this has shaped social work policy and affected practice.

Child abuse is a socially constructed category that has undergone considerable changes since the 1970s but remains difficult to define in terms of policy and law and impossible to define in practice in ways that meet with universal agreement from policy makers, professionals and the wider community. This shifting, socially constructed quality has been

highlighted by providing a historical perspective which has briefly mapped some of the controversies and tensions which are inescapable when trying to deal with an intractably complex problem.

Another way of trying to understand the way responses to child abuse are constructed is to examine the characteristics of the welfare systems which exist in the UK and in other countries. The ways in which child abuse has been defined and constructed are not isolated from wider social changes that have gathered pace since the 1970s: the growth of globalisation and of a more individualised politics based on neo-liberal economics which has profoundly questioned the post-war welfare consensus in which state-sponsored social work was born.

As a consequence social work practice is characterised by high levels of uncertainty, complexity and ambiguity and decision making cannot be understood without an understanding of these characteristics. While a focus on risk has become the key concept around which social work is organised, the studies discussed here highlight the complexity of the concept of risk in child protection work and the difficulties for social workers in assessing risk in situations where families have complex sets of interacting risk factors. Some workers appeared to be overwhelmed or frozen by this complexity. Others devised short-cuts to process the work more quickly. This has in some cases led to workers developing fixed ideas about families which were impervious to new information. Others tried to adapt the procedures in an attempt to engage with families more closely. Local practices, carried out by "situated actors" vary and a mix of official and unofficial practices and discourses exists. Such is the complexity and uncertainty of the work that, Munro argues, mistakes are unavoidable.

Policy-makers have created ever more complex and prescriptive webs of procedures and bureaucratic and managerial processes to try and eradicate errors and keep children safe. But the studies discussed here raise serious questions about how effective these processes have been and about the impact they have on working environments – particularly as to whether such processes can be part of working environments most likely to encourage professional expertise and critically aware decision making.

It has been suggested that real-world decisions are not made on the basis of some sort of "pure" disinterested reason but are bound up in complex professional practices and contexts. The making of moral judgements is an ineradicable aspect of professional work and parenthood and childhood are particularly powerful moral domains (White & Stancombe,

2003). Such reasoning is not captured in official systems. This provides a link to the next chapter in which the nature of professional decision making, and in particular social work decision making, is examined in more detail.

CHAPTER 3 LITERATURE REVIEW II: Decision making and knowledge in social work

3.1 Overview

In the previous chapter it was argued that social work, configured as child protection, is centrally concerned with recognising and assessing risk but that, however rigid and prescriptive official procedures are, local practices vary because of a mix of local rationalities and conditions and professionals' beliefs and values. This would suggest that professional decision making is inseparably embedded in the complex conditions of everyday practice. It has also been argued that those conditions of practice contain, an unavoidable and ineradicable element of uncertainty and complexity.

It is within this context that this chapter examines the nature of decision making in social work and the nature of the knowledge base that social workers may draw upon when making decisions. The chapter begins with a discussion of the literature on how people make decisions and in particular the differences between more intuitive and more analytical models of rationality. The nature of decision making in social work with children is then examined. The evidence suggests that intuitive or naturalistic models of decision making, which are prone to a range of errors and biases, are dominant and so the next section examines the use of more analytical and actuarial decision tools in social work and what the nature of their contribution might be. Another complexity in decision making is that social workers frequently work alongside other professionals whose approaches to the work may be very different from their own. Failures in inter professional working are often highlighted by inquiries and reviews into child deaths and so the nature of this kind of working is discussed. Finally the chapter considers the exceptional diversity of social work's knowledge base and the variable status of the different kinds of knowledge social workers draw upon to make decisions.

The conceptual contribution of this chapter to the thesis is:

(i) To examine different models of decision making, their strengths and weaknesses, and the different ways in which they may be used in complex and uncertain practice situations

(ii) To examine the nature of social work practice and its reliance on largely intuitive and experience-based forms of rationality.

(iii) To examine the more analytical forms of rationality that may be incorporated into social work practice – the use of decision aids and collaboration with other professionals – and to explore why these forms may be problematic. It is suggested that some areas of practice that take place in more controlled environments such as supervision may give opportunities to utilise more analytical reasoning.

(iv) To examine the diverse and contested forms of knowledge that social workers draw upon when making decisions and how that knowledge may be used in practice contexts.

3.2 Theories of decision making: analysis v. intuition

Hammond (1996) argues that there are two fundamental distinctions when theorising about decision making: that between cognitive and analytic rationality and that between coherence and correspondence theories of truth. Hammond defines analytic thought as "a step-by-step, conscious, logically defensible process" (p.60) whereas intuition is a process that produces an answer without going through the step-by-step logic of analysis but by utilising experiential and tacit knowledge, imagination and metaphorical thinking – forms of cognition that may be difficult or impossible to verbalise.

Coherence theories are primarily concerned with the logical process of proceeding from a particular premise. The key criterion is whether or not the process of thinking is consistent and logical. Correspondence theories are more concerned with empirical accuracy: whether the judgement fits the facts as they are known.

Hammond suggests that analytic and coherence modes of thinking are more likely to be used by the *producers* of knowledge who are concerned with creating logically consistent theories whereas intuition and correspondence are more relevant to the *users and applicators* of knowledge who must make decisions in complex real-world situations. These modes of cognition, he argues, are often seen as opposites but in reality they exist at the extreme ends of a cognitive continuum and humans move between the two depending on circumstances and the task in hand.

In analytical decision theory or decision analysis (Munro, 2008; O'Sullivan, 2011; Taylor, 2012) all possible options in a situation will be considered usually by constructing a decision tree (Munro, 2008, p.106; O'Sullivan, 2011, p.142; Thompson & Dowding, 2009, p.177). As Munro's example shows these trees can be extremely complex and present the decision-

maker with an enormous range of choices that take a long time to go through. Even then, it may not be possible to identify every option. Options are assigned utility values in which the likelihood and the desirability of each are numerically weighted (O'Sullivan, 2011). Many decisions will require subjective values, such as stakeholders' wishes, to be assigned a value. Thompson & Dowding (2009), writing about nursing, suggest that patients can be asked to rate the outcomes desirable to them but this may be more difficult in social work where possible outcomes may be much more contested and the variables ambiguous (White & Stancombe, 2003) and there is evidence that different professionals evaluate cases and possible outcomes very differently (Taylor & Donnelly, 2006). In child abuse work many decisions, as we have seen, are based on moral reasoning. Even if outcomes appear relatively straightforward the assigning of utility values has an intuitive element to it and in decisions in health and social care there will be a degree of uncertainty which is not calculable (Thompson & Dowding, 2009). The strength of a decision tree is that it is a way of setting out all the options in a systematic way that can help break down complex decisions into smaller steps (O'Sullivan, 2011) but it can never be a purely logical, mathematical process: human judgement, intuition and emotion play a role (Munro, 2008). Decision trees are poor at accounting for complexity, context and unpredictability (White & Stancombe, 2003; Thompson & Dowding, 2009). Atkinson (1995) argues that such orderly models are based on single decisions made single-handedly whereas in reality a series of decisions may be made, separated in time and place, and will be made by different actors interacting with each other in different ways. In social work decisions are often dependent on the knowledge and actions of other professionals. Decisions are rarely couched in the language of objective neutrality: cases have to be "formulated" and "sold" to managers (White, 2003) according to an agency-preferred "tacit hierarchy of credible accounts" (White, 2003, p.181). Atkinson calls this an "ecology of knowledge" (1995, p.54): who you are in an organisation influences the knowledge you have, the knowledge you share and how that knowledge is treated. Decisions then may be enmeshed in social processes in a way that cannot be represented by classical decision analysis.

Because intuition does not follow a logical step-by-step process does not mean it is a mystery: it is based on a rationality, a set of heuristic devices, that can be articulated (Munro, 2008). Intuition is both a way of thinking and a type of knowledge (Thompson & Dowding, 2009): intuition tends to be heavily based on tacit, experiential knowledge or what in terms of professional decision making is called practice wisdom (O'Sullivan, 2005). As a way of

thinking it is characterised by "fast and frugal" reasoning (Gigerenzer & Goldstein, 1996). Instead of working sequentially through all the options as in a decision tree this involves drawing inferences from a small number of options and making a decision quickly, based on an unconscious processing of data. O'Sullivan defines it as "decisions without deliberation (involving)... the rapid identification of relevant cues and the making of connections and associations.....it involves sensing rather than deliberative thinking" (O'Sullivan, 2011, p.90).

Even critics of this kind of reasoning accept that in many situations this produces decisions that are as successful as reasoning in a more deliberative way and because it happens much more quickly it is better suited to real-world situations (Tversky & Kahneman, 1974; Gigerenzer & Goldstein, 1996; Thompson & Dowding, 2009). However, it is recognised that such thinking, simplifying problems as it does for the sake of speed, involves a number of biases irrespective of the decision-maker's expertise. Tversky & Kahnemann (1974) suggest the most common are: representativeness bias (thinking that an outcome is caused by a factor that seems related to the outcome but is in fact un-related so alternative causal factors are overlooked), availability bias (estimating the likelihood of an outcome based on outcomes we are aware of or which can be brought vividly to mind whereas factors that we are less familiar with or are less vivid are overlooked: in other words we think something is risky because of hazards we can easily imagine so we overlook factors that may be more likely to occur but which we *can't* imagine) and adjustment or anchoring bias (we predict an outcome based on what our experience tells us is the most likely outcome. The cause-and-effect we predict tends to be simple and linear so more complex, unfamiliar patterns of cause-and-effect are overlooked). These biases (and there are many others: Taylor, 2013, p.70; Thompson & Dowding, 2009, ch.7; Gambrill, 2005) suggest that in a search for heuristic short cuts to quick decisions we pick out the familiar, the vivid, the "obvious" and overlook the unfamiliar, the complex, the less predictable. A lot of the time "these heuristics are highly economical and usually effective" but they give rise to "systematic and predictable errors" (Kahneman, 2011, p.431 both quotes). In child abuse work, where children may be at risk because of complex interactions of factors which are presented in the form of ambiguous and uncertain information, the possibility of making mistakes is significant. Yet such heuristics are essential: we have to make decisions quickly and avoid the risk of simply being overwhelmed by more information and complexity than we can process manageably. The dilemma is that:

> *The very mechanisms that enable us to learn and to take complex decisions are the same mechanisms by which we may be open to bias (Taylor, 2013, p.71)*

Intuitive and analytical thinking both have their strengths and weaknesses and rather than seeking some "perfect" form of rationality it is important to be aware of how errors will occur and how different ways of thinking can complement each other in order to minimise mistakes.

More analytic models are useful for telling us how things "ought" to be and for systematically setting out the known options (Taylor, 2012; Munro, 2008; O'Sullivan, 2011) but they do not represent the ways in which professionals actually think and make decisions in practice. Neither do they account for uncertainty and it is the irreducible uncertainty of the world that forms the context for decision-making. Thompson & Dowding (2009) argue that the world is "probabilistic" (p.121) – it cannot be known completely or with certainty. For Hammond (1996) the world is full of multiple fallible indicators – cues whose meanings are uncertain and need to be evaluated alongside other, equally fallible, cues to arrive at a best possible understanding but one which will not be perfect. Taylor (2012) argues that compared to areas such as medicine and psychology there is a lack of research into social work decision-making and there should be a much more conscious understanding of the models of decision-making practitioners use so that the limitations of each can be made explicit. A number of authors (Schwalbe, 2004; Thompson & Dowding, 2009; van de Luitgaarden, 2009; Taylor, 2013) have suggested that Klein's Recognition Primed Decision Making and Brunswik's "Lens" theory are especially useful models of more naturalistic real-world decision making.

Klein (Klein & Klinger, 1991; Klein, 1993; 1999) argues that intuitive or naturalistic decision-making is best suited to complex and rapidly changing situations where information is incomplete and fallible but decisions have to be made quickly. He suggests that in such situations people opt for a good-enough solution based not on a logical examination of every option but on the creation of a coherent story or mental representation of the situation based on prior experience that tells them what the typical response to this kind of situation is. This may be amended to another typical response if the first choice does not work. Conscious deliberation is minimised and this allows the decision maker more flexible and rapid responses. Researching how fire fighters make decisions Klein (1999) argues that mental representations and metaphors create a link with experience and make that experience available for decision making in situations of uncertainty. However, as Munro (2008) suggests, professionals who lack experience or have not learnt from their experiences would struggle to construct adequate representations to assist them.

Brunswik (Hammond, 1993; 1996; Thompson & Dowding, 2009) argued that, faced with multiple fallible cues we create a sense-making representation of what we think these cues mean. This cognitive process is likened to a "lens" through which we see the cues in our environment and are thus able to create a holistic picture. The lens is our representation of the world and will be made up of the knowledge, values, experiences and beliefs that we use to make sense of our environment. So in a child abuse investigation or assessment the many fallible and uncertain indicators will be seen by the social worker through a lens made of a mix of personal and professional knowledge, beliefs and experience. This provides a quick way of intuitively making sense of a situation. The lens determines which cues are seen as more or less significant (or relevant) so there is a danger that the lens will distort the importance of some indicators introducing the possibility of error (Thompson & Dowding, 2009). O'Sullivan (2011), for example, suggests that social workers' preoccupation with risk can skew their sense-making so that clients' weaknesses are highlighted and their strengths overlooked

These models of cognition map the ways that in real-world situations people intuitively build pictures or mental representations that make sense of situations holistically and do not rely on deliberative atomised choices between options. Another way of thinking about this, using the pictorial metaphor, is framing. O'Sullivan (2005) uses this metaphor to describe a process where people select information from indicators in the environment to construct a frame or picture within which they make a decision. Such thinking is intuitive because this representation-construction does not follow a step-by-step process (Hammond, 1996) but moves quickly to decisions based on a small number of cues identified as the most relevant in a mental process that is not explicit. It is not a fool-proof process but if the thinking processes are made explicit then the errors and biases can, ideally, be openly acknowledged and strategies developed to minimise them.

Another approach to considering errors is to take a more systems-based approach: that is, one where "poor case outcomes are likely due to multiple causes even though the most immediate cause may be the error of an individual" (Rzepnicki & Johnson, 2005, p.395). Gambrill (2005) suggests that any consideration of child protection situations where mistakes have occurred must consider "local rationality.....the unique context in which a decision is made" (p.349). It was suggested in the previous chapter that systemic changes to "improve" practice can have unexpected consequences and create latent conditions for error. These can remain dormant for long periods until a combination of pressures such as heavy workloads, high performance targets, rushed assessments and poor supervision can result in an active

failure (Reason, 2000). Munro (2005b) and Broadhurst et al. (2010a) identify technical, bureaucratic procedures that rigidly prescribe individuals' practice yet are poorly suited to the ways in which humans actually think and to the ambiguous nature of the work. Munro (2005a; 2005b, 2008) singles out prescriptive assessment schedules, new technology and IT systems as particularly problematic in this respect. Organisations that are more successful at learning from disasters, as in engineering and aviation, build an awareness of human flexibility and adaptability into their solutions (Munro, 2008; Reason, 2000). Rather than trying to eradicate all error such organisations expect them to occur and place a high priority on recognising and addressing them. It is argued that health and social care organisations should be built not around efficiency and procedure but around creating strategies for minimising inevitable or unavoidable errors through good supervision, the facilitation of thoughtful reflective practice and mechanisms for encouraging team discussions (Taylor, 2013; Thompson & Dowding, 2009; Munro, 2008). These strategies are designed to create good "practice reasoning" (Munro, 2008, p.137) within a "culture of safety" (Thompson & Dowding, 2009, pp.128-130). The concept of the "learning organisation" which creates a context for critical reflection and learning is also relevant here (Gould & Baldwin, 2004). A good example is the use of skilfully managed supervision in using the strengths of more analytical decision theory to revisit decisions made heuristically so that, ideally, those decisions can be reviewed and any errors or oversights inherent in heuristic reasoning can be addressed (Helm, 2011).

As decisions have a significant emotional and moral element (White & Stancombe, 2003) a culture that serves to minimise error requires that its practitioners are supported emotionally in coping with the demands of the work as well as cognitively (Munro, 2008). The ways in which workers judgements can be frozen or distorted were discussed in the previous chapter. Taylor (2013) emphasises the importance of developing practitioners' skills in retrieving, understanding and appraising research so that this kind of evidence can be used as well as more experiential sources. Social work has a diverse knowledge base and the ways in which social workers construct and use knowledge in practice is discussed later.

3.2.1 Summary

This section has examined a body of literature that makes explicit the ways in which people think and make decisions. A distinction may be made between prescriptive and descriptive models: the former based on logical, rational, deliberative analysis of the available options and the latter on the intuitive, heuristic processes followed by people making real life decisions in an uncertain world full of fallible indicators (Taylor, 2013). While classical models

of decision making can be helpful in considering all the options (or all those that can be identified) systematically (provided there is enough time) they are not useful in reproducing the uncertainties and contexts of the real world or the realities of sequential and collaborative decision making across time and space and involving several actors (Atkinson, 1995). Intuition is, by definition, not an explicit process (Hammond, 1996) but its rationalities have been examined and persuasive models created which make clear the ways in which people make sense of uncertain, fast-moving situations and come to quick, good-enough decisions which are often very accurate but which can contain errors and biases. Decision making rationalities are best seen as existing on a cognitive continuum (Hammond, 1996) with actors moving between different modes of thinking depending on the task in hand and the local conditions. Given that people have only a limited ability to understand complexity – what has been called bounded rationality (Gigerenzer & Goldstein, 1996) – all forms of human rationality will contain the possibility of error.

It is suggested that being aware of the models of rationality professionals use and the strengths and limitations of their reasoning is more useful than trying to create fool-proof procedures that will somehow prevent any mistakes occurring. Such procedures, as we have seen, have become widely used in social work. They are invariably highly technical, rational and orderly, as bureaucratic procedures are by definition, so there may be a fundamental mismatch between the models of thinking they represent and the ways in which practitioners actually think: they represent prescriptive models of how professionals *ought* to think in perfect and logical conditions rather than the ways in which practitioners really think given the nature of their work and the ways in which humans reason about the real and irreducibly uncertain world. By forcing practitioners into certain ways of working they may actually increase the possibility of error and may do little or nothing to improve the ways in which practitioners think and make decisions.

Taking a systems approach to error means examining such latent systemic conditions for error and assessing the degree to which individual mistakes are a result of wider systemic dysfunctions. A systems approach also means taking steps to create a culture and a set of strategies that encourage more critical and reflective practice so that errors are to be expected and decisions can be revisited to minimise mistakes rather than creating rigid procedures in an attempt to eliminate all error. Good supervision and team discussions are often seen as vital in creating such a culture (Gould & Baldwin, 2004) and these aspects of the work were a focus of the empirical phase of this study.

3.3 Decision making in social work: making decisions in conditions of extreme uncertainty

In the previous section the fallible nature of indicators in the environment was examined, suggesting that professional decision making across health and welfare was inherently uncertain but in this section the specific issues of making decisions in child protection are discussed.

In her review of child protection for the UK Government Munro (2011, p.15) argued that one of the major drivers of child protection practice since the 1970s has been "the sometimes limited understanding amongst the public and policy makers of *the unavoidable degree of uncertainty involved in making child protection decisions, and the impossibility of eradicating that uncertainty*" (my italics).

Some of the reasons for this uncertainty have been examined such as the social construction of child abuse as a category and the ambiguous, complex and demanding nature of many cases social workers and other professionals have to deal with. As a result, as Munro (1996) has noted, mistakes are unavoidable. Benbenishty et al. (2003) argue that professional mistakes in this area are made for four reasons: human inability to process a lot of complex information, uncertainty about the completeness and status of much of the information gathered, the impossibility of predicting outcomes from present circumstances and a lack of universal agreement on many aspects of child protection work.

Parton & O'Byrne (2000) argue that social work may be seen as either a technical-rational activity that can provide scientific solutions to objective problems or as a practical and moral activity which deals with issues that are socially defined as problematic and whose definitions and meanings are contested. There is a distinct moral element to social work judgements (Dingwall et al., 1983; Dingwall, 1989; Taylor & White, 2000; White & Stancombe, 2003; Keddell, 2011). Indeed, it would seem odd if there was not a moral element to decisions about child protection as decisions on such matters do not belong to the realm of "pure" reason and in the frequent absence of objective, uncontested evidence such judgements form an important element of social work practice (Dingwall et al., 1983; Buckley 2003; White & Stancombe, 2003).

Social work in child protection is then an inherently contestable activity and it takes place in situations that are often characterised by high levels of stress and complexity with many fallible indicators and the need to make decisions quickly: "environments that are rich in

contested clues and short on time for thinking" (Helm, 2011, p.905). Helm (2011) argues that home visits – central to much social work practice – "may present hundreds of cues...that are all highly fallible" (p.896). These cues all appear at once rather than sequentially, there is no time to consider all the options, there are no explicit models of reasoning to apply and decisions may have to be made quickly. Many social work situations are like this, he suggests, and they "(defy) purely analytical thinking" (p.897) . Intuitive reasoning to produce a swift evaluation of the situation and arrive at a quick decision is, he argues, the form of rationality best suited to this kind of situation. Because the indicators are fallible they are open to interpretation and reasoning takes the form of a search for meaning, often amongst competing versions of events (Taylor & White, 2000) which casts doubt on their ecological reliability (Hammond, 1996, p.120). While intuitive reasoning may be the best form of rationality in such situations it is open to error especially if the social worker does not have the opportunity to consider the available options, and the range of possible meanings and accounts more fully at a later time (perhaps, Helm suggests, in supervision or team discussions). Limits on the human ability to quickly process and make sense of large amounts of complex information, or bounded rationality (Gigerenzer & Goldstein, 1996), is also a factor here.

There is a link between task characteristics and modes of decision making with more pressured and poorly defined situations favouring experience-based, intuitive thinking (Orasanu & Connolly, 1993). van de Luitgaarden (2009) and Schwalbe (2004) come to similar conclusions, arguing that the more analytical models of decision making do not take account of the situations social workers have to deal with where the requirements for such decision making may be hard to come by. van de Luitgaarden suggests eleven "task characteristics" common in social work and concludes that nine induce intuitive thinking (2009, p.251), arguing that the conditions for more analytical thinking simply do not exist. He argues that analytical models require a clear set of options whose utility and probability values can be measured whereas social work situations consist of contested definitions of the problem (or even whether there is a problem at all) and incomplete and uncertain information. Attempting a utility-based analysis, he argues, would simply induce paralysis.

Other studies have confirmed the heavy reliance on intuitive thinking by social workers. Collins & Daley (2011), interviewing social workers and their supervisors, found that a number of factors led social workers to call on primarily experiential thinking: lack of evidence that was considered definitive, incompleteness of evidence, disagreements between professionals and

clients and between different professionals meant that more intuitive sense-making was seen as more useful than analytical thinking. O'Connor & Leonard (forthcoming) undertook a study based on focus groups which highlighted social workers' sense of having to make decisions quickly in chaotic and difficult situations where intuitive thinking enabled them to take account of "gut" feelings in the absence of more definitive information.

Taylor (2007) and Hackett & Taylor (forthcoming) undertook a study based on interviews and document analysis across four local authorities to identify practitioners' decision making strategies. They looked for key indicators of either intuitive or analytical decision making:

Indicators of intuitive thinking	**Indicators of analytical thinking**
Did practitioners use their prior experience to form a representation of the situation? Did they look at similar cases for comparison? Did they rely on memory of vivid, easily retrievable knowledge? Did they show signs of other heuristic biases such as anchoring?	Did they use any risk assessment scales or measures? Did they draw on research based evidence? Did they make explicit use of specific theories? Did they use specialist assessments by other professionals to add to their knowledge?

Table 2 Indicators of different decision making strategies

(Hackett & Taylor, forthcoming)

They found that all the cases examined showed evidence of intuitive, experiential thinking. Analytical thinking was never the primary strategy for making decisions and where analytic thinking was used it was often retrospective, justifying decisions already made intuitively. However, unlike the other studies cited, Hackett & Taylor found some evidence that practitioners did occupy different places on the cognitive continuum (Hammond, 1996), using more analytic thinking where certain factors were present. The vast majority of cases involved high levels of uncertainty and ambiguity which, as other studies suggest, favour intuitive thinking. Such thinking was particularly heavily used where cases seemed familiar or routine and could be framed according to prior experience but in cases involving very high levels of perceived risk or the need for more forensic evidence practitioners seemed to be less sure that their prior experience was valuable and used more analytical strategies (most commonly seeking specialist assessments or making explicit use of theories). Hackett & Taylor found that the least-used analytical strategy was the use of assessment aids which tends to confirm the pessimism about how relevant practitioners find such tools (Schwalbe, 2004; Gillingham & Humphreys, 2010).

The prevalence of intuitive thinking contributes to the finding by a number of studies (Benbenishty et al., 2003;Buckley, 2003; Broadhurst et al., 2010b) that social workers rarely seem to use wider theories and research evidence but respond to cases on an individual basis. Broadhurst et al. found that social workers responded to each case according to the case's individual needs and the norms of the localised team culture. Each family had its own specific needs and the social workers responded to these without recourse to theoretical or research based evidence that could provide a more comprehensive understanding of their situation. Buckley (2003) found that investigations into abuse focused narrowly on the incident under investigation and there was no attempt to examine the impact of structural stress factors such as poverty, poor housing or poor health. Well established theories about attachment and family systems were similarly neglected although they were well represented in social work literature. Benbenishty et al. (2003), comparing the responses of social workers from different countries to a set of vignettes, argued that their participants were able to make "basic" arguments – making a claim, providing evidence to support the claim and then showing how judgements were made based on this evidence – but did not provide "complementary" arguments which the authors define as engaging in a process of qualifying and limiting claims, considering alternative possibilities and looking for disconfirming evidence. As has been argued, intuitive thinking tends to concentrate on the vivid, the familiar, the most easily retrievable information and more abstract knowledge is neglected (Munro, 2008; Tversky & Kahneman, 1974). These complementary arguments are weighted towards a particularly abstract form of knowledge - what White & Stancombe (2003) call "journal" science, academic knowledge which is far more tentative and doubting than more popular certainties. It is also the case that practice itself is never abstract – it is always concerned with specific cases and abstract knowledge must be applied to those specific situations to be practically useful (Hardiker & Barker, 2007) so the process of applying more abstract and theoretical knowledge is far from straightforward.

3.3.1 Assessing risk: using decision aids

The use of decision aids, scales or measures is, as Hackett & Taylor (forthcoming) suggest, a key indicator of analytical thinking, providing an explicit step-by-step model to reasoning (Hammond, 1996). Given that much social work decision making is intuitive and experiential in nature such aids may provide a valuable dimension to decision making that is not prone to the same biases and errors as intuitive rationality. Although there is evidence that decision aids can improve the accuracy of clinical judgement there has been a marked reluctance on the

part of many social workers and other professionals to use them (Barlow & Scott, 2010). Their usefulness in social work decision making is the subject of this section.

As has been argued, child protection social work is centrally concerned with assessing risk. The concept of risk originally meant simply the probability of an outcome, positive or negative, but in more recent times it has come to refer primarily to undesirable outcomes only (Stalker, 2003; Munro, 2008). This is certainly the case in social work where risk has been defined as *"the process of predicting whether or not a child will be maltreated at some future point in time"* (Jones, 1994, p.1037 author's italics). It was argued in the previous chapter that the recasting of social work with children as "child protection" meant an increased emphasis on the assessment of risk. As this concept of risk refers to future events, assessment is about prediction and this became part of UK legislation with the passing of the 1989 Children Act which defined the threshold criteria for making a legal order as that a child is suffering *or is likely to suffer* significant harm. Much of the work the participants in this study referred to involved assessing and predicting what might happen in the future as well as trying to determine what had already happened. Focusing on risk can mean overlooking families' strengths and the wider social work task of improving children's well-being (Munro, 2008).

There are actuarial and clinical models for predicting and assessing risk. Actuarial models involve statistical calculations which relate the evidence gathered in an assessment to factors known to be more common in abusing populations than in non-abusers (Munro, 2008). However, many factors which are more common in abusing populations also exist amongst non-abusers whilst some factors that are statistically more associated with abusing than non-abusing populations are so widespread in the overall population (such as living in poverty or being male), and the risk of finding false positives or false negatives is so high, that their predictive value is very limited (Hammond, 1996; Munro, 2008). Clinical models rely on the expertise of the practitioner and the risk here is that intuitive, informal and subjective assessments will be made which will overlook or miscalculate key risk factors. Meehl's influential work (cited in Hammond, 1996; Shlonsky & Wagner, 2005; Schwalbe, 2008; Taylor, 2013) has found that assessments that rely purely on clinical judgement are less accurate than ones that incorporate some element of decision making based on actuarial methods. The problem, as Munro (2008) argues, is that clinical and actuarial models are presented as either/or choices (rather as intuitive and rational reasoning can be) whereas there may be ways of combining the two.

Reviews of actuarial risk assessment tools in both the UK and the US conclude that they are of extremely limited predictive value (Peters & Barlow, 2003; Hughes & Rycus, 2007). Stalker (2003) in a review of the literature argues strongly that defining risk and assessing how families manage the risks in their lives is a complex process which cannot be reduced to actuarial calculations in an uncertain world. Hughes & Rycus argue that many tools have been insufficiently empirically tested and the way such tools are used varies depending on local cultures of practice, a finding reproduced by Gillingham's research on the use of decision tools in the US and Australia (Gillingham & Humphreys, 2010; Gillingham, 2011). Hughes & Rycus (2007) suggest too that the effectiveness of such tools will depend a great deal on the degree of skill with which the practitioner uses them: a poorly managed assessment will not engage the family and gather sufficient accurate information for the tool to be of any use. Gillingham & Humphreys (2010) found that social workers used these tools very variably, depending on local cultures, seeing them as administrative burdens to be filled in mechanically and retrospectively. The previous chapter noted Broadhurst et al.'s (2010a; 2010b) findings that social workers filled their forms in very skimpily or tried to find strategies for using them more flexibly. A number of these studies point to the work pressures experienced by social workers who were required to process the forms as quickly as possible. Munro (2004) argues that interpreting actuarial scales involves an understanding of statistics, notably Bayesian probability theory, that is likely to be beyond practitioners. Gillingham & Humphreys (2010) found that social workers were given training in filling in the forms but not in how to use them critically, combined with their professional judgement, and concluded that they thus became mechanical exercises, designed to meet the organisation's audit needs and may have *decreased* professionals' expertise and critical thinking.

Nonetheless, Barlow & Scott (2010) in a review of the research concur with the argument cited above that assessments based purely on clinical judgement are not adequate and require an actuarial element to improve their accuracy. The antipathy of social workers, particularly the more experienced, to such tools is "no longer supportable" (Barlow & Scott, 2010, p.50).

The conditions of social work practice mean that social workers rely largely on intuitive, experiential reasoning. Yet decision aids and assessment schedules, it is argued (Schwalbe, 2004, 2008; Shlonsky & Wagner, 2005) are based on actuarial and analytical models which do not match the conditions of practice and so they tend to be ignored or subverted, being used – if at all – to retrospectively validate a decision that was reached intuitively (Schwalbe,

2004; Barlow & Scott, 2010). In addition, there are many reasons why clinical skill and judgement should be central to decision-making because of the skills required to engage families and gather comprehensive information, to assess family functioning and to plan and carry out appropriate interventions (Shlonsky & Wagner, 2005; Hughes & Rycus, 2007). Shlonsky & Wagner (2005) recommend integrating clinical and actuarial judgements in a single schedule that incorporates risk factors identified by practitioners rather than statistical tables. Rather than being scored numerically, these factors can be graded adjectivally and the grade used as an indication of the importance of undertaking further assessment. This is a much more tentative approach than an actuarial tool but one that can, they suggest, provide an advance in accuracy over purely clinical judgement because such a schedule can be rigorously tested empirically. Barlow & Scott (2010) refer to such a schedule as “Structured Decision Making” or “structured clinical judgement” (p.16) and suggest it fits the definition of Evidence Based Practice proposed by Sackett et al. (1996) that integrates the best external evidence with clinical expertise and client preference. This structured model, Barlow & Scott argue, prevents the blind or dogmatic application of “best evidence” irrespective of client wishes and thus, ideally, will improve critical thinking and expert practice as more actuarial schedules, used mechanistically, do not.

Schwalbe (2004), similarly, is concerned to improve decision making by creating tools that conform more closely to the ways professionals actually think in practice. He suggests that assessment aids should be developed that focus on developing skills in “situation awareness” (Gambrill, 2005), where whole situations are explored, and on skills in constructing narratives and building pictures (that is, building the mental representations of the world which occur in naturalistic decision making) and so encouraging the appraisal of further options and meanings. This process is built on the Recognition Primed model of Klein (Klein, 2000; Klein & Klinger, 1991). Where Helm (2011) and Munro (2008) suggest the use of more analytical models in supervision or team discussions Schwalbe is suggesting a model that renders aspects of the intuitive process explicit. Intuition is based on tacit and experiential knowledge which usually remains unspoken and lacks a step-by-step approach (Hammond, 1996). Schwalbe’s model is designed, like Klein’s, to render this tacit knowledge explicit so that it can be articulated and examined. The use of such a model in supervision and team discussion may be a way of improving social workers’ cognitive skills in decision making.

3.3.2 Making decisions with other professionals

Social work in child protection almost always involves working with other professionals and government procedures are designed to ensure that decisions on child protection are taken in multi-professional forums. Failures in professional communication and information-sharing are often highlighted in reviews and inquiries. Yet, as Hackett & Taylor (forthcoming) argue, using the specialist skills of other professionals is a key indicator of more analytical reasoning. In this section the key literature on inter professional working is reviewed to examine why such failures occur and how inter professional working contributes to the nature of social work decision making in child protection.

Failings in inter professional collaboration in child protection were first identified by the inquiry into the death of Maria Colwell in 1974 (see previous chapter). As a result the government created a set of procedures to try to ensure that child welfare professionals would work together better. In the 1980s statutory guidance on inter professional collaboration in child protection, known to social workers as the "Working Together" guidelines were created. These have been repeatedly rewritten in the light of further high profile inquiries and reviews which have highlighted continuing problems. The most recent iteration of these guidelines dates from 2013 (Dept of Education, 2013) while as a result of the Climbie report the 2004 Children Act was passed strengthening the statutory requirements for welfare agencies to work together. Reder et al. (Reder et al., 1993; Reder & Duncan, 1999; 2003; 2004) and Parton (2006) have summarised these inter professional failings as: failures to communicate and share vital information, confusion over roles and problems with coordinating activities. As noted in the previous chapter Reder & Duncan (2003, 2004) and Corby, Young & Coleman (2009) have highlighted complexities in inter professional communications within bureaucratic agencies which statutory guidelines and bureaucratic procedures fail to acknowledge.

Historically the professions have proliferated in modern societies where a very complex division of labour has arisen so that specialised tasks can be undertaken by qualified experts and this division has been marked by deep social differences (Loxley, 1997; Frost, 2005). This historical perspective suggests that professions may be seen as self-interested groups seeking the political influence necessary for them to become established as providers of essential services able to exercise power, operate autonomously and control resources (Loxley, 1997). "In many ways", Frost (2005, p.11) argues, "professions are defined by what makes them distinctive rather than by what brings them together".

Hudson (Hudson, 2002; 2007) has suggested that these fundamental differences may be divided into three areas concerning professional identity, status and discretion.

Professional identity refers to the deeply ingrained set of values, beliefs, customs and practices into which professionals are socialised during their training and then in their practice. Hudson argues that this identity becomes so deeply embedded that it attains the status of common sense and is difficult for individuals to articulate. Loxley (1997, p.5) argues that this identity includes "the negative stereotyping of other professions especially those perceived as competitors". Anning et al. (2010) found that different identities involve differences in professional language which can cause considerable conflict with those from other professions.

Issues of professional status refer to the existence of a distinct hierarchy of professions. In health and social care doctors are seen as higher status professionals than nurses or social workers. Professions such as medicine are high in status, Hudson argues, because they have acquired the autonomy to define their own standards whereas lower status professions or "semi professions" (Etzioni, 1969) such as social work lack such autonomy. Again it is argues that these status differentials can cause considerable conflict.

Professional discretion or accountability refers to the level of discretion professionals have as they go about their work. This is often seen as a mark of status: the higher the level of discretion allowed the higher the professional status. Social workers have, in the past, enjoyed considerable discretion as "bureau professionals" (Harris, 1998) or "street level bureaucrats" (Lipsky, 1980; Evans & Harris, 2004) although, in common with many other professionals, they are now more tightly managed (McDonald, 2006). Professional discretion here also refers to the degree to which professionals are prepared to change some of their working practices to work more closely with other practitioners.

Hudson argues that these differences can all be potent barriers to collaboration but are largely ignored when services are reorganised or required to work together. Research into how professionals collaborate on the ground has suggested that there are considerable barriers and while some of these may be overcome inter professional collaboration cannot be taken for granted. Horwath & Morrison (2007) suggest in their review of the research that when agencies reorganise to more "integrated" practice the changes are often rushed and poorly managed with senior managers and policy-makers failing to communicate to front-line

professionals who are then more likely to experience the changes as threatening as a result of which they lose motivation and skills.

Systematic reviews of research into inter professional working (Atkinson et al., 2007; Cameron et al., 2012) have identified a range of facilitating and hindering factors while also highlighting the lack of really clear evidence that closer inter professional working improves outcomes for service users. Glasby & Littlechild (2004) have argued that inter professional working has become the dominant ideology, a professional shibboleth whose actual benefits to professionals and those who use their services are far from evident. While there appears to be evidence that professionals can renegotiate their professional identities and work together in "communities of practice" (Wenger, 1998; Frost & Robinson, 2007; Anning et al., 2010) there is also evidence of enduring frictions. The telling of "atrocity stories" about other professionals as a way of strengthening professional identity by exposing the apparent inadequacies of others has been well documented (Dingwall, 1977; White & Featherstone, 2005)

An enduring problem which has bedevilled child protection work is the sharing of information between different professionals and agencies. Failing to pass on important information, sometimes because it is considered too confidential and communicating it to other professionals might breach data protection legislation, or passing on too much information unnecessarily are problems that cause professionals concern (Parton, 2006). Richardson & Asthana (2006) suggest that different professional groups have different models of causation – some medical or individual, others more social models – and these influence what information professionals think is important to communicate. So medical professionals, using a medical model may refuse to pass on information because they feel it is not relevant or appropriate while others, they argue, such as the police may pass on too much. There is evidence that different professionals reason differently about cases, disagreeing about which factors in a case are most important and disagreeing too about the most desirable outcomes (Britner & Mossler, 2002; Taylor & Donnelly, 2006). Social workers' relationships with the police and with medical professionals can be problematic (Thomas, 1994; Garrett, 2004; Lymbery, 2006). In this study social workers frequently worked alongside the police, doctors, health visitors, schools and other professionals and the conflicts these working relationships could cause was a theme for many of the participants. It may be that different professionals frame situations in different ways or, to use Brunswik's terminology, that their training and experience has given them different lenses through which to make sense of the world. Given

the contested nature of child abuse inter-professional working may be as likely to cause disagreements as it is to facilitate better decision making.

Interprofessional meetings are a cornerstone of modern child protection practice and are the sites of important decisions in which social workers participate. Ideally such meetings will pool the various participants' expertise and knowledge. Brandon, Dodsworth & Rumball (Brandon et al., 2005), drawing on their work analysing Serious Case Reviews (see previous chapter), argue that bringing professionals together can be problematic. Some families with complex and enduring problems were involved with very large numbers of professionals (173 in one case they cite!) and often key professionals with vital expertise were overlooked. In their review of SCRs between 2003-5 Brandon et al. (2008) noted that differences in professional perspectives were often not pursued and concluded. Some professionals lacked confidence in their own expertise and were hesitant to challenge other professionals where they disagreed with them. It would appear that the differences in status and authority between professions played a part in these processes.

Group decision-making can be as prone to error and bias as individual decision making (Munro, 2008; Kelly & Milner, 1996). According to Kelly & Milner (1996) "groupthink" suggests that groups can silence or discount those who present evidence that runs counter to the views of the majority so that a sense of group solidarity and unanimity is fostered. They argue that groups can polarise around particular decisions: a decision is adopted cautiously but group polarisation then acts to move the group to a much firmer commitment to that particular decision.

3.3.3 Summary

Social work may be seen as a contested activity, dealing with poorly defined situations where moral reasoning forms part of decision making. Child protection work involves an ineradicable element of uncertainty and consequently errors are unavoidable due to a mix of factors to do with the ways in which child abuse has been socially constructed and defined, the lack of universal agreement and objective standards in many aspects of the work and the complex, ambiguous and often incomplete nature of much of the information available to practitioners.

Social work practice situations, then, are often ill-defined, dynamic, uncertain and chaotic, involving many fallible indicators and making great cognitive and emotional demands on social workers. Such situations favour the use of intuitive, experiential reasoning and a

number of studies have confirmed this. The conditions for a more analytical consideration of clearly defined options leading to clear outcomes rarely exist in practice situations.

One consequence of the reliance on intuition is that cases tend to be assessed without reference to more abstract theoretical and research-based knowledge and this may limit the quality of social workers' arguments and claim-making. A number of authors question how, or if, more analytical tools and strategies can be employed to complement intuitive reasoning and reconsider quickly made decisions, correcting the errors and biases to which intuitive thinking can be vulnerable. Skilled supervision is one possibility. Another is the development of structured decision tools that can introduce more analytical thinking and actuarial evidence into decision making. However there are problems with such tools. They are of limited value as predictors, many have not been sufficiently tested and practitioners geared to thinking intuitively in conditions of uncertainty appear reluctant to use them or use them only to retrospectively to justify decisions already made intuitively. Structured decision making tools which combine actuarial methods with expert clinical judgement by developing practitioners' skills of naturalistic decision-making such as situation awareness and constructing coherent narratives may be a way forward.

However there is also evidence that structured tools are used as mechanical exercises by overburdened social workers who are not encouraged by employers to use them in a critical way that enhances practice expertise.

Social workers frequently work alongside and make decisions in partnership with other agencies and professionals. Utilising the specialist skills of other professionals is a key aspect of analytical decision making. But despite major changes in policy to ensure such inter professional working runs smoothly there continues to be evidence of breakdowns in communication between professionals with information sharing a particular issue. While, ideally, inter professional working should enable a synthesis of expertise, such working can, in reality, be problematic with professionals often divided by deep differences in cultures, practices, values and beliefs.

3.4 Types of knowledge in social work

Social work has a particularly diverse knowledge base and one in which forms of knowledge of contested status play a significant part (Pawson et al., 2003). This section examines the debates around what constitutes the knowledge base of social work and what forms of knowledge social workers draw upon, or fail to draw upon, when making decisions.

Sibeon (1991) tells an instructive story about the first social work training courses. In 1903 the Charity Organisation Society, wanting to professionalise the volunteer activities of philanthropy (the title "social work" was coined at this time to reflect this professionalisation), organised social work training at London University, provided by former practitioners. The leaders of the COS and the university were soon troubled by trainees' lack of interest in book-learning or theories, wondering if social work education really belonged in a university. In an attempt to inject more academic content into the training London University relocated the course to the London School of Economics. Here the training was provided by university academics rather than former practitioners. The leaders of the COS now became worried that the trainees would become corrupted by socialist ideas. Having worried that future social workers were not interested in theories and books they now worried that they would fall under the influence of the wrong ones.

The question of what constitutes (or should constitute) social work knowledge has been contested ever since and there remains a lack of universal agreement about it. Social work may be seen as either a practical-moral or a technical-rational activity (Parton & O'Byrne, 2000). The latter might be expected to provide scientific solutions to objective problems. This has been an important strand in the development of social work with many of the pioneers of professionalisation concerned to put social work activity on a purely scientific basis (Smith, 2004). Social work involves negotiating with people, taking their perspectives into account and finding the best possible (but very probably not the optimal or the universally agreed) option for change. Here the practical skills of the street-level bureaucrat (Lipsky, 1980; Evans & Harris, 2004), who works flexibly with regards to "official" theory and policy, will be at least as important, as those of the academically trained professional who knows which research-based evidence provides the best solution to the problem. These two different conceptions of social work will prioritise very different forms of knowledge. Sheppard et al. (2000) argue that there are two contrasting social work cultures: one learning reflectively from practice (with little value placed on academic knowledge) and the other favouring more academic knowledge (which may have little relevance for practitioners).

Holland (1999; 2004) found evidence of both discourses in her research on how social workers do assessments. In the technical-rational "scientific observation" version the social worker is the detached expert, gathering facts and weighing up strengths and weaknesses, sometimes assisted by a decision aid to structure thinking. In the "reflective evaluation" model the social worker engages closely with the family and works alongside them to evaluate the

situation. Hunches and gut feelings are just as important in this model as facts. Holland suggests that social workers may shift between these models depending on the situation. She argues that both models have strengths but that the more “scientific” approach is now the dominant discourse in social work, particularly if decisions must be accounted for in court.

The home visit, one of the central activities of social work practice, provides another example of different discourses at work. Hall et al. (2006) cite Lord Laming’s recommendation in his report on the inquiry into the death of Victoria Climbie (Laming, 2003) that home visits should be like inspections but they argue that the home visit serves several simultaneous purposes – “assessing and diagnosing, assessing eligibility, troubles-telling and advice-giving....an ongoing helping relationship and, with it, ongoing surveillance” (pp.71-72). They note that there is a certain lack of direction in the way social workers conduct home visits but argue that this provides the space they need to listen to clients and to negotiate with them. It is dreadful to contemplate the visit where the social worker leaves thinking all is well, unaware of a child dying in another room, as happened in the Climbie and Beckford cases, but if all home visits were *just* inspections or investigations then many social work functions could not be carried out.

White & Stancombe (2003) argue that proponents of the more scientific or “evidence based” approach do not take into account what actually happens in practice situations where moral judgement, tacit knowledge, values and beliefs all play a part in the way encounters are constructed or in the ways sense is made of ambiguous and uncertain situations (Taylor & White, 2000). On the other hand Smith (2004) argues that while there is much evidence that social workers, like other people, do not think in a scientifically rational way they are in positions of considerable power “and have an obligation to think harder, more systematically and more conscientiously about what they ought to do” (p.12). While social work has borrowed heavily from other academic disciplines it has sought to shape this knowledge to make it relevant to a professional activity that sees itself as centrally concerned with human justice and individual self-determination (Gray & Schubert, 2013).

Unsurprisingly, then, social work’s knowledge base is, Pawson et al. (2003) argue, exceptionally diverse and any attempt to classify it must simplify the complexity. They suggest a typology of five sources of knowledge: organisational, practitioner-based, user-based, research-based and policy-based. Focusing on sources, they argue, acknowledges that they all have value though what that value is will depend on a number of factors. They conclude

that practitioner and user-based sources have incomplete, latent or emerging standards of quality and are often based on tacit knowledge while policy-based knowledge is often compromised by the political viewpoints of its proponents. Research-based and organisational knowledge appears to have the most well-established standards of quality.

However, this research-based source is itself very diverse with knowledge drawn from, amongst others, sociology, psychology, law, philosophy (especially ethics), psychiatry, social policy and medicine. Hardiker & Barker (2007) argue that such diversity is not only difficult for social workers to understand and synthesise but also to apply in their practice. Social workers work in organisations which prefer some elements of knowledge to others (White, 1997a), so their choices may be to an extent dictated by organisations and practice contexts, and this knowledge must then be applied to often complex situations in order to address a category of behaviour – child abuse – which is ambiguously constructed. Hardiker & Barker argue that in the face of such difficulties the social workers they studied fell back on a mix of values, beliefs and tacit understandings which was difficult to articulate. The tacit, inarticulate nature of this practitioner knowledge – which they call an ideology – is demonstrated by the phrases they use such as “the best interests of the child” which are short-hand metaphors simplifying complexity and masking significant differences in meaning. They conclude that a more articulated approach should be able to synthesise and develop social work knowledge into “practice theories” (p.48), new forms of thinking about how social work is actually done.

Trevithick (2008) suggests that social work knowledge could be divided into theoretical knowledge, factual knowledge and practice knowledge. The first two categories encompass a range of academic theories and research-based knowledge, material that can be used as “fact” to justify decisions, while the final category is about how knowledge is acquired and then transformed so that it can be applied in practice. Another attempt at a classification of the knowledge base (Drury-Hudson, 1997; 1999) identifies personal knowledge and practice wisdom alongside categories of theoretical, empirical and procedural knowledge. These categories include values, beliefs, “common sense” knowledge and experience-based knowledge. While Trevithick places high value on practice-based knowledge and argues that it should be incorporated more into research Drury-Hudson argues that it is not as useful as more academic knowledge. This lack of agreement reflects the contested nature of the standards by which practitioner knowledge may be judged.

There is consistent evidence that social workers' use of theory and research is minimal (Sheppard, 1995) and the more established categories of academic knowledge are rarely cited by social workers as influencing their practice though this could in part be due to an inability to articulate theory and research knowledge (Drury-Hudson, 1999; Osmond & O'Connor, 2006). Hackett (2012) argues that social workers do use theories but draw on them implicitly, using them as flexible tools rather than inflexible prescriptions. There appear to be barriers to practitioner use of research evidence in social work and other welfare professions. Sheppard & Ryan (2003) argue that the constraints and pressures social workers experience cause them to perceive academic knowledge as irrelevant. Gray et al. (Gray et al., 2013) reviewing the literature on strategies for implementing research-based information identify a range of barriers such as practitioners' limited time, their limited IT skills, their negative views of research, the difficult format of most research studies and agency cultures that do not encourage accessing research. Thompson et al. (Thompson et al., 2000; Thompson et al., 2005) identified similar barriers for nurses despite a perception that the NHS is better at encouraging its staff to access research than are social work agencies (Gira et al., 2004). One area identified as having some success was in educating supervisors to be more research-informed (Gray et al., 2013).

Strategies for encouraging more research-based practice appear to be in their infancy. The picture that emerges is of a social work practice dominated by more experiential knowledge alongside personal beliefs and values. Scourfield & Pithouse (2006), drawing on their ethnographic studies of social workers, argue that professional and lay or common-sense knowledge are closely intertwined and this mix of knowledge for practice is largely constructed through the routines of the workplace. They argue that such is the uncertainty of the work that purely technical or academic knowledge is not sufficient and so practical theorising and sense-making is based on an interaction between professional and lay knowledge. Sheppard & Ryan (2003) found in their research that the hypotheses social workers came up with in response to case vignettes mixed lay and professional knowledge and they also suggest that many concepts central to social work have entered everyday language so it can be hard to know if social workers are using terms in their everyday sense or in a more precise and expert way.

Like other authors (such as White & Stancombe, 2003; Parton et al., 1997; Dingwall et al., 1983), Scourfield & Pithouse found that moral judgements play an important part in decision

making and these moral judgements are based on common-sense knowledge to a significant degree. While some forms of expert knowledge were respected experiential knowledge or practice wisdom was highly prized. Fook et al. (2002) found in their study that those social workers regarded by colleagues as expert were judged on their experience-based knowledge not their familiarity with theories or research, a finding echoed in nursing by Benner (1984) and drawing on the model of experiential practice wisdom developed by Dreyfus & Dreyfus (Dreyfus & Dreyfus, 1986; Eraut, 1994)

A number of authors have argued that there has been insufficient attention paid to the contexts in which knowledge is *produced* and in which it is *used* (Gray & Schubert, 2013; Osmond & O'Connor, 2006; Sheppard, 1995; Sheppard & Ryan, 2003). Some authors have adopted a "critical best practice" approach (Ferguson, 2003; Jones et al., 2008; Gordon & Cooper, 2010) whose "core distinguishing feature....is detailed description and analysis of actual social work practice drawn from real events and cases" (Jones et al., p.3). The proponents of this approach argue that they are not trying to produce a portrait of ideal practice but of social work as it is actually done, in all its complexity and under the many constraints and difficulties practitioners face. Like Hardiker & Barker (2007), who might see in this approach a development of the "practice theories" they recommend, they see liturgical phrases such as "the best interests of the child" and crude dichotomies of "good"/"bad", "safe"/"unsafe", "oppressive"/"anti-oppressive" as meaningless and crude compared to the complex sets of contested meanings that practice encounters produce. This is an inductive approach, beginning with the complexities of practice and trying to identify theories and research evidence that can make sense of it. The model highlights the sheer complexity of practice and the very diverse kinds of knowledge required to make sense of it, though what constitutes "best" practice in such a contested arena will always be contentious. Sheppard (1995) arguing for inductive or retroductive (White, 1997a; Blaikie, 2009) analyses of practice emphasises that such is the uncertainty and complexity of practice that any hypotheses will be limited in scope and universality or, as he puts it, "hypotheses which are least likely to be wrong" (p.281). Researchers who take an ethnographic approach have revealed the complexities of day-to-day practice and how it differs from official accounts – such work has been discussed throughout this literature review. Paying close attention to what practitioners do and say in their work is necessary to uncover the ways knowledge is constructed and used in practice (Gordon & Cooper, 2010; White & Stancombe, 2003).

Practice wisdom has been defined as both a particular amalgam of knowledge drawn from experience and the product of particular knowledge production processes (O'Sullivan, 2005; Sheppard, 1995). Collins and Daley (2011) define it as a way of integrating and making sense of the multiple, diverse and uncertain sources of information that practitioners must deal with and then apply to specific cases. O'Sullivan (2005) sees it as a form of naturalistic decision-making in which practitioners draw on this diverse information and the perspectives of all those involved to create pictures or mental representations which can then be triangulated with more formal knowledge. This may be an ideal but it is an attempt to create an explicit model of an often tacit process, the testing of which could improve the quality of the standards by which such knowledge is evaluated (Pawson et al., 2003). Too often, Sheppard (1995) argues, practice wisdom is "parochial...folklore" (p.284) which is not open to rigorous testing. In his research into the ways social workers hypothesised about vignettes (Sheppard et al., 2000; 2001; Sheppard & Ryan, 2003) Sheppard has identified a range of hypothesising processes as workers search for meaning in uncertainty (Helm, 2011) and argues that seeing practice knowledge as a process of cognitive reasoning rather than a collection of pieces of knowledge helps to uncover the ways social workers think about cases. It also suggests that training supervisors in identifying social workers' cognitive processes and improving the range and precision of their hypothesising could be a useful way of developing social workers' decision making skills. This is congruent with arguments presented earlier regarding the use of structured decision tools that combine actuarial and clinical criteria to improve practitioners' decision-making skills.

3.4.1 Summary

There are different conceptions of social work as an activity – practical moral or technical rational – and this is reflected in sharply differing cultures regarding knowledge: one more academic and espousing research-based evidence and the other more focused on reflecting on the complexities of practice. As a result, the types of knowledge in social work are diverse. They are also varied in terms of their status. At one end of the continuum research-based evidence is high in status but low in practice use while more experiential practice wisdom is of low or debatable status but much used and respected by practitioners. There are numerous barriers acting against practitioners accessing and using research evidence. Practice-based knowledge may be seen as a cognitive process that enables practitioners to make sense of the uncertainties of their work but also as a social process as knowledge is constructed through practice routines.

Research that begins inductively by exploring the complexities of practice and attempts to create models of how social workers hypothesise and use knowledge in their thinking about cases may be a fruitful way of developing more rigorous models of practice-based knowledge and bringing these opposing ends of the continuum together.

3.5 Conclusion

As with the previous chapter this section has suggested a number of concepts that are important in the formulation of the research question and the design of the empirical phase of the study.

The distinction between intuitive and analytical modes of thinking has been examined. Humans use a range of modes of thinking in their lives and while intuitive and analytical models are sometimes posited as polar opposites they are best seen as existing along a cognitive continuum (Hammond, 1996), with the mode of rationality depending on context and the task in hand. Both forms of rationality have their strengths and limitations.

In social work, where practice situations are often fluid, complex and uncertain the more intuitive, experience-based forms of rationality are most commonly used as practitioners have to quickly make sense of contested situations containing a multiplicity of unreliable indicators. More analytical modes of thinking involving logical step-by-step processes are ill-suited to these kinds of situations but may be much better suited to more controlled situations such as supervision and team discussions where they may be able to complement the biases and errors to which intuitive thinking is prone.

It has been argued that there are two important ways of introducing a more analytical element to practice decision making: the use of schedules and aids and the utilisation of the specialist skills of other professionals. These more analytical forms of rationality may counteract the errors to which intuitive thinking is vulnerable. But there are numerous problems that bedevil the introduction and use of such strategies. Practitioners are reluctant to use structured decision aids, or use them superficially, because they do not reflect the ways in which practitioners think about and make sense of complex and uncertain situations. Aids that avoid narrowly actuarial methods and are structured so as to reflect practitioners' thinking may be more useful. Working with other professionals is beset with problems arising from poor communication caused by entrenched differences between professional groups that are very difficult to break down. In terms of decision making theories, different professionals employ

different frames or lenses to form representations of the world and so these representations may differ fundamentally and cause disagreements that make decision making more difficult and contested.

The knowledge base that social workers draw upon is very diverse and contains some forms of knowledge whose status is unclear or contested. The largely intuitive and experiential base of much social work reasoning means that much of the knowledge social workers use is based on experience and practice wisdom while knowledge forms with higher status, such as research-based knowledge, are used much more rarely. This may limit the quality of arguments social workers use when reasoning.

In the next section the concepts examined in the two literature review chapters are synthesised and linked to the formulation of the research question.

CHAPTER 4: THE RESEARCH QUESTION

4.1 Developing the concepts from the literature review and formulating the research question

A literature review should provide a framework for the development of concepts that can be used to formulate a research question that will test those concepts empirically. The conceptual contribution of the literature review in this thesis has been summarised in the two preceding chapters. The relationship between deductive and inductive theorising in qualitative research is not straightforwardly linear. As the next chapter elaborates, qualitative research is often an abductive and iterative process of moving back and forth between deductive ideas drawn from existing literature and ideas developed inductively from the data. In the next chapter the construct validity of the study – Yin's (2009) model for establishing a chain of auditable evidence – is discussed and that process begins here by stating the concepts developed through reviewing the relevant literature and setting out the research questions that flow from them.

Charmaz (2006) argues that these deductive concepts form an anchoring framework from which more inductive theorising can flow, refining, extending and challenging existing ideas, rather than a set of specific hypotheses. Blumer (Blumer, 1954; 1956; Mason, 2002) argues that concepts for social research are "sensitising instruments (which) suggest directions along which to look" (Blumer,1954, p.7),providing a bridge between the unique happenings of the social world and wider, more theoretical understandings. Blumer (1956) and Mason (2002) argue strongly against seeing these concepts as discrete variables which can be isolated, objectified and studied because such a process will give only a narrow and superficial version of events. Intervening between variables is the "vast interpretative process in which people...guide themselves by defining the objects, events and situations they encounter" (Blumer, 1956, p.686) – the world of meanings, customs, social codes and constructions.

This study, as the next chapter argues, is centrally concerned with the meanings and constructions through which the participants act and make sense of the world in specific contexts because, it is argued, only through a detailed examination of that meaning-making and sense-making can a comprehensive understanding of how and why social workers make decisions be reached.

So the literature review has not been used to provide a set of hypotheses but a conceptual framework and this has been used to shape the main research question and its associated sub-questions.

The table below sets out the key concepts deriving from the literature review to the different elements of the research question. It links with the construct validity table set out in the next chapter (table 6) which covers the operationalising of the research question.

Key concepts from the literature review	**Research questions**
The intrinsically ambiguous and socially constructed nature of child protection. The importance of situated moral reasoning The sufficiency or insufficiency of available information on the child The existence of the "Rule of Optimism" (Dingwall et al. 1983) The existence of sense-making, localised, unofficial rules and customs Pressure of work: high workloads. Pressure of work: the emotionally demanding nature of the work especially with families with complex and enduring problems The pros and cons of rapid, often intuitive decision making The need to revisit decisions more deliberatively The nature of decision making in team contexts The issues raised by increasing use of structured aids to decision making The significance of disagreements between professionals The nature of social workers' knowledge base The language through which judgements and decisions are made	The overall research question: ***How do social workers form judgements and make decisions about child protection within everyday working contexts where those contexts may be marked by significant degrees of stress, complexity and uncertainty?*** Sub-questions: How do social workers manage the contested definitions of child abuse? How are risk factors and strengths in families conceptualised and assessed in everyday practice? What new information might change the way risks and strengths are conceptualised and assessed: having made decisions rapidly do practitioners revisit and rethink them How does the emotionally demanding nature of child protection work affect decision making? How do workload levels and pressure on time affect decision making? How does localised context and team culture affect decision making? How does the nature of team support and supervision affect decision making? Does the contested nature of definitions of child abuse result in disagreements between professionals? If so what is their nature?

Table 3 Concepts from the literature review and the research questions

CHAPTER 5: METHODS

5.1 Introduction

In this chapter I discuss how I planned to answer the research question: how my study was designed and my rationale for choosing particular methods. I also discuss how the research process unfolded from foreshadowed problem to data analysis and conclusion. The intention is to set out the key theoretical and methodological issues behind the research design and choice of methods and to present alongside this what actually happened. This should therefore constitute a reflexive "thick" description (Geertz, 1973; Ponterotto, 2006; Creswell, 2007) of what I actually did rather than a sanitised and linear account. Learning to become a researcher has been a central part of this process and I hope to give that learning proper emphasis in this account.

The choice of research design is shaped by a complex interplay between ontology, epistemology and methodology – between philosophical beliefs and practicalities (Guba & Lincoln, 1994; Mason, 2002; Silverman, 2010).

Once my "foreshadowed problem" (Malinowski cited in Hammersley & Atkinson, 2007) had been turned into an answerable research question this interplay shaped how the study was designed, what data collection methods were used and how that data was managed and organised. Qualitative research is not a linear process and in presenting my account it is important to provide a "thick description" in order that the study can be judged in terms of credibility and possible generalisability or transferability (Lincoln & Guba, 1985).

5.2 Case study design and thick description

A case study design was utilised because it is a flexible design that enables the detailed study of groups in their natural settings and because it provided an overall strategy for pursuing a bounded, small-scale study which lay within the means of a lone researcher conducting an unfunded study. (Gomm et al., 2000; Robson, 2002; Yin, 2009).

The case study method is a research design or "strategy of inquiry" (Creswell, 2007, p.73) that covers the entire research process and should produce an auditable chain of evidence (Yin, 2009, p.122) from research question through to final conclusion. It provides a methodological framework for investigating a case empirically within its real-life context (Yin, 2009). A case can be almost anything (Robson, 2002): it could be a single person or an event, a group or an

organisation. Robson suggests that any study that takes place in a specific setting where that setting or context is important could be seen as a case study. Cases may be chosen for their intrinsic interest (Stake, 2003) but it should be a “case of something” (Silverman, 2010, p.139) that may produce knowledge that can be generalised or transferred to other settings albeit with caution. It is the bounded, small-scale nature of the case study that is both a strength and a limitation: the small scale nature of the inquiry sacrifices breadth for depth and thus allows for a highly detailed exploration of social processes “that can cope with the complexity and subtlety of real-life situations” (Denscombe, 2007, p.38) but this small scale raises obvious questions about generalisability.

Case studies are ideal for examining everyday work and the contexts within which it takes place, taking account of the unofficial and localised practices that exist alongside more official versions and seeking to uncover the enmeshed relationship between human activity and official production (Wikstrom & Larsson, 2003) Social work is fruitful ground for such a study. Buckley (2003, p. 202), for example, argues in her study of social work practice “the ‘official’ version tends to be stripped of the contextual and occupational realities of day to day work in a way that conceals the very nature of the job” . By limiting the scale of the study a case-based design can focus on the depth of detail within a small-scale case thus uncovering the level of day-to-day detail I was interested in, paying attention to meaning, context and complexity (Pawson & Tilley, 1997)

Stake (2003) suggests a balance must be struck between what is particular about the case and what features of it may be generalisable. Too much attention to the former may produce a mass of descriptive material that is insufficiently analysed and may lack generalisability, too much focus on the latter robs the case of the complexity and depth of detail that is the rationale for adopting this method in the first place. He suggests that a case study should produce both a “thick description” that gives a highly detailed and reflexive account of the case and a “comparative description” which focuses on certain key features of the case which may be generalisable.

Geertz (1973) argues that all human social action is symbolic, drawing upon the rich and complex webs of meaning culturally available to the actor and others in his or her social context. While the “thin” description of an action might be a brief surface account, a “thick” description will explore the action in much more concrete detail and through that

concreteness, rather than abstractions about "culture", examine the range of meanings it might have both to the actor and to his or her audience.

It is through thick description that meaning may be elucidated and thus such description lies at the heart of qualitative research: the thickness lying not just in an accumulation of detail but in its interpretation, its analysis of possible meaning (Ponterotto, 2006) But the term means more than this. The thick description is written down or inscribed, thus turning an ephemeral event into something permanent which others can consult and examine to help them judge the credibility of the researcher's data and this is essential for the thick description is not some objective truth but a guess, a hunch, an interpretation. It is, Geertz argues, a fiction, an account of an event and not the event itself. Originally Geertz was using the term as a way of describing what the anthropologist observes but, as Patton (1990) uses it, it becomes a more general term covering observational field notes, interview transcripts, analytic memos, the coding and analysis of data by the researcher: in short the entire auditable trail of a research study. If the research is described sufficiently "thickly" then others can decide if it meets what Popay et al. (1998) describe as the "primary marker" of qualitative research: "adequacy at the level of meaning" (Popay et al., 1998, p.345).

However, generalisability is always likely to be limited. Case studies explore phenomena within their natural contexts and so produce contextually-bound data. Identifying which features may be generalisable and which not is an essential element of analysis. The concept of construct validity is important in ensuring the theoretical clarity necessary for this ((Gray, 2009; Yin, 2009)

Careful sampling is one way of making generalisability more likely.

5.3 Sampling for generalisability

In a small-scale case study statistical generalisability is not possible but carefully chosen purposive sampling can lend itself to theoretical generalisability (Mason, 2002; Silverman, 2010). Qualitative research uses a logic of enquiry different from that of quantitative research where generalisability is statistical and based on large, randomised samples. In qualitative research generalisability will be theoretical - a well-designed case can produce theoretical and analytic propositions which can be tested through further research and comparison with data from other case studies (Silverman, 2010; 2011). So theoretical sampling requires a clear statement of the theories and concepts underpinning the research which can be established through the process of construct validity (Yin, 2009) which will be discussed in

more detail below. Samples are strategically chosen in order to facilitate the generation and testing of theoretical concepts which may produce potentially generalisable theory for further study (Hammersley & Atkinson, 2007).

The chosen cases had features, such as the nature of child protection work, the encounters between the social workers and service users, the relationships between the different professionals, that were likely to be found in other social work teams. It could then be argued that the chosen cases were likely to produce the kind of data needed to answer the research question and both test existing theory and generate new concepts. Scourfield (2003), in his ethnographic case study of a social work team argued that while all teams, their local cultures and their employing agencies vary there are likely to be significant similarities due to common training, identical laws and policies, broadly similar clients and dominant discourses about children, families and the field of child protection.

Theoretical sampling may also occur dynamically during the research process (Mason, 2002) if a situation arises that seems to offer particularly fruitful opportunities to produce data that bears upon the theories and concepts making up the research question. An example in this study was the decision to interview the social workers involved in investigating a child protection referral that was made to the team during one of my observations. I observed the social worker deal with the initial referral and the following week interviewed this worker and the others who had visited the child's home, accompanied the child and his carers to hospital and made decisions about how to investigate and conclude the referral.

5.4 Construct validity

Yin (2009) argues that construct validity is one of the tests of quality in case study design and is crucial in establishing a chain of evidence. He defines this as "identifying correct operational measures for the concepts being studied" (p. 41). Yin argues that the case study method should link the whole study together from the formulation of the research question to the final conclusion. In design terms a case study should begin with a clear statement of the concepts or constructs that are being studied which are then linked to the methods that will be used to gather data about those constructs (Gray, 2009). This begins the process of establishing a chain of evidence that enables the research process to be clearly mapped from start to finish and the generation of a thick description (Geertz, 1973; Stake, 2003). A construct validity table can then be drawn up showing a clear process (see for example Mason p.69-70):

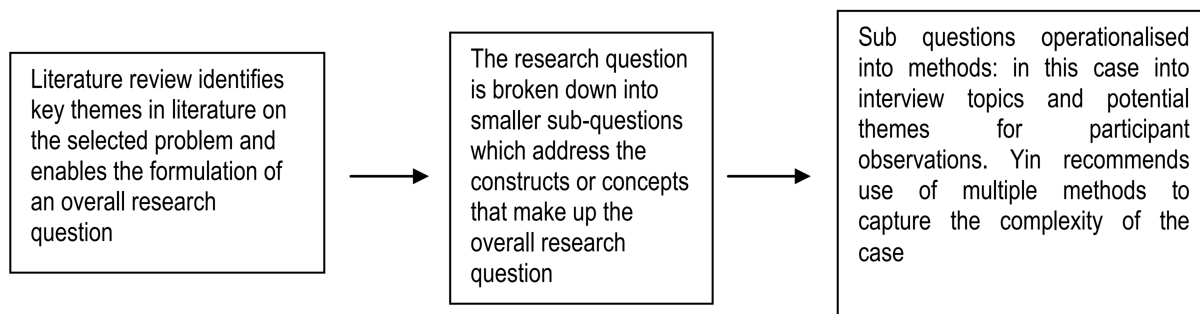

Figure 1 The process of construct validity

I saw this as a very important way of establishing methodological and theoretical rigour and as I shall discuss later I drew up a construct validity table (Table 6 at end of chapter) showing the key concepts drawn from the literature review, the research questions and how these were operationalised for data collection purposes.

5.5 Choosing the cases for study

A team of social workers engaged in child protection work forms a clearly bounded case and my intention was to gain access to such a case. More specifically I wanted to gain access to a social work team employed by a local authority as these teams are legally required both to support children deemed as in need and to investigate situations where children might be at risk. Through the use of delegated statutory powers these teams, uniquely, can make investigations, draw up child protection plans in conjunction with other professionals and make applications for legal orders through the courts according to the 1989 Children Act and the "Working Together" guidance (Dept for Education, 2013). These teams are seen as the "front line" in child protection work and often have to make the most difficult decisions about the most difficult cases. To provide a contrast I planned also to gain access to a different kind of social work team – one that works with cases referred by local authority teams for more in-depth assessment and support. These teams, typically employed by voluntary or charitable organisations but usually funded by the local authorities, are able to work in a more planned way with cases deemed suitable for the kind of service they offer.

As I have argued choice of case will have considerable consequences for the potential generalisability of the data and I wanted to ensure that the cases studied would have features that were not unusual for child protective social work.

Both cases were geographically located in Banksfield Metropolitan Borough Council. Banksfield is a former coal mining town in the north of England. About 82,000 people live in

Banksfield itself and a further 150,000 in smaller communities in the borough. It is, on 2012 figures, the 47th most deprived local authority in Britain out of 326. In recent years the non-White population of the borough has increased to about 4% of the total. By comparison about 9% of the UK population is non-White and about 15% of the population of the county, Northshire, in which Banksfield lies (Ofsted, 2012)

Dept of Education statistics for 2012 (Dept for Education, 2012) show that the numbers of children per 10,000 classified as In Need (according to s17 1989 Children Act) or subject to a Child Protection Plan in England were as set out below. It can be seen from these figures that levels of need and risk of significant harm experienced by children in Banksfield are about or below average for England and below average for Northshire which has some urban centres with very high levels. This suggests that the client group the social workers were dealing with was not markedly unrepresentative of social work caseloads in England & Wales thus adding to potential generalisability.

Children in Need in England (rate per 10,000)		
National	Northshire	Banksfield
325	352	255
Children in England subject to a Child Protection Plan (per 10,000)		
National	Northshire	Banksfield
38	42	38

Table 4 Rates of children in need and children subject to a Child Protection Plan 2012

(Source: Dept for Education, 2012)
(these are approximate figures as children move in and out of need and on and off Child Protection Plans so populations are not constant)

Within children's services there were two locality-based duty &assessment teams which held cases from initial referral for a period of assessment and four children-in-need teams which took on cases which had been assessed as requiring longer term intervention. I was able to negotiate access to one of the assessment teams which was located on one floor of a Health Centre in the village of Moorhouse about 4 miles from Banksfield. Moorhouse is a former mining community of about 12,000 people located in a semi-rural location surrounded by green land largely reclaimed from disused coal mines. The assessment team shared a large open-plan office with two children-in-need teams, a team of admin workers and a team of

Health Visitors from the local Health Authority. These teams did not just cover Moorhouse but the whole eastern half of the metropolitan borough.

The team consisted of 1 team manager, 2 senior social workers who also acted as deputy team managers, 8 social workers and 1 social work assistant who did not have a social work qualification. The team manager left shortly after I began my study and the new manager arrived towards the end of the study. I interviewed both of them and all the other workers apart from one social worker who did not make herself available. I also interviewed the senior manager who managed this team. In addition I observed 6 duty/intake sessions, sitting with the social worker who was "on duty", that is, tasked with dealing with new referrals as they came in, and a number of team meetings and 1 supervision. The duty observations took place in the team room so I was able to observe informal team talk and activity as well as the duty work. In addition, during one of my observations a suspected child abuse case was referred and dealt with. I interviewed the workers involved in dealing with this case with a focus specifically on this incident and using an improvised interview schedule. A more detailed schedule of observations made is given below in section 5.6

Banksfield, like many local authorities, funds a variety of charitable and voluntary organisations and I negotiated access to a Family Project, run by a national charity, located on the outskirts of Banksfield. This Project ran a variety of services but the one I gained access to had 3 social workers, one of them the team manager, who assessed and worked with families referred by Banksfield children's services. This was a much smaller project and during the course of my study it lost its funding and was forced to close. This meant that I was unable to directly compare the two cases. However I had by this time interviewed all 3 social workers and observed some of their meetings and one supervision. I interviewed one of them twice as I observed her being supervised after one interview and asked if I could interview her again to discuss the material that had come up in the supervision. At the time of the study, and subsequently during thematic analysis of the data, it became clear that many of the preoccupations, perceptions and experiences of these social workers addressed very similar themes to those of the Moorhouse team and I felt justified in using this data alongside the Moorhouse data. As suggested earlier, a key aspect of qualitative designs is flexibility so that the real-life contexts being studied can be followed in all their complexity.

5.6 Detailed schedule of observations and interviews

The fieldwork for this study at the Moorhouse site took place between late February and end of June 2011. A further visit was made in May 2012 to interview TM2 and to meet members of the team to inform them of my progress with my findings. During the period when the main part of the fieldwork was done TM1 retired and TM2 took her place. The bulk of my fieldwork was done during this changeover when the team was being temporarily managed by SSW1 and SSW2 with oversight from SM1. TM2 did not take up her post until late May/early June 2011 and it seemed appropriate to come back and interview her at a later date when she had been in the team for a longer time. There were no other personnel changes in the team during this time period. This was a felicitous turn of events from a research point of view as the data was enriched by my being able to interview and observe both TM1 and TM2. See section 1.4 for my key to anonymised participants.

Before beginning the fieldwork I attended two team meetings to meet members of the team and seek their consent for my study as discussed in the next section. Three team meetings were held during the period of my fieldwork and I attended them all. They took place on 22/3, 3/5 and 8/6. Each meeting lasted about 1.5 hours and took place in a glass-walled room off the main open-plan office. I did not speak at any of these meetings but did take handwritten field notes which were later word-processed (see section 5.11).

I also undertook six observations of office "duty" each of which lasted approximately four hours as recommended by Emerson et al. (1995) (see 5.11). I decided to do these observations in the mornings as the team informed me that mornings were the busiest time for referrals and moreover in the afternoons the duty worker might leave the office at times to follow up referrals with home visits or visits to other professionals. All the observations therefore took place from approximately 9 am – 1 pm. These visits took place on 17/3, 29/3, 21/4, 3/5, 27/5 and 8/6. Dates were chosen by consulting the team's duty rota and ensuring I observed a range of team members doing duty. I observed one social worker doing duty twice and four workers do it once. I sat next to the worker during the observations, occasionally following her if she went to talk to a colleague. These observations as can be seen were spread throughout the fieldwork.

I observed one supervision session at Moorhouse but decided not to observe any more as I was clearly disturbing the setting.

As well as these more formal observations I observed informally on numerous occasions. I stayed on beyond my four hour sessions of duty observation several times and I spent time in the team before and after team meetings and before and after interviews. I did not formally take field notes during these times but I did jot down handwritten notes for the diary I kept during the fieldwork and I was able to add to my knowledge of team dynamics, in particular how workers and managers communicated over cases, and to my sense of the atmosphere within the team. Some of these informal observations and feelings proved valuable when coding and analysing the data (see 5.15 for more details on my use of my diary and memos). In Appendix C Extract 1 I give an example from my diary during an early stage of the fieldwork that shows how such informal observations provided insight into the daily atmosphere and the activities of the team which is discussed in more detail in chapter 6.

On one occasion a participant made a studiedly neutral comment about an error made on a case by a colleague and then a much more caustic remark as I turned the tape off at the end of the interview which I noted. This suggested to me that the participant had, in the recording, been at pains to maintain an assumption of collegial competence (Pithouse, 1998) which she did not entirely believe (see section 9.4). As I suggest in section 9.4 such assumptions may limit how thoroughly collegial errors are analysed.

I conducted 13 full-length and 2 shorter interviews at Moorhouse, the shorter interviews being specifically about the child protection referral noted earlier. Of the full length interviews the shortest was 48 minutes and the longest 78 minutes. These took place between 2/3 and 28/6 apart from the interview with TM2 on 1/5/12. All interviews took place in the glass-walled office where the team meetings occurred. This was quite soundproof so other members of the team could not hear what was being said. Although they could see into it they could not do so from their desks – they would have to walk across the room to look in. So despite its glass walls the room felt relatively private to me and to the participants.

My fieldwork at the Family Project took place between mid-March and early June but the bulk of the data was collected between March and mid-May. At the end of April the Project found that it was to lose its funding and would cease operating by mid-summer. Much of the day-to-day work began to run down as soon as this news became known and this reduced my opportunities to gather data. One team meeting took place during this time which I observed and took field notes on. I also observed a supervision between the manager and one of the social workers on which I also took field notes. Both of these observations took place in May.

Again some informal observation took place though a good deal less than in Moorhouse. This was a much smaller team and the workers had separate offices so the opportunities to observe them were restricted.

I interviewed the three social workers in the Project – one of whom was the manager – in April. In addition I returned in early June to interview one of the workers (SW9) a second time to follow up on points I had observed during the supervision. All the interviews took place in private offices in the building

5.7 Gaining access

In many ways gaining access to the field is a practical issue (Hammersley & Atkinson, 2007). I anticipated that access to a child protection team might not be straightforward as the work is both contentious and highly confidential. There is seen to be a distrust of, or at least ambivalence towards, research and evaluation amongst front-line social workers (Everitt et al., 1992; Bilson, 2005; Dominelli, 2005) . I hoped that my status as a former social worker and as an educator of social workers would establish my trustworthiness but my initial attempts to negotiate access through former colleagues and professional contacts came to nothing. Social work takes place in bureaucratic agencies and trying to gain access as I was doing, through more junior managers, meant that even if they agreed there was a long chain of more senior managers who had to be persuaded. I then decided to adopt a more formal approach and wrote to the senior managers in a number of local authorities in the North of England that would be within practical travelling distance from my home. I was invited to meet the Head of Service in Banksfield and, having met with him and explained the purpose of my proposed study, was then invited to meet a team of senior managers. This was a vital meeting as their agreement (or lack of it) would determine whether or not I would gain access to a team. While they were rather cautious they agreed to facilitate my request. Banksfield had recently had a very positive inspection report from Ofsted and this clearly played a big part in their decision. At the time social work was still reeling from the "Baby Peter" case and a number of local authorities had experienced quickly arranged and negative Ofsted reports. My assumption was those authorities would not be interested in facilitating my study. One of the senior managers who oversaw one of the assessment teams agreed to introduce me to the team and I then had to "pitch" my ideas to them in a team meeting and they agreed to participate. Gaining access then was not a single episode but a series of agreements all conditional on the next layer down in the hierarchy agreeing. This made for a prolonged and, for me, extremely anxious process but did mean that the participants in the team were all in

agreement and (with one individual exception) cooperated fully. Hammersley & Atkinson (2007) give graphic examples of situations where researchers have been given access to organisations by senior managers but the front-line workers they actually want to study haven't been consulted and are consequently very resistant to the researcher.

Gaining access means identifying and working with gatekeepers (Hammersley & Atkinson, 2007) and the complexities of informed consent (Heath et al., 2004). In my case the gatekeepers were senior members of the organisation. When I first met the Moorhouse team I realised that I was seen to some degree as a representative of the senior manager who introduced me to the team which accentuated the sense of me being a somewhat untrustworthy outsider. She didn't attend the team meeting where I had to convince the front-line workers and I decided to put myself in a rather "one-down" position which turned out not to be difficult as I had got hopelessly lost driving to Moorhouse and arrived in an anxious state very worried I was late. I began my pitch by saying how my journey had accentuated my anxiety at meeting them and this helped enlist their sympathy. While, as a former social worker, they expected me to have some insider knowledge and expertise (a double-edged sword as I shall discuss later) I was initially able to follow Pithouse's (1998, p.184) tactic when doing his ethnographic study of a social work team of casting myself as an "acceptable incompetent" which I think helped defuse any distrust they might have felt about me as a researcher and as a "protégé" of the senior manager. As Patton (1990) argues, going into the field as a qualitative researcher means close personal contact with participants and, as I shall discuss later, this meant constantly negotiating my identity and presentation with people I hardly knew.

By contrast gaining access to the Family Project was much easier. I negotiated this through the team's former manager who was known to me and who was warmly regarded by the team. Agencies in the voluntary sector, not being statutory agencies with legal powers and working with smaller numbers of clients in more controlled situations tend to be viewed more positively and are less suspicious of potentially critical outsiders and inspectors and this was the case at this Project. They also tend to have flatter hierarchies and I did not have to see more senior managers to convince them: the Project manager, having agreed to give me access, simply contacted her senior and my access was agreed without any further ado.

5.8 Ethics

Ethical approval for the study was granted by the School of Healthcare Research Ethics Committee. Neither field site required separate compliance procedures but did look at the Ethics form that I had submitted.

Two particularly important elements of ethical approval were confidentiality and informed consent (Mason, 2002). In researching my chosen field sites I was privy to a great deal of confidential information so all possible identifying information had to be anonymised. It was important that all the participants were fully aware of what it meant to consent to being interviewed and observed. The gatekeeping and access issues discussed above meant that the participants were able to make their own minds up about participating rather than having consent given on their behalf by senior staff. All the participants said they were happy to be interviewed and observed in their daily work though it became clear that one member of the Moorhouse team was not happy and used a variety of strategies to avoid being interviewed. It could be suggested that once the team had made a decision to work with me that the more reluctant members felt they had no choice but to go along with this, particularly as the managers had all consented. Participant information and consent forms are in Appendix A

The importance of research ethics committees does not remove the need to deal with ethical dilemmas that arise during the study, indeed it has been argued that the growing power of ethics committees has reduced the management of ethics to a formula (Brewer, 2012) It is in the nature of the kind of close personal contact that my research entailed that ethical dilemmas would arise and as dealing with them is not, in fact, formulaic it is important to be reflexively aware of how well (or not) one deals with dilemmas as they arise (Hammersley & Atkinson, 2007). It cannot be assumed that because you have been granted ethical approval that you have blanket, fully informed consent (Mason, 2002; Heath et al., 2004).

I was studying professionals and while I was privy to material relating to vulnerable service users I did not have any direct contact with service users although I observed social workers talking to them on the telephone. Nonetheless I was always aware that my research did involve access to data about vulnerable people and it was important to present data respectfully and, of course, anonymously. All names of people and places have been fictionalised to avoid any identification.

Interviews of one sort or another are a relatively familiar phenomenon in our society, they have a specific beginning and end and all the social workers were used to using interviews as

part of their work. Observations are rather different and even though my observations were overt and had prior agreement participants found themselves under observation from me for quite extended periods of time when they were engaged in potentially important and stressful decision-making as well as going about their daily business generally. I made it clear that if anyone objected at any time I would stop observing but this did not happen. There were occasional jokes about being careful what was said because I was writing it down but in practice I did not detect that anyone, apart from the noted exception, felt concerned about my presence. Indeed, I was usually welcomed very warmly and made to feel comfortable.

5.9 Methods: studying talk and action

It is widely suggested (Robson, 2002; Gray, 2009; Yin, 2009) that multiple methods of data collection are used in case studies as no single method will capture the complexity of the case. Yin suggests six commonly used methods in case studies which include interviews and observations as well as other methods which I felt were not suitable for the focus of my study. This is because I wanted to use methods that were best suited to exploring the details of daily practice and the meanings participants made of them. Lofland et al. (2006) suggest a typology of data collection methods for studying social settings in which participant observation gets the researcher closest to the routines of the setting followed by data on talk in action (gathered through observation) and data on talk on action (gathered through formal or informal interviews). Case studies are not ethnography but the boundaries between them can be blurred (Hammersley & Atkinson 2007; Yin, 2009) and in developing a model of good practice for making observations and taking field notes I was inevitably drawn to texts on ethnography.

Ethnography might be defined as a study of a particular culture or setting and the way that culture is shared by a group (Creswell, 2007). The ethnographer studies the ordinary processes and routines of everyday life and tries to give an insider account of them. Hammersley & Atkinson (2007, p.3) define ethnography as “usually (involving) the researcher participating in people’s daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews.....People’s actions and accounts are studied in everyday contexts, rather than under conditions created by the researcher.....The focus is usually on a few cases, generally fairly small-scale, perhaps a single setting or group of people. This is to facilitate in-depth study” (p.3). As I wanted to gain an in-depth understanding of how social workers made

decisions in their everyday practice elements of an ethnographic approach were suitable for answering the research question.

As I have argued in the literature review my focus for this study was to get close to the routines of every-day practice and to try to uncover the contexts, the unofficial rules and the culture that shaped daily or situated decision making for the social workers and this led to a decision to use participant or qualitative observation and in-depth qualitative interviewing as my data collection methods. As I have suggested, these are the methods of choice if "especially profound and nuanced understandings" of routines and cultures are being sought (Lofland et al., 2006, p.85).

From the beginning I wanted to try and capture as much concrete detail as possible about participants' talk and action in order to produce a detailed description of the routines and culture within the cases which could then form the basis for further analysis. Description here would be of "practical, situated and lived forms of social action" (de Montigny, 2013, p. 142) rather than abstractions. Routines of talk and action may be seen as "metaphor(s) for how social order is constructed" (Silverman, 2006, p. 101) and "performed" (White, 1997b; Hammersley & Atkinson, 2007, p. 169). These actions become routines because they are regularly repeated and this repetition gives the actions "a degree of intrinsic significance" (Hammersley & Atkinson, 2007, p.169) as they repeat and sustain key aspects of the culture (Gobo, 2008) and they can take on a ritualised, liturgical (Atkinson, 1995) or ceremonial (Strong, 2001) meaning through which professionals construct and communicate their professional identities (White, 1997b, p. 179). These routines are acted out and can be observed but are also re-enacted or reconstructed in interviews. Talk and action are not completely separate as talk is action and can be observed like action as Lofland et al. (2006) argue with their distinction between talk *in* action and talk *on* action (or "interview talk" p.87) which is a reconstruction of something that has happened elsewhere spatially and temporally. It is also action because it is activity and performance through which people tell cultural stories, do identity work, explain, justify, account for themselves and attribute motive to others(Silverman, 2006; Hammersley & Atkinson, 2007) rather than give the researcher conveniently direct access to their "inner states". Treated this way, seen through an ethnographic lens, talk becomes what Hammersley & Atkinson (2007, p. 171) call "situated stories" in which even the most personal accounts are told using culturally shared formulations. As they argue (2007, p.170) "social actors *do* things with words".

As I have argued in the literature review, unofficial, local cultures play a significant role in determining social workers' actions. They also play a significant role in constructing the knowledge that is available to them. Local knowledge is constructed through the routines and rituals of the workplace and consists of a mix of lay and professional knowledge couched as moral tales (Atkinson, 1995; White & Stancombe, 2003; Scourfield & Pithouse, 2006). Through closely studying talk and action these processes may be uncovered.

From an ethnographic point of view , then, just as talk and action overlap so do the methods of participant or qualitative observation and in-depth interviewing. Certainly they are underpinned by similar ontological and epistemological assumptions: that the social world is best understood by studying the way people subjectively make sense of their worlds through their talk and action (Mason, 2002). Of course these methods will produce different kinds of data and bringing them together will help in understanding the complexity of a case in a way using a single method does not (Yin, 2009). It is useful to, for example, compare what people *do* to what they *say* about what they do. But these are, to some degree, artificial distinctions and Hammersley & Atkinson (2007) suggest that interviews can be seen as observation: the artificiality of the interview setting providing data on how people behave in different circumstances.

However, they are also different methods that require different ways of gathering and recording data.

5.10 Qualitative Observation

Participant or qualitative observation is so called because the researcher participates in the situation being studied. Gold's typology (Murphy et al., 1998; May, 2001) ranges from the observer as complete (and covert) participant (obviously impractical for my study as well as unethical) to complete observer (in which there is no participation but only detached observing as through a one-way mirror: also unsuitable and impractical for my study). His participant-as-observer (May, 2001, p.156) accords most closely to that of traditional participant observation where the observer actively participates in the setting, making his or her role explicit and seeking to form relationships with those being observed (who are usually referred to as participants or informants). However it cannot be said that I participated actively in the settings I observed so I am reluctant to use the adjective "participant". For example I sat in on team meetings but did not participate in the discussions. Of course my presence was a participation but to avoid confusion I prefer to use the term "qualitative observation" to distinguish this

method from more structured and non-participant forms of observations and allow room for the nuances of what I actually did.

Qualitative observation is a flexible method, the aim being to immerse oneself in the setting so as to understand the perspectives of the participants. It is challenging and exhausting (Emerson et al., 1995; Mason, 2002) as the researcher is on show for extended periods and must choose and maintain an acceptable persona. Observing people, perhaps developing quite close relationships with them and writing down what they say and do raises numerous issues of ethics, of informed consent (Mason, 2002) and the risk that establishing such relationships can involve “going native” (May, 2001, p.156). The great advantage of the method is that the researcher is able to observe the mundane and routine everyday activities that no other method would reveal so closely (Lofland et al., 2006) and through this gain an understanding of how social order in the studied context is created and maintained. A criticism here is that the researcher is disturbing the setting (though this is a criticism that could be levelled at more or less all social research). However Strong (2001) in his ethnography of paediatric clinics points out that, when observed, professionals still carry out the tasks they are professionally obliged to do.

Qualitative observation tends to start in quite an open fashion with general questions about what is going on, what are people doing and what am I seeing. It then begins to focus onto more specific issues identified in those beginning stages (Spradley, 1980; Silverman, 2011). This generality is rather overwhelming and focusing down is important because this enables some classification of phenomena and creates “topics for analysis (that) ultimately enable us to make social scientific sense of our observations (p.121)...an analytic scheme.....a mind-set for coding (the data)” (p.143: quotes from Lofland et al., 2006). Spradley (1980) suggests a matrix of things to look for (though as this contains 81 possible combinations it is itself rather overwhelming at first) that divides settings into spaces, actors and activities. Lofland et al. (2006) suggest a schema for breaking settings down into units ranging from small-scale practices and encounters to larger scale units at organisational level and above. This scheme was used to enable me to think of situations as different topics for observation and later coding and analysis, seeing them as for example, hierarchies, social practices, social encounters which reveal rules about how to “do” them. Gobo (2008) discusses the importance of using observations to uncover social structures and this schema was useful for this. Otherwise it would have been difficult to think about focusing. I decided that my main focus

were small-scale episodes, practices and encounters, usually verbal, and I concentrated on trying to record the talk produced in these social units as verbatim as possible.

Central to qualitative observation is the taking of field notes. Emerson et al. (1995) distinguish between the raw "scratch" notes taken "in the field" and the more polished versions written up later which appear in the finished study. Field notes often accord to one of several well established styles (van Maanen cited in Emerson et al., 1995) and these reflect the choices researchers make in how they write up their observations. They are bound to be selective – partly because it is impossible to write down everything that is going on in any situation so choices must be made about what to focus on and partly because they are narratives, reconstructions of the world: fictions not neutral mirrors (Geertz, 1973; Emerson et al., 1995). When Lofland et al. (2006, p.113) say "Your goal in writing fieldnotes should be simply to get detailed descriptive accounts on the page" they are not suggesting these descriptions will be neutral and objective but that they will be concrete in their detail, they will be separated from the researcher's thoughts, hunches and feelings and the researcher will have an explicit model for note taking which others can judge.

From a reading of key texts I developed a model for taking field notes based on Spradley's (1980) three principles:

(i) using participants' language as much as possible. Emerson et al. (1995) recommend getting down fragments of talk and action that serve as focal points for coding and analysis.

(ii) making a verbatim record (and clearly identifying where you have had to paraphrase) and

(iii) describing situations in concrete, specific detail with as little generalising gloss or social science abstraction as possible. Emerson et al. recommend avoiding assigning mood, motive or other "psychologised explanations" (1995, p.33) although Lofland et al. (2006) point out that participants' statements and beliefs should be noted (*as* beliefs rather than explanations).

The aim is to produce what Gobo (2008, p.206) calls a "thin" description that tries to avoid interpretation, generalisation and abstract language as much as possible. Reflections, thoughts, feelings, analytic hunches should be written down but kept separately.

These notes should be taken contemporaneously if possible (Spradley, 1980) and then written up as promptly as possible more fully as contemporaneous notes will almost certainly contain abbreviations and *aides memoires* (Lofland et al., 2006)These fuller notes are time consuming, especially as the researcher may be tired after hours of observing but once written up they preserve fleeting actions and talk and can be coded and analysed like any research data. This data – drawn from observing people do their daily work and from talk-in-action – is that which, Lofland et al. (2006) argue, gets the researcher closest to the day-to-day routines and activities I wished to study.

5.11 Doing the observations, being an observer

As I have said I drew up a model of good practice for taking field notes based on some of the key methods texts. I tried to keep observations as descriptive, concrete and detailed as possible and, as far as I could, to capture participants' talk verbatim. I had to paraphrase at times but key phrases would stick in my mind and I would write them down. An example was the discussion of the "not grandma" in a team meeting, a very suggestive phrase that was useful in shaping some of the ideas emerging for me about the relevance of the "new" sociology of the family in exploring how the social workers thought about the often fragmented and unconventional families they were dealing with. I was also able to record verbatim phone conversations the social workers were having as I could write while they paused to listen to the person at the other end. In this way fleeting moments of talk were preserved which I could come back to. Language is "the primary symbol system that encodes cultural meaning" (Spradley, 1979, p. 99) and here I had talk-in-action in participants' own words. After one or two rather confused observations where I cast around for a focus I decided that my main focus were small-scale episodes, practices and encounters (Lofland et al., 2006), usually verbal, and I concentrated on trying to record the talk produced in these social units as verbatim as possible. This process of finding a focus after a rather generalised start to the observations is usual in participant observation (Spradley, 1980).

I initially produced a template for taking field notes based on some of the texts that influenced my thinking but I quickly jettisoned this as it lacked the flexibility I found I needed and I did not use a template at all but hand-wrote in freestyle and then word processed the notes verbatim. Hunches and feelings were kept separately. The word-processed field notes could be commented-upon, or tagged, or coded like interview transcripts.

Of course my observations, and the field notes which stand as the inscribed records of the observations, are not objective descriptions any more than interview transcripts are objective windows into participants' true feelings. They are accounts of social actors acting in contexts and can be coded and analysed to draw out themes and patterns of talk and action just as interview transcripts can be.

A common criticism of observation is that the observer disturbs the setting but again this is not dissimilar to the artificiality of the interview: if "objectivity" is discarded then observations, like interviews, provide data on how people behave in certain situations. As I previously noted, Strong (2001) in his ethnography of paediatric clinics points out that when observed professionals still carry out the tasks they are professionally obliged to do and the social workers I studied were busy people with heavy caseloads. I was well aware that my presence disturbed the team settings when I was observing but there was a process over time where the social workers did become to some degree used to my presence though I would not be naive enough to suggest they forgot about me or treated me as an insider. I observed one episode of one-to-one supervision at Moorhouse but my presence here was so clearly disturbing the setting, and the quality of data I gathered was so poor (at one point one of the participants turned to me and said "what do you want us to talk about now?" !!), that I did not do any others there though I did do one at the Family Project which, although again my presence was clearly disturbing the situation, provided me with valuable material to use in one of my interviews there.

Emerson et al. (1995) suggest that for the beginner four hours observing is enough and I found that after this time I would be very tired and the quality of my recordings would deteriorate. The texts I used all emphasised the importance of writing up the hand-written or "scratch" field notes as soon as possible so I would, as much as I could, word-process these on the same day. It was brought home to me forcibly how tiring and time-consuming the process of observing and recording the observations is.

Part of the tiring and demanding nature of the method is that the observer is on show all the time and the participant nature of the method meant that I was constantly having to think about how to respond to casual talk. I would be asked, for example, what did I think about a programme on television the night before, what my experiences as a social worker had been and even what did I think should be done about a tricky referral. I would try to give away as

little information about myself as possible while trying to be friendly and approachable. This was not easy but I had expected this kind of challenge and even welcomed it as part of the process of becoming a researcher so the meaning of such challenges for me was such that I saw them in a positive light. As the participants knew I had been a social worker my initial character as an "acceptable incompetent" became unsustainable as I was expected to show some expertise as an academic and former social worker. This sense of being a bit "inside" as well as an outsider was an uncomfortable position. I was always aware that I was a marginal figure, having to think carefully about my every action and statement and I am sure this contributed to the tiring nature of the observations. There was always some relief at getting into my car and setting off home, often tinged with guilt that the participants were still at work. Being to some degree an insider can be problematic as some degree of shared understanding may be assumed by the participant (Miller & Glassner, 2004). I got some odd looks and found it slightly uncomfortable when I asked participants to explain some pieces of social work jargon the meaning of which they assumed I already knew.

Which brings me to the well documented risk of "going native" (Bryman, 1988; Murphy et al., 1998). It would have been extraordinary if as an observer I had not been vulnerable to this risk: the people I was observing were doing a difficult job, one I had done myself, and whose professional culture I was not unfamiliar with. As Murphy et al. (1998, p.111) argue "(t)he line between empathetic understanding and going native is a fine one" – suggesting that if the observer does not at least flirt with going native then (s)he is not getting close enough to the participants for the kind of rich data (s)he wants and runs the risk of too much detachment which means (s)he is unlikely to gain an insider viewpoint. The answer for me was to come back to my observations after a good break from the field, carefully read all the field notes and analytic memos and identify areas where there seemed to be evidence of having "gone native". As I will suggest later there is perhaps a similar issue when transcribing interviews away from the field when the (lone) processes of transcription, coding and analysis transform the interview material gathered in (albeit artificial) social interaction into data for analysis.

5.12 In-depth qualitative interviews

My second data collection method, and the one which produced the bulk of my data, was qualitative interviews.

Qualitative interviewing may be semi- structured or unstructured (Mason, 2002). Semi-structured interviewing would enable me to shape to the interview around the key concepts in

the research question with a “shopping list” of topics and questions whilst retaining the flexibility of sequencing and wording questions differently for different participants and being able to use probing, prompting and follow-up questions (Legard et al., 2003) to give participants space to develop ideas and themes they considered important. This format is suited to exploring existing theories while allowing unanticipated themes and concepts to emerge. Hammersley & Atkinson (2007) cite Dexter’s comment (p.118) that interview questions that are too sharply defined are likely to result in the omission of important data which the researcher has not foreseen. The balance between deductive and inductive theorising is thus facilitated.

As I have suggested, qualitative observation and qualitative interviewing have similar ontological and epistemological assumptions: that gaining access to the views, experiences and perceptions of participants – the meaning they make of the situations they are involved in – is essential for understanding what is going on.

While interviews are further removed from the everyday routines of action they provide another avenue for exploring the insider viewpoint by gathering participants’ reconstructed accounts of social action: reconstructions which are themselves a form of social action (Carter & Little, 2007)

As with the observations I designed the interview schedule based on a reading of some key texts but also on previous experience of carrying out interviews for a small piece of research at Masters level. My intention was to design a series of main question areas which would act as “scaffolding” for the interview (Rubin & Rubin, 2012) These were “content mapping” questions (Legard et al., p.148) designed to cover the main areas I anticipated would be important themes following my initial literature review and drawing up the Construct Validity table (see Table 6). These needed to be couched in language that would encourage participants to talk and I wanted as much as possible to design the questions so that participants could answer them based on their own experiences rather in general, abstract terms as questions designed to enable participants to draw on experience are much more likely to produce rich and detailed data (Charmaz, 2006; Rubin & Rubin, 2012). Interview questions need to have both a thematic and a dynamic purpose (Kvale, 2007).

Alongside content mapping questions were subsidiary questions designed for “content mining” (Legard et al., 2003, p. 148). These were probing, prompting, follow-up questions designed to encourage participants to expand on their accounts, to add depth, detail and nuance to the

breadth which the content mapping questions were designed to produce. I tried to avoid "why" questions (Patton, 1990; Rubin & Rubin, 2012) and ask what Patton (1990) calls "when", "who", "where", "what" and "how" questions which are designed to encourage exploration and amplification. I was also concerned that "why" questions might make participants feel they were being interrogated and I was anxious to avoid this. This was particularly important when I conducted some shorter interviews with the social workers involved in a child protection referral I observed.

Interviews are social encounters. They are "conversational partnerships" or "extended conversations" (chapter headings in Rubin & Rubin, 2012) in which it is important to establish a rapport or empathetic respect that encourages participants to talk in detail and depth whilst maintaining a neutral, non-judgemental position regarding what they say. Silverman (2011) suggests that this does not require any special skills as "active listening" (Hammersley & Atkinson, 2007; Kvale, 2007), attentive body language, going "mmmmm" and so on are the normal skills of everyday conversation. I would suggest though that in an interview these skills do need more conscious thought than might be employed in everyday talk. The interview may be a form of conversation but it is a very particular and peculiar one, that is being recorded for a specific purpose and which requires the interviewer to show both rapport and neutrality (Patton, 1990). These are not a set of conditions likely to be reproduced in much "everyday" conversation. They do, however, accord with the skills social workers are encouraged to use when interviewing service users and this, plus the fact that we live in a society where interviews in various forms are common, gives the method a certain familiarity to both interviewer and interviewee.

The nature of interviews as social events affects the nature of the data they produce. Silverman (2006, p.137) argues that "interview talk" always reveals that participants are doing "identity work" (how the participant presents themselves to the interviewer, or what Goffman (cited in Murphy et al., 1998, p.118, calls "impression management") and telling "cultural stories" (locating their narratives within prevailing cultural ways of understanding the phenomena under discussion). Sheppard (Sheppard, 2004) suggests that what participants in interviews are doing is creating meaning – constructing a story that gives a particular perspective on the world, one that enables them to make sense of it. And this meaning-making is taking place in a social encounter which will affect the nature of the participants' responses. Much depends then on the relationship between interviewer and participant: had I been undertaking an inspection of the quality of children's services I would surely have got

very different responses. Just like the participant observer, the interviewer has to give a good deal of thought to the persona they are going to adopt (May, 2001).

As I suggested earlier, interview data seen through an ethnographic lens may be treated as culturally situated stories. Rather than seeing participant accounts as "the truth" they may be seen as multiple versions of a social reality whose complexities the researcher is only slowly and imperfectly learning about in an emergent way. There are different traditions of viewing interview data: is the knowledge a "given", valuable stuff waiting to be collected during the interview or is it something constructed during (and after) the interview through processes of construction, reconstruction and interpretation in which both participant and researcher play a part? (Mason, 2002; Carter & Little, 2007; Silverman, 2011).

5.13 Doing the interviews

I devised a semi-structured topic guide (Appendix B) designed to explore the themes and concepts drawn from the literature review and listed in the construct validity table (see table 6 at end of chapter) but with enough flexibility to allow for other themes to emerge.

Some time prior to the interview I gave each participant a copy of the opening question in the topic guide which asked them to choose a particular piece of decision making from their experience so they could prepare (see Appendix B for the full question).

This opening question had a number of functions. It was designed for both breadth and depth. In many cases participants launched into quite extensive narratives so that this section of the interview could feel almost like an unstructured interview but I also had an armoury of probe and follow up questions to encourage participants to go into more detail or to focus them on areas of their narrative that seemed particularly relevant. However, I had to be careful not to interrupt or force these narratives but allow them to unfold and, often, to go in directions I did not anticipate. It was not unusual for this opening question, with all its associated probes and follow ups to take up half the total time of the interview. Initially I could get quite anxious that the participants' accounts were too long or were losing focus but over time I learned to relax and allow them to unfold as, once I began to transcribe the first interviews, I realised what rich and nuanced accounts these were.

I was able to add to or amend some of the topics in the guide based on what I had observed in the team, particularly regarding the ubiquity of the IT systems and their central place in the management of referral data and the writing up of case notes and the high levels of informal

team talk. The time I spent observing also had the effect of creating rapport before the interviews began and I think that this is reflected both in the richness of some of the data and that participants felt able to discuss some quite difficult and not always successfully managed case examples.

I also conducted two shorter interviews prompted by my observation of how a child protection referral was dealt with. This was an example of theoretical sampling (Mason, 2002): focusing strategically on a situation within the wider case for theoretical reasons in order to examine the decision making processes that took place. In this case a Health Visitor phoned the duty worker I was observing to report a bruise on a small child. I observed how the duty worker initially dealt with this situation. It required two workers to make a home visit and accompany the child and his mother to hospital for a medical. I asked if I could interview the workers involved and conducted two interviews of approximately 30 minutes each, one with the duty worker I had observed and her immediate manager and one with one of the two workers who had gone out on the visit/medical. I was very careful to restrict my questions to very neutral and descriptive ones and made it explicitly clear that I was not doing the interviews in order to judge the quality of their decision-making but to get more information on the process of decision making they had gone through.

5.14 Data analysis in qualitative research

Qualitative research typically produces a huge amount of data which cannot be reduced to numbers as in quantitative studies.

While there may not be universal rules for coding and analysing qualitative data there are some very common themes. A first stage is "data handling" (Coffey & Atkinson, 1996) in which the mass of data is sorted, organised and manipulated into themes and categories through coding. This is an important step in organising the great mass of data that has been gathered and this organising renders it suitable for "generating concepts" (Coffey & Atkinson, 1996). Miles & Huberman (1994) see data reduction or data condensing as an important step here. Only then can "the imaginative work of interpretation" (Coffey & Atkinson, p. 6) take place.

However this may be too linear a model. Spencer et al. (2003) argue there is an "analytic hierarchy" (p. 212) from collecting raw data through to final explanatory and theoretical accounts and the researcher often moves up and down it rather than starting at the bottom and proceeding in an orderly way to the top. Analysis is a cyclical, iterative process (Coffey &

Atkinson, 1996). Collecting a lot of data without some preliminary organising and analysis going on alongside it runs several risks (Coffey & Atkinson, 1996; Silverman, 2006; 2011): preliminary analysis helps shape subsequent data collection so that emerging themes can be addressed as in grounded theory approaches (Glaser & Strauss, 1967; Charmaz, 2006) and without any preliminary analysis the researcher is likely to be left wondering what to do with all the data that has been gathered. An invaluable tool is the analytic memo in which hunches and thoughts are written down and the process of thinking conceptually about the data can begin (Coffey & Atkinson, 1996; Charmaz, 2006; Lofland et al., 2006; Birks et al., 2008; Corbin & Strauss, 2008). Another tool is drawing up diagrams or matrices (Miles & Huberman, 1994; Lofland et al., 2006) in which the often complex interrelationships between elements of the data can be visually expressed. I made a great deal of use of such tools, particularly memos, and found them very useful in developing analytic ideas alongside data collection, transcription of notes and interviews and coding. I discuss the use of memos in more detail and my fieldwork diary in the next section.

An essential part of data handling or data management is coding or indexing (Mason, 2002; Ritchie et al., 2003; Gibbs, 2007) – tagging pieces of text with codes for ideas and themes. Similarly coded data across the dataset can then be retrieved and compared and themes within the data brought out. Much qualitative research mixes deductive and inductive reasoning, moving frequently between data and theory (Blaikie, 2009). Having an initial list of codes drawn from the literature review provides a useful framework to start with but more inductive coding is also required as themes emerge from the data (Ritchie et al., 2003). Initial codes often stick descriptively close to the data before becoming more abstract and when I began systematically coding my data I tried to keep as close as I could to the rich detail of participant accounts. I will discuss this process in more detail later.

A choice to be made was whether or not to use a computer program for coding and organising the data or do it by hand. I chose the latter for reasons I discuss later.

The data that has been gathered should be very detailed and should capture the complexity of the situation and the range of participant meanings (Mason, 2002). Coding splits the data up but should facilitate recombining it in such a way that fresh concepts are generated and themes and categories and higher order analysis are developed (Dey, 1993). At every point the researcher is making decisions about how to condense, order, interpret and recombine

the data and these stages should be explicit in the thick description so that a clearly auditable chain of evidence can be seen and judged by the reader (Mason, 2002).

5.15 Using a fieldwork diary and analytic memos

I kept a fieldwork diary in the form of handwritten notes throughout the fieldwork phase of the study. In the early stages of the fieldwork the diary was a valuable tool for jotting down my feelings – particularly my anxiety that I avoid doing anything that might jeopardise my hard-won access and my initial thoughts about how to think about this new environment in a way that would help me structure my observations. The field diary has a different role from field notes taken during observations – it can provide a vivid, un-sanitised record of the researcher's feelings and struggles and thus contribute to a reflexive account of the research (Punch, 2012). It also helped me to keep a record of my learning as a researcher. In Appendix C I have provided several extracts from my diary. Extract 1 has been discussed above in section 5.6. Extract 2 is a very early entry which vividly portrays the anxieties I was feeling at the beginning of the fieldwork. Extract 3 was written after a team meeting where some of the team's frustrations were shared with me and I reflected on the dilemmas of becoming accepted. These extracts show my preoccupation, in the earlier stages of the fieldwork in particular (though the preoccupation never left me), with learning to cope with the pressure of being a researcher spending a relatively extended period of time "in the field" in quite close contact with participants. Extract 4 was written a month after extract 2 and shows that I have begun the process of really thinking about my observations. This extract, which has me reflecting on the importance of routines and taken-for-granted activities in revealing the social rules of the setting, is influenced by Lofland et al (2006) and is more like an analytic memo. I think it clearly shows the development of my thinking about how to understand the forms of social action I was seeing and was an important early step in developing my analysis. It also shows that as the fieldwork progressed the diary became less impressionistic and more reflective – I made less entries into it and made more use of analytic memos.

In section 6.2.2 I include an extract from a field note taken during an observation of a team meeting and my associated comment. Here the use by team members of the phrase "not grandma" was particularly useful in developing my thinking about the complex, unconventional nature of many of the families and the sociological theories that might be of relevance in understanding them. This developed into a key area for discussion within the thesis and also in a journal paper I have written (Saltiel, 2013).

In section 5.14 I have briefly discussed my use of analytic memos as a way of thinking about the data. Glaser & Strauss (1967) described memo-ing as essential in developing ideas and building theories about the data and, following them, grounded theorists have provided particularly useful discussions of their importance (Charmaz, 2006; Corbin & Strauss, 2008; Charmaz, 2014). Birks & Mills (2011) stress that *how* you take memos doesn't matter so long as it works for you but their golden rule is that you *must* do so. Dey (1993) makes similar points: write them on the back of an envelope if you like but write them! Whether they are imaginative leaps or pedantic notes doesn't matter – they all contribute to rich analysis (Dey, 1993, p. 89). Charmaz (2014) argues that memos are a crucial step in moving from data collection to analysis and prompt the researcher to begin analysis early in the research process. As the study progresses memos are likely to become denser and more analytical (Corbin & Strauss, 2008). Dey (1993) emphasises that they must link to the data they comment upon. I word-processed all my memos and gave them titles that linked them to particular interviews or observations and I also noted relevant memos when adding review comments and tags to the word-processed transcripts and field notes

I had been keeping such memos from the start (I used them to complement field notes for example, following advice to keep all such material separate from the descriptive material in the field notes themselves). But it was when I began to use memos during transcription to comment in detail on the transcripts – noting thoughts and hunches, identifying key quotes, comparing themes across interviews – that they really came into their own and these detailed memos formed an invaluable bridge between coding and analysis when I came to that stage. These memos particularly focused on two areas: where I drew out connections between the interview data and key literature and where I made comparisons across the interviews. In Appendix D I include some examples of these memos and comment on how they underpinned my thinking about certain themes emerging from the data or confirming findings in published literature. While not all the themes and ideas emerging from these memos are represented in the final thesis many are there and the memos provide evidence of the manner in which my thinking developed from the data.

5.16 Managing and analysing the study data

All field notes were word processed and all interviews transcribed verbatim. This gave me something in the order of 220 pages of text which could be coded. I made a decision early on in the process of coding and analysis that I would not use a computer programme (NVivo was the one available to me) to code my data. This was not because of any technophobia on my

part: I could see how useful it could be but NVivo is a very complex program which would take a lot of learning that might distract me from coding and analysis so I decided that the search and comment functions in my word-processing program were sufficient. I did experiment with creating codes (or nodes) in NVivo but then decided to code everything by hand as this seemed a better use of my time and would enable me to really immerse myself in the data. It is noticeable how many authors, while using CAQDAS programs still advocate use pens and paper. Ritchie et al. (2003, p. 220) and Ziebland & McPherson (2006) both point to the advantages of using a really big sheet of paper to note down codes, emerging themes and their interrelationships in one big diagram so everything can be seen holistically. Miles & Huberman (1994) and Lofland et al. (2006) similarly find diagrams useful because they can represent the complex and non-linear nature of the webs of interrelationships that emerge from qualitative data analysis. I found these examples very useful in ordering and making sense of the data. They emphasise the importance of *local,* context-bound factors in causality: whatever wider social and historical factors exist it is local factors in the here-and-now of a particular setting that make things happen (Miles & Huberman, 1994; Pawson & Tilley, 1997).

I paid someone to transcribe two early interviews because I wanted the transcripts quickly to inform future interviews but I then transcribed the rest myself and wished I had not paid for the two early transcripts partly because they had a number of errors in them but also because I realised that transcribing is absolutely the best way to get to know the data in depth. Transcription was time consuming and sometimes tedious but richly rewarding.

I was struck by the way the data is transformed by the act of transcription. As I have said interviews are social encounters and the interview is constructed within that encounter but transcription is a lonely business – not only are you alone but, hunched over the keyboard with a pair of headphones on, you are fairly isolated from the world. Shorn of the social-encounter element the data now often took on a completely different meaning. It became *data* rather than the words of one or other of the participants and this acted as a valuable corrective to the risk of “going native” and, alongside the memo-ing, created for me what Lofland et al. (2006) call a “mindset” for coding and analysis.

I wanted to be able to code for both *anticipated* and *emergent* themes (Ziebland & McPherson, 2006) and thus strike a balance between looking for the themes identified in my literature review and emergent themes. Miles & Huberman (1994, p.58) recommend “creating a provisional ‘start list’ of codes arising from the literature review whilst also recommending

more inductive coding. Ritchie et al. (2003) use a thematic framework which allows for this mix of deductive and inductive analysis and also describe an "analytic hierarchy" which emphasises a stage of staying close to the data while coding in order to draw out emergent concepts before beginning to develop higher order descriptive and then explanatory accounts.

Burnard's (1991) steps in moving from initial thoughts to open coding and then to more focused and thematic analysis provided a useful step-by-step guide. Charmaz (2006) advocates open coding which arises from a close reading of the data before moving to more focused or thematic coding. She also advocates avoiding coding categories that are too abstract and general (eg coding for "stress") and using codes rooted in concrete detail and action and I tried to follow this recommendation in order to keep codes grounded in the settings I was studying and avoid, at this stage, imposing social-scientific concepts and abstractions although I was, as stated above, making some initial conceptual thinking. This grounding of data in the concrete specifics of the situation was, as I have said, also an important element in the taking of observational field notes

The key aim when coding initially was to keep close to the data with as few preconceptions as possible and my initial codes (using the "Comment" function in Microsoft Word so all coding was saved electronically even though I did not use CAQDAS) were very descriptive and data-driven (Gibbs, 2007) Words and phrases were tagged, actions highlighted and, as far as possible, *in vivo* codes that kept participants' words and meanings were used. I then grouped descriptive codes into a number of categories and highlighted these codes and categories across the dataset. Codes based on *a priori* concepts and theories came in at this stage. This involved a lot of synthesis of data across transcripts and field notes, frequent referral to analytic memos I had written and a constant movement between theory and data (Mason, 2002; Blaikie, 2009)

This was a time consuming process. What I was aware of was that while the coding was breaking the data down into chunks or fragments that were tagged with codes the grouping together of codes into wider categories was *recombining* the data but in a new way that generated new ideas and concepts. This breaking down and recombining or reconnecting data is a regular feature of models of coding and analysis and is useful in developing fresh thinking (Dey, 1993; Coffey & Atkinson, 1996)

These themes came together into four overall themes which I initially gave descriptive titles which then became more theoretical as analysis developed. The data chapters in this thesis

are organised into these four themes which corresponded to the set of concepts set out in the construct validity table (Table 6 at end of chapter) thus extending the chain of evidence further. The numbered concepts can be found in Table 6.

Theme 1 **The Nature of the Cases/A Day in the Life (became** **The Nature of the Work and the Nature of the Cases: mapping complexity and uncertainty)**	**Construct Validity Themes** **1,2,3,5,7,8,9,11,12,13,14**
Theme 2 **How Social Workers Responded to The Cases (became** **Case Decision Making in Practice)**	**Construct Validity Themes** **1,2,3,4,5,6,7,8,11,12,13,14**
Theme 3 **Management & Supervision**	**Construct Validity Themes** **1,2,5,6,7,8,9,11,14**
Theme 4 **Knowledge For Social Work** **(became** **The Nature and Construction of Knowledge for Social Work Practice)**	**Construct Validity Themes** **1,2,7,11,14**

Table 5 The four key themes

But within the themes were many subthemes which had not been initially anticipated which emerged out of the richness of detail in the data. So, in Theme 1 there was the focus on the nature of the families and the social workers' lack of theoretical models to make sense of them (Saltiel, 2013). In Theme 2 the complexities and uncertainties of the cases discussed in depth caused many subtleties to emerge about the situated nature of decision making and the troublesome sources of the knowledge the social workers used. In theme 3 there were the subtleties of the social encounters between social workers and managers and how these were artfully negotiated – subtleties that suggested a rich mix of official and unofficial processes. In theme 4 the troublesome and contested sources from which workers drew their day-to-day knowledge was returned to and the ways in which this knowledge was reconstructed in daily practice. The importance of this grounded, local material in understanding what is going on fits with Miles & Huberman's (1994) model of causality that highlights the importance of local, context-bound factors, whatever wider social and historical factors may be at work, making the researcher ask constantly *what is going on here and now?* Coffey & Atkinson (1996) argue that good analysis is always grounded in local data but may generate ideas that are relevant beyond the local setting. And this would seem to exemplify Mason's argument that

qualitative research “can provide a detailed, contextual and multilayered interpretation which is unlikely to simplify or caricature developmental processes” (2002, p. 175).

While the overall shape of each theme was related deductively to existing literature a good deal of the content and detail of each theme was emergent, inductively reasoned and required a rethinking of some elements of the literature review to link emergent themes to existing theories. An example of this was the relevance of writings on the “new” sociology of the family in providing a theoretical analysis of some of the data emerging about the kinds of families the social workers routinely dealt with. This material was absent from my initial thinking but became an important topic in the discussion of findings. This constant movement between data and theory facilitated by the flexibility of the qualitative case study method forms an important element in the thick description of this study.

As the themes took shape there was a constant temptation to force emerging data into them or to dismiss it if it didn’t fit and I had to make myself go back to the data again and again and ensure that it was included and the boundaries and shape of the themes remained flexible. This continued the process suggested earlier when discussing transcription: the increasing separation of the data from the social encounters that produced it. While it was important to keep a sense of those encounters because they formed part of the context of the study it did enable me increasingly to see the data more analytically. There had been moments both during the observations and the interviews when participants told me what they had done with cases and I found it difficult not to respond (internally) by thinking I would (or wouldn’t) have done it like that but once immersed in analysis I found it much easier to treat these stories as participant accounts which provided me with useful data.

As well as keeping the themes flexible it was important to step back and see them overall and how they fitted the research question, which I tried to reproduce in a memo (reproduced in figure 2). This began the process of a further move up the analytic hierarchy by further condensing the themes in order to move from a descriptive to an explanatory account:

Findings I: The Nature of the Work and the Nature of the Cases: mapping complexity and uncertainty	Findings II: Case Decision Making in Practice	Findings III: Management and Supervision	Findings IV : The Nature and Construction of Knowledge for Social Work Practice
What was the nature of the cases the social workers had to deal with? How might this have affected the ways in which they worked with and made decisions about them?	What were the ways the social workers conceptualised, dealt with and made decisions about the cases?	What were the perspectives of the social workers and their managers about their supervision and day-to-day management? How might this have affected the way they made decisions?	What was the knowledge that informed the social workers' practice? Where did it come from? How was it constructed in practice? How might this have influenced the ways in which they made decisions?

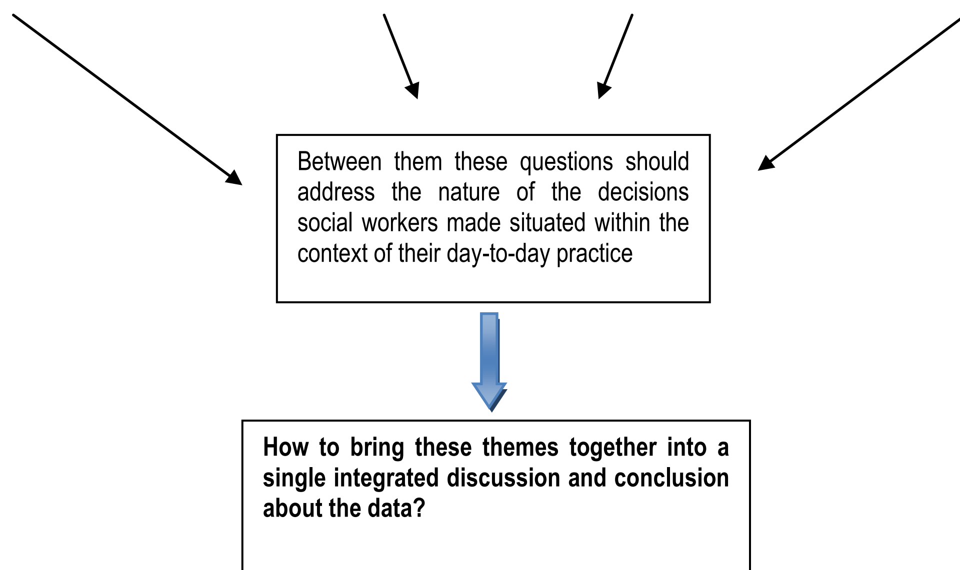

Figure 2 Bringing the four themes together

The final process involved a further condensation of the themes into a series of summaries which proved an important step in identifying higher order thematic categories which might lead to substantive theorising and explanatory accounts. This meant going over the data again and again steadily reducing or condensing it until the key patterns stood alone and could be brought together both verbally and visually as a diagram in the final discussion and conclusion.

This was not always easy as qualitative data, however much it is ordered and condensed, remains unruly and refuses to fit neatly into neat theoretical boxes. I came to realise that that it is the richness and nuance of detailed, local data and the slow, patient analysis of that detail

that creates new ideas. The validity of these ideas and interpretations rests on the transparency of the audit trail, the appropriateness of the methodology, reliable and accurate methods and a thick description that demonstrates the validity of the researcher's interpretations. Good analysis seems to come from a rigorous organising and classifying of the data in order to render it suitable for interpretation and explanation with the imaginative art of interpretation arising out of this process of rigorous organisation: as Coffey & Atkinson put it (1996, p. 10):

> *Analysis is not about adhering to any one correct approach or set of right techniques; it is imaginative, artful, flexible and reflexive. It should also be methodical, scholarly and intellectually rigorous.*

This chapter concludes with a table demonstrating the study's construct validity (Yin, 2009) showing how the research question was developed from the concepts arising from the literature review and then operationalised by the use of specific data collection methods designed to produce the sort of data that would enable the research question to be answered:

5.17 Construct Validity table

Overall research question	Specific concepts for study as identified in the literature review	Operational measures and use of multiple methods	Interview topic guide	
			Questions	Associated concepts (see column 2)
How do social workers form judgements and make decisions about child protection within everyday working contexts where those contexts may be marked by significant degrees of stress, complexity and uncertainty? Having made those decisions do they revisit and rethink them? Sub-questions: How do social workers manage the contested definitions of child abuse? How are risk factors and strengths in families conceived and ranked in everyday practice? What new information might change the way risks and strengths are conceived and ranked? How does the emotionally demanding nature of child protection work affect decision	1.Intrinsically ambiguous and socially constructed nature of child protection. 2.Situated moral reasoning 3.The "Rule of Optimism" 4.Significant disagreements between professionals 5.Pros and cons of rapid, often intuitive decision making 6.Need to revisit decisions more deliberatively 7.Nature of social workers' knowledge 8.Sufficiency or insufficiency of available information on child 9.Nature of decision making in team contexts 10.Issues raised by increasing use of structured aids to decision making 11.Use of sense-making, localised, unofficial rules and customs	Interviews Interviews Interviews Interviews. Observations of meetings and team work Interviews Interviews Interviews Interviews. Observation of meetings & team work Interviews. Observations of meetings and team work Interviews. Observations of meetings and team work Interviews. Observations	**The Critical Incident:** Please tell me about the critical incident you have selected: Prompts to use during this phase of the interview: Can you tell me what happened? What decision did you take? Was this decision supported by your manager? By your colleagues? What emotions/feelings did you have at the time? What were the key factors influencing your decision? What were the key risk factors and strengths and how did you rate them in importance (e.g. high risk/low risk/positive strength)? Did any new information cause you to re-evaluate your assessment of risks and strengths Discuss whether or not the case involved assessing "significant" harm – how easy is it to decide whether or not harm is "significant" ? Do other colleagues agree on this definition or is there a range of views? Can you give an example of this? In retrospect was the decision the best one or would you now make a different decision? **More general issues:** How are decisions	This opening question and associated follow-ups was designed to address all the specific concepts

making? How do workload levels and pressure on time affect decision making? How does localised context and team culture affect decision making? How does the nature of team support and supervision affect decision making? Does the contested nature of definitions of child abuse result in disagreements between professionals? If so what is their nature?	12.Pressure of work. High workloads. 13.Emotionally demanding nature of the work especially with families with complex and enduring problems 14.Use of language through which judgements and decisions are made	Interviews Observations Interviews. Observations of meetings and team work Interviews. Observations of meetings and team work	made in your team? Do you find you have to make decisions rapidly? What if you do not have all the information you need at the time? How do you review or revisit the decisions you have made? In what ways are decisions affected by team dynamics and relationships? Follow up questions about team culture and communication: seating arrangements, desk space. What are the key words you would use to describe the team? What do you find useful/not useful about the supervision you get? To what degree are your decisions influenced by your training? Academic research? Practice wisdom and experience? The views of your manager? The views of your colleagues? Probes about stress: issues of stress in the work. How does this affect you? One team member has had a client accused of murder: this seems to highlight issues of safety and security in the work. How has this affected you? Can you give an example? Questions about IT and computerisation? How does it affect your work? Do you find it easy/useful to use?	Decision making questions: 1,2,3,4,5,6,7,8, 9,10,11,14 Team culture/communication questions: (I added to this topic following observations) 1,2,3,7,8,9, 11,14 Supervision questions: 1,2,5,6,7,14 Questions on knowledge and decision-making 1,2,5,6,7,8,9,11 Questions on stress: 11,12,13,14 (I added to this topic following observations) I added this topic following observations: 7,8,10

Table 6 Construct Validity table

CHAPTER 6: FINDINGS I - The Nature of the Work and the Nature of the Cases: Mapping Complexity and Uncertainty

6.1 Overview

This chapter examines the day-to-day context in which the social workers' practice was embedded. Parts of this chapter can be read as a descriptive account, and this is deliberate as it is the intention to provide a detailed account of the context of the work. However its purpose is to move beyond description to map out the elements of uncertainty and complexity that shaped the social workers' practice.

There are two elements to this context. One is the ways in which the workers went about their business in the office and elsewhere. The account of their work within the office is based partly on data drawn from observations of team meetings and of office "duty" sessions where new referrals are dealt with by the "duty" social worker. This is a vital stage of decision making, where cases are initially assessed, and which formed the main focus of the observations undertaken for this study. Only the local authority team did duty: it is not a part of the voluntary team's work as their referrals all came from local authority social work teams. The other locus of their work (and another vital area where decisions were made) took place in families' homes. These home visits are an essential element of social work practice. They were not directly observed and data is therefore exclusively drawn from the interviews.

The second element is the particular nature of many of the families who the social workers worked with. The cases discussed here are often complex, unstable and difficult to understand with any degree of certainty. Much of the knowledge and information produced about them is contested both by the families and by the professionals who work with them. The data for this section is drawn from observing social workers dealing with cases on duty and from the interviews. Some additional interviews were carried out with several workers involved in dealing with a case of suspected abuse: a case which I observed being managed on duty.

Uncertainty and complexity are ineradicable elements of child protection work (Munro, 2008; 2011) and this chapter attempts to map the key elements of this world: to examine the factors that create such uncertainty and complexity and the strategies the workers used to make sense of them. The factors highlighted here are the working practices within which they gathered information and made decisions and the nature of the families who were the

subjects of those decisions. The factors that shape decision making are situated in and influenced by practice contexts and so an understanding of that context is essential.

6.2 The Nature of the Work

6.2.1 The day-to-day background

The team worked in a large open plan office space shared with several other teams and duty took place against the background of the team's other activities and those of the other teams. Several aspects of this background stood out.

Physically the team's desks seemed arranged in a way that facilitated team talk and a flow of communication between workers and between workers and managers (who sat strategically in the middle of this seating arrangement). I refer at several points in this thesis to the importance of the team talk that went on constantly and added a question on this to my interview schedule. I asked if I could take some photos of the desks (see Appendix E) and was given permission provided all casefiles were tidied away or covered up. Each desk was individualised by its owner and given a "homely" feel that contrasted with the nature of the work being done and discussed:

> *I'm struck by the heterogeneous mix of work- and home-related things: family photos, children's toys, work diaries, little plastic gonks, packets of Cup-a-Soup, coffee jars......The books on SW6's desk: one on neglected children, a Research-in-Practice guide to working with young people who abuse alcohol, a book on emotional abuse....(field note extract)*

Another was the omnipresence of unpleasant cases which provide ample evidence of the worst kinds of human behaviour. These formed a constant and taken-for-granted background. Two examples might be mentioned. I came into the office one morning and heard one of the workers calmly discussing with someone over the phone the case of a young man grooming and abusing two children known to him. She talked about it very matter of factly. Everyone else could hear her and although it was quite common in the team for people to publicly comment to each other about their telephone calls no-one felt this one was worthy of any comment (see Fieldwork diary Appendix C, extract 1). On another occasion reading about a case on the IT screen with a social worker, I made some comment about how unpleasant this sounded and she dismissed it as "low priority, nothing unusual".

> *Girl told her father her 15 yr old boyfriend had "digitally penetrated" her (as the referral puts it). Father says she wanted the boy to do it. The girl has been seeing another boy too and the father disapproves. Girl has been discouraged by father from complaining to the police. SW7*

and I silently read through the referral on-screen. I say to her that written down baldly like this it sounds so dreadful. She says "oh it's low priority. Nothing unusual" (field note extract)

Another element of this background is hearing workers routinely talking to clients over the phone about reducing or ending their contact with their children, quizzing them about suspicious bruises, asking for intimate details of family life. What seemed noteworthy was the routine and matter-of-fact way these matters were discussed: it is the everyday meat and drink of their work and thus largely taken for granted on a day-to-day level yet these are extremely intimate and stressful issues which have a profound impact on clients' lives and identities.

There was also a good deal of gallows humour which revolved around how hopeless and useless or horrible some clients were and around how they as social workers were routinely blamed when things went wrong - by their clients, other professionals and in a wider sense by politicians and the media. One observed example was of a social worker hearing that a troubled teenager on her caseload had taken an overdose:

SSW2, SW6 and SW4 are discussing the case of a girl who has overdosed on paracetamol. SSW2, whose case this is sighs and said "Oh well, that'll be my fault then". "Oh yes" agrees SW4. (field note extract)

There was a sense that this is dirty, stigmatising work – both because they work with the most marginal people in society and because they themselves are viewed negatively or ambiguously by the public: both social workers and their clients are stigmatised. Buckley (2003, p.187) draws attention to the applicability of Hughes' concept of "dirty work" to child protection work, the sense that in some ways this is a necessary but morally dubious activity (Watson, 1995)

6.2.2 Team meetings

I observed 4 team meetings – 3 at Moorhouse and 1 at the Family Project.

These meetings covered a range of topics. In all the meetings team members discussed work cases which they thought were of particular interest, other professionals (these were invariably negative, or, as Dingwall (1977) calls them, "atrocity" stories on such topics as GPs failing to pass on information, workers in other teams being reluctant to take on cases and admin staff passing on poor quality duty referrals), administrative business such as shifts and rotas (at Moorhouse there was a Borough-wide flexitime policy of a rather limited nature which was known by the rather grand name of "work-life balance"), the occasional social event such

as a team night out and a “topic of the week” slot where any team member could raise a topic of interest though in none of the meetings I attended was this used.

“Atrocity” stories, as Dingwall (1977) argues, are designed to emphasise the team’s competence and cohesive identity by highlighting shortcomings in other professionals and a central element of the meetings seemed to be to air anxieties and complaints and emphasise the duty team’s “special” identity and work-load, especially if the managers were not there. At one meeting I noted

> *Throughout the team meeting there is a tone of dissatisfaction, of feeling overworked and under-appreciated, of being put-upon by management...of weariness that I haven’t really felt from the team before now (field note extract)*

At one discussion about a case the presence of someone pretending to be a grandparent – a “not grandma” was discussed

> *There’s a discussion about a case that’s been live recently with a complex and confusing family structure. A key figure is the grandma who turns out not to be the grandma and the team refer to her laughing as “the not-grandma” (field note extract)*

In the margin of this note I have commented:

> *I like this phrase. Could be a useful metaphor for the complexity of family structure in so many cases, their refusal to even come close to conventional nuclear family structures. The “not grandma” is one of those new family roles like step grandparents.*

As I discuss elsewhere this was an important moment in my thinking, crystallising some ideas I was developing about the nature of the referred families and their complex structures (see sections 6.3.4 and 10.7.3)

6.2.3 Doing office duty: front-line decision making

The team had a rota system and each worker in the team took turns to do duty approximately once a fortnight. When it was their turn workers were on duty all day though they might get a colleague to stand in for them if they had an important meeting to go to. Workers took in initial referrals through the duty system where they made initial decisions on whether to take them on for further work or “NFA” them – take no further action. A NFA decision could be because a case was deemed low priority or it could depend on the willingness of another agency such as a school to take on work that it was judged needed to be done. Some referrals were deemed urgent enough for the worker to go out and do a visit.

If a decision was made that further work was necessary cases were allocated to a social worker in the team who managed it for a period of time and either closed the case or passed it to one of the longer term teams in the same office. Depending on how long the official procedures took this could be anything from a few days to several months. If a case was going through the statutory child protection procedures as specified in the guidelines for working together to safeguard children (Dept for Education, 2013) then the case would usually be transferred following the Case Conference where a decision is made as to whether or not the child will be made subject to a Child Protection Plan.

In some cases workers had to hold on to cases for longer because the longer term team couldn't take them on though some specifically asked if they could hold on to a case for a longer period of time for their own professional development. Many of the workers in this team said their team was more stressful than the longer term team because they had to take new referrals – they couldn't turn them away because they were too busy as they believed the long term team could – and work with cases they didn't know well or at all. That their work was especially demanding was a key element in the team's sense of its identity.

6.2.4 The experience of doing duty

Duty was seen in the team as a very important and stressful area of decision making in the work. None of the social workers said they liked doing duty. One of the workers summed it up:

> *I think duty can be really stressful because it can get really, really busy and you're constantly having to read through those referrals and you are constantly having to prioritise and make decisions with your duty manager about what needs responding to a-s-a-p and what can wait and then, apart from all the referrals, you get the constant battles with the professionals who think that your thresholds are completely different to theirs and it's about getting other professionals to understand about risk, and about significant harm and about whether or not it can be worked at a lower level than... us...(SW6)*

The sheer volume of referrals, the unpredictable and uncontrollable nature of duty work, the constant concern that something really awful was going to come in necessitating a stressful investigation, the arguments and dilemmas over where thresholds for intervention lay and the reliance on colleagues and the Duty Manager to help you feel safe were frequent themes. Having to work with cases or visit families who were not known to you was seen as particularly stressful and demanding.

I ask SW7 if she likes duty. She says no, you can't control it. Too much coming in. You might come in to 3 pages of "contact-ins" (referrals) and you've got to clear them all. It's not like your own work she says, you can control the pace of it better, prioritise. With duty you don't know what's going to happen next (field note extract).

At the beginning of another observed duty I noted the work awaiting the duty worker:

Workdesk (the computer screen): 13 cases open. Half are red requiring immediate action (field note extract).

Of course this was the workload *before* the duty session began when more cases would come in rapidly. Observing another duty I noted:

SW5 comments to me how stressful today has been as when she came in there were 15 cases on the workdesk. She says it's stressful because "you're in and out of different cases, managing information and managing risk". Now there are more yellows (today's cases) on the workdesk and even where it's all one family each child has to have a different referral form.....SW5 looks at the workdesk – "new cases...you have to keep it in your head who you've seen". (field note extract)

There was a student in the team on placement. He had his own caseload but the team did not allow him to do duty until relatively late on in his placement and then he acted as assistant to one of the regular social workers. About 3-4 weeks before his placement ended he was allowed to "take the lead" in a duty session (with another team member alongside him - he was never placed formally on the "duty rota") an indicator of how difficult this aspect of the work was seen to be.

The duty and assessment team saw themselves as rather special and this was often raised in team meetings and informal team talk. They contrasted their job – taking all the new referrals, having a constant input of fresh cases – with that of other teams such as the longer term teams they shared an office with who they felt could work at a slower pace, hold cases for longer, put off closing cases which meant they could not then take on cases that the duty team were ready to pass on. This meant duty team cases piled up – they couldn't get rid of older cases but they couldn't stop taking new ones. This talk was frequently shaped around "atrocity stories" (Dingwall, 1977) about senior managers, other professionals such as doctors, head teachers and health visitors and other social workers. This all seemed to function as a way of asserting the teams identity and solidarity and their assumption of collegial competence (Pithouse, 1998) though as time went on it became increasingly clear

that team members did not see each other as equally competent with critical comments voiced to me informally and in interviews.

However one worker who had also worked in the long term team felt there was less stress and work in holding cases for a relatively short time:

> *I spent quite a long time working in the long term team ...the pressures there, they're totally different to the pressures here. But I've spoke about this to my colleagues in this team but if they've only ever worked in assessment and duty they don't see that because they don't have an understanding of long term work and what that involves. Because you get very bogged down in long term work. Not only do you have all your child protection reviews, looked after children reviews, all the scheduled things that you have as a long term worker you also do deal with all the crisis situations that happen on your caseload on a daily basis. So you still have your child protection medicals, you're still having to respond to domestic incidents as well as all the court work you have to do and all the court statements you have to write and all the things for adoption and all the adoption procedures...so in my long term job I would spend a lot of my weekends working at home, a lot of evenings, getting up early in the morning and working just to keep on top of the amount of work that I had and to keep the court deadlines and the adoption stuff all ticking over to timescale, whereas here I've not had to work at home at all..in a year. (SW6).*

Nonetheless, the particular demands of duty were central to the team's view of itself. It may well have been the case that the long term team too had constructed a strong identity around the different demands of their work.

6.2.5 Taking referrals

Referrals came through the IT system and were written up by admin workers who were not trained social workers. Team members often complained that these referrals lacked important details such as failing to "flag up" cases where significant harm was suspected as the admin workers should have done. Similarly police reports, reports from the emergency team that dealt with out-of-hours situations and reports from other professionals were often lacking key details and much time was needed to track down information (sometimes as basic as peoples' telephone numbers) and check the information that had come with the referral.

> *Duty worker (looking at a new referral): "Honestly! That's useless...tells me nothing!" (field note extract)*

Workers often needed to spend a good deal of time gathering information and would make a judgement when they felt they had enough: one worker, after looking through all the available details on a family, declared:

"I've got enough information now to have a snapshot of this family" (verbatim field note)

It was expected that the Duty worker would do everything she could to clear up a case so the next day's Duty worker did not have to deal with it so there was a constant tension here between the need to make quick decisions and the time it took to gather and check information.

SW4 mentions about trying to clear the work-desk every day. TM1 was very keen on this but in reality it doesn't happen very often as cases often have to stay open til next day (field note extract)

Duty referrals were a heterogeneous mix that had not been filtered and might be a mix of high priority cases and much lower ones which could be delegated to another agency such as a school or NFA'd.

The importance of prioritising cases was a common preoccupation. One worker complained about "twitchy professionals" referring cases because they had some generalised anxiety about them but where there appeared to be no specific concerns.

"Twitchy professionals expect us to deal with all the rubbish". (Fieldnote extract of duty observation)

Another referred to "lunch box" referrals as in:

sometimes we have calls from school and there's nothing wrong with the child other than the fact that… they're hungry when they come into school in the morning, and...or we've had it when a child's come in and has just had two rounds of bread, with a bit of cheese in or something and nothing else for their lunch, and you sit there and you're sort of like almost like waiting for the punch-line, you know...you think "well, what have you rung me for?" (SW2)

This worker expressed concern that these "lunch box" referrals got in the way of dealing with more serious cases:

a lot of the time I don't think that people appreciate the fact that you've got calls like that and then you have got a call from a hospital with a child who's got a non-accidental injury, and you're gonna have to wade through twenty of these lunch-box ones before you get to the crux of what we do, and that is what we do, that is the bread and butter, you know, the non-accidental injuries, the domestic abuse, the substance misuse, …, you know and having education welfare officers and health visitors ringing us up and saying well they've knocked on the door three days in a row and they won't answer the door and there's nobody in, …, and, well, "we need you to go and have a look" well if we go and have a look we're gonna knock on the door and if there's nobody in we're gonna come away. You know, we haven't got Santa's

magic key to let us in the door! (SW2)

Both of these workers were expressing a frustration that others also mentioned: nervy professionals not sure what to do next, referring to the Social Work team rather than making a decision themselves. It was a feature of duty work that workers were constantly having to apportion priority to cases and it could be easy on a busy or stressful day to miss a high priority case mixed up with all the lower priority ones. Such cases added to the social workers' sense of being on the front line....the buck stopped with them.

Having to distinguish between high and low priority cases could be complicated by lack of information or inaccurate information, making decisions harder to make and more likely to contain errors. Even referrals made by other professionals were not uncommonly problematic in this respect. In one case I observed the police had referred an incident where a teenage girl had wrought significant damage to her family home. The worker followed up the name of the girl and found that she and her siblings had been previously subject to Child Protection Plans and decided this warranted further investigation but she was hampered by a lack of basic information on the police referral. The girl lived with her aunt but which one? She had two aunts in the area. It was not clear which one was being referred to. Addresses and telephone numbers were inaccurate or missing. This involved time-consuming checks, trawls through the computerised records of previous case events which had to be interpreted not merely read through, discussing the case with other professionals and talking to the family on the phone. At the end of this process she wrote a brief casenote on the case log to say the case was being closed as NFA. At the same time she was dealing simultaneously with other cases being referred. NFA decisions are clearly a central element of gatekeeping and threshold management and some of the most important decisions the team takes yet the skills and time involved were not recorded.

Sometimes, even where there is substantial information, the computerised recording system has to be carefully interpreted or "storied" by a human:

SW5 now dealing with another case....(some family details omitted here)....father controls all the finances and goes off leaving mum and children with no money. She is thinking of leaving him. SW5 scrolls through a whole series of contacts/referrals trying to piece what appears to be a complex series of events...each referral has a contact detail then staff comments. The computer doesn't make links between them. It needs a human to create a chronology...SW5 makes a story of it – mother in a refuge, leaves refuge, goes into another, father trying to get contact with children.....and transforms it into a coherent story.....(SW5 then relays this

transformed information to another social worker over the phone)...She then writes up this contact v briefly: "passed on info to social worker. NFA" (field note extract).

Lack of information and the complexity of many of the referred families made gathering accurate information very difficult.

The Safeguarding Section ring back re. details on....this case. Very complex family structure. Mum has 3 partners or ex-partners and 5 children but they don't all live at the same address. Not clear where some of them live as not all the computer records have been inputted properly. Later it turns out 3 of the children live in another local authority. (field note extract of observation of duty).

Making a decision on how to respond to such a referral is far from straightforward and there were many pressures on the duty worker's time

SW6 decides she will ring mum to see how she is feeling and if she is accessing support services...She wants to gauge mum's mood. If she is upset she may decide to "go out" on this (ie make a home visit). I ask whether she will make a visit. She's not sure: she talks about how computer- and timescale-driven the work is and how there's not time to do "social work" by which she means, she says, face-to-face work during a home visit (field note extract).

I observed one Duty worker take an anonymous call alleging abuse. How social workers treat anonymous calls from non-professionals has been noted as a problem in a number of child abuse deaths. This worker at one point asked the caller for her name because she said she found it hard to have a conversation with someone whose name she didn't know. She emphasised that she would not reveal her identity – it was just so they could talk more. The result was that the caller felt drawn into a relationship with the worker and revealed a good deal of extra information. When I later commented to the worker how effective she had been she was surprised and dismissed what she'd done as routine. I observed a number of the workers forming such alliances with parents over the phone, often offering professional advice in "common sense" or lay language. Forming these alliances required time and patience (which not all the workers had so these skills were not universal) but again acted to keep thresholds from getting too high. The skills used were not commented upon by others or written up in any way.

The police have to notify Social Services when there is a domestic abuse incident where children are in the household. These notifications (known as "pink forms": see Appendix C extract 1) stem from the change in the law in 2002 when witnessing such abuse could be classified as "significant harm" under the Children Act. They went straight to the Duty

Manager who, more or less every day, had a pile of these to work through. They were often poorly completed, time consuming to process and, according to recent research, rarely result in families being provided with a service while overwhelming social work teams with a flood of referrals (Stanley et al., 2011) There was potential for raising thresholds and distracting the manager from other tasks. The manager's importance in managing thresholds and gatekeeping is discussed in the next section.

6.2.6 Gatekeeping and thresholds

A dilemma the team faced was that of how to gatekeep a resource-limited service whilst keeping thresholds for intervention at a low enough level so that high-risk cases are not missed.

Deciding which cases to proceed with and which to NFA was influenced by the team's awareness of their limited time and resources and the pressure of constant referrals. Gatekeeping was a central aspect of duty work and clearly this was a point at which vital decisions were made and errors could occur. Given the volume of work and the team's limited resources gatekeeping was inevitable. I observed cases where other agencies such as schools and Health Visitors were asked to take on work. Several participants said that these more universal, less stigmatising services were more likely to be able to work with families where social work intervention might make things worse rather than better especially in cases where situations were not fully known or understood. Families with problems that weren't seen as high priority, such as difficult teenagers, would be advised to go through the school or the health service or to use their own parenting resources.

Participants often advised parents in this way, offering "common sense" solutions in lay language.

But a number of workers also commented on "getting rid" of referrals and sometimes I observed the manager intervening to prevent referrals being passed on to others too quickly. Workers sometimes used the bureaucratic systems to avoid taking on cases. On several occasions I observed workers encouraging referring agencies to use the Common Assessment Framework (the CAF) when making referrals because, I was told, if schools and other agencies could be persuaded to refer to them via a CAF (a multi-agency procedure for identifying children's needs) the case would go to one of the longer term teams rather than them. Sometimes the workers would advise the school to instigate a support meeting with

other agencies by making a CAF referral. This did ensure that some further action took place and the response was not as minimal as it might have been:

> *SSW1 decides that as there aren't any concerns the school can do as it wishes. But she says to SW6 the school could fill in a CAF and trigger a support meeting. So SW6 rings school and says if you have any concerns you could trigger a CAF (field note extract)*

On one occasion I observed a Duty social worker (DSW) try to send a case back to the long term team rather than take it as a new duty referral because it was technically still open to them because the worker hadn't closed it properly on the IT system.

The presence of the duty manager (DM) acted to keep thresholds down, making sure things got done and checking if the duty worker had considered other options. There were situations which I observed where a minimal service might have been offered by the DSW but on consulting the DM the DSW agreed to undertake further tasks (or – as in the case noted above – ensure others would offer support). The DSWs referred regularly to the DM for advice and reassurance or just to air their feelings. The DM played an important role in ensuring a range of tasks got done that left to themselves the DSW might not have done. One example was advice to go and talk to the long term team (who were in the same room) rather than just electronically pass a case over to them. This was designed to keep relationships between the two team relatively harmonious though the duty team still complained the long term team wouldn't take cases, took too long over their cases and kept them open for ages (unlike the duty team who couldn't indulge in such luxuries).

The DM sometimes offered perspectives that the DSW hadn't considered. Many referrals were so complex, ambiguous and little-understood that there were many ways to think about them, many options that might be taken. The DM could be vital in presenting some of these but I noticed how cautious she was about being seen not to call into question the judgement of the DSW and this may have limited her effectiveness. Most of the team readily talked about depending on the manager's physical presence for guidance, reassurance, a sense of safety and security. There was nearly always a manager there and available and this seemed very important to the safe carrying out of the work – she was constantly involved in the management of cases

> *SW3 discussing his case with SSW1. SW6 talks to her about whether or not to go a visit. SW2 says to SSW1 I've put that risk assessment in your tray, will you look at it? SSW1 keeping an eye on the M case SW5 is dealing with....keeps "going in" to the computer to check on it. Now SW3 is telling her what she plans to do on another case.....(field note*

extract).

How many times has SW6 consulted SSW1 who is here all morning and sits opposite her? SSW1 is constantly present and available. She responds supportively and with humour – the humour being particularly useful when SW6's stress levels start rising. The arrangement of the desks seems to facilitate this communication (field note extract)

See Appendix E for photographs of the team's seating arrangements.

6.2.7 Visiting at home

The home visit has a prominent place in social work practice. Much of the day-to-day work with families took place in their homes rather than in professional clinical settings and many of the most vivid stories the social workers told revolved around such visits. Yet there is remarkably little writing specifically about this activity in the social work literature. Ferguson (2011) has drawn on anthropological concepts of liminality and the morality of dirt in discussing the home visit as a crossing over into a dangerous world of mess and contamination where families are encountered in their most intimate spaces. These visits could be frightening and difficult, drawing workers into complex relationships, yet they were also the situations within which vital assessments of family functioning and child safety took place. The home visit typifies the task characteristics that require rapid, intuitive reasoning (Orasanu & Connolly, 1993; van de Luitgaarden, 2009; Helm, 2011) including uncertain problems, rapidly changing environments, time pressures and high stakes (Orasanu & Connolly, 1993, p.7). The home visit, then, presents major emotional and cognitive challenges to social workers but at the same time it provides unique opportunities to engage with the most intimate aspects of families' functioning.

The social workers had to investigate and assess cases whilst at the same time trying to build supportive relationships with adults and children, combining both the care and control elements of their work. The social workers gave vivid accounts of the difficulties and hostilities they face sometimes whilst in families' homes – on their territory – from parents and extended family while at the same time trying to carry out complex monitoring and assessment work. This hostility may well have an effect on decision making (Reder & Duncan, 1993; Ferguson, 2011)

The social workers' experiences of home visiting is discussed in detail in the next chapter. Here I want to emphasise the importance of home visiting to the nature of the work the social

workers did as a significant proportion of that work took place in families' homes. Some of the key themes which emerged about home visiting in the study were about the social workers:

- intimately encountering poor and dirty homes and experiencing considerable difficulty in identifying universally agreed standards for assessing poor home conditions
- managing situations featuring intense emotions, where pain, distress, aggression and even violence can be encountered.
- being drawn into webs of complex relationships with extended family networks where it can be difficult to separate the child's needs from those of the adults, as social workers are officially and legally meant to do.

6.2.8 Recording the work

It was an essential part of duty to write up case notes on the computer. The quality of case notes or "case events" on the IT system were variable particularly with cases where families had been referred repeatedly and dealt with by several different workers. A good deal of the literature analysing child deaths emphasises the importance of chronologies, of linking together separate events which taken alone may not raise concerns but which taken together can show significant patterns (Reder et al., 1993; Brandon et al., 2008). I observed some DSWs spending time writing up case events in a way that enabled future readers to make links between separate events. This required time and thought and in some cases reordering/rewriting previous notes. I observed one DSW take 20 minutes carefully going through the entries on one case for a social worker from another agency and linking them together – creating a coherent narrative out of a series of disparate events. She then wrote her discussion with the other worker up in a couple of sentences. It was a routine task, apparently barely worth recording. Yet this creation – verbally or in writing – of narratives gives meaning to information and turns it into knowledge (Aas, 2004; Parton, 2008): a crucial requisite for analysing and assessing information.

On the other hand several workers said that they tended to abbreviate when writing up case events, entering just the bare bones.

> *SW4 talks about the difficulty of trying to type up what someone has told her – it's often a long story which can't be typed up in its entirety and has to be abbreviated so you have to choose what to leave out and what to write so it makes sense. I noted earlier that half the keys on SW4's keyboard don't have letters on them and some keys don't work! (field note: observing SW4 on duty)*

One duty worker said to me that, when seeking information from previous case events, these entries gave limited information compared to the case events you wrote up yourself because, although these might be similarly abbreviated, you could recall all the thoughts, hunches, feelings that you had had but had omitted from the case record. The case event records are not "thick descriptions" (Geertz, 1973). If the case event had been written up by someone else in the team and they were still working there you could consult them to round out the case event and provide more detail and background, make it into a richer, more detailed story. This lack of detail meant that processes of the worker's thinking were not available for subsequent discussion in supervision where such thinking could have been analysed for error or bias. It also meant there was no evidence of how the situation seemed at the time rather than in hindsight – a key issue in reviews and inquiries into child deaths (E. Munro, 2005).

Some of these issues are discussed in more detail later.

6.2.9 Summary

The day-to-day nature of the work of the social workers has been explored using data drawn from interviews and observations. The focus has been on how the social workers processed initial referrals through the duty system and how they worked with families through home visits. Both duty and home visits are very important sites of day-to-day decision making.

Duty was seen as stressful and unpredictable. Little was known about many of the referrals due to incomplete or inaccurate information but important decisions needed to be made about them: not just what service should be offered but whether there should be a service at all. Cases had to be prioritised and as social work resources were limited there was a significant element of gatekeeping. A number of factors came into play in making these decisions. A variety of ways were used to avoid taking cases by passing them on to other agencies or taking no further action. Sometimes this was because of pressure of work, high thresholds and expectations that work would be cleared rapidly but also because of an awareness of social work as a "dirty", morally dubious enterprise that could stigmatise both workers and families. Other less stigmatising, less "dirty", agencies might provide better solutions or at least not make difficult situations worse and in some cases families would be better off employing their own resources. These strategies were usually used with cases at the lower end of perceived seriousness but such was the ambiguous and incomplete nature of many cases that this perceived seriousness might not be accurate. There was a tendency for

thresholds for providing services to rise which was partly counteracted by the duty manager being available and aware of the work.

A number of previous studies have found that social workers use simplified and informal processes for screening out cases (Buckley, 2003; Platt, 2006) as they seek to make sense of complex and ambiguous referrals. There is clearly a possibility of error. As Brandon et al. suggest "child protection (does) not come 'labelled as such'" (Brandon et al., 2008a, p.319) : in their analysis of Serious Case Reviews where children have died or been seriously injured 45% were seen upon referral as below the threshold for protective intervention.

A significant element of the work with families took place in their own homes. This could be challenging for the workers, as entering families' homes often meant entering a complex, chaotic, intimate and even frightening environment, but also provided unique opportunities to engage with the intimate aspects of families' lives. It was also an arena where they were required to make vital decisions.

The social workers often summarised their actions very briefly in the computerised case files, giving little or no detail of their thinking. Studying these case files, which represented the official record of their work, provided little evidence of the ways in which the workers thought about cases, prioritised them or made decisions about them. Instead much of their thinking lay in unofficial, informal, even private, processes quite separate from the formal world of official procedures.

Pithouse (1998) characterised social work as an "invisible trade" because so much of the activity takes place in private, and is therefore literally invisible to outsiders, and because so many of its processes are unofficial and based on taken-for-granted assumptions. The thinness of the case notes may contribute to this invisibility, rendering much of the workers' decision making activity and reasoning unavailable to others.

6.3 The Nature of the Cases

I would like to begin this section with a snapshot of some (by no means all) of the referrals from a single duty session to give a flavour of the kind of cases workers routinely dealt with:

> *A young child whose parents have separated and share custody. The child alleges his father hits him and locks him in his bedroom. There is a previous history of domestic abuse. The police are contacted but decide to take no action.*
>
> *A young child whose parents have separated and share contact. The father alleges that the*

child has returned from mother with a scratch. Mother lives with her parents. She is visited and says that the father has made several allegations about her and she tries to shelter her son from the antagonism between her and the father.

A six year old child whose parents are separated. There is considerable friction between the parents. The father has told the child his mother is "bad" and he has given the child a mobile phone with which to report back to him on the mother's behaviour. He sometimes refuses to allow the child to go back to his mother after contact.

A young woman whose baby has been legally removed from her care and placed with her mother. Mother and grandmother have a volatile relationship and the young woman has alleged that her mother's care of the baby is poor. She now alleges that on a visit to see the baby her mother assaulted her while she was holding the baby.

A teenage girl whose parents have separated. She lives partly with her father and partly with a sister. Her mother visits the father's house. The girl alleges that her mother has punched her in the face for stealing cigarettes from the father (extracts from field notes reproduced in Saltiel, 2013, p.19)

6.3.1 The children in the cases

At the extreme end of the spectrum there were two cases where children had died and another where a child was in hospital with severe injuries that are usually associated with shaking or some other serious trauma (retinal haemorrhage and subdural haematoma). In one of these cases the father had been arrested for murder and while he was denying responsibility the child had been in his care and the social worker could see no other explanation. In the other two cases there was uncertainty: in one because the injuries could have been caused by congenital problems arising from a difficult birth and in the other there was also uncertainty if the injury was non-accidental.

These are extremely serious cases, stressful to deal with, and the uncertainty as to what happened was very difficult to manage. The workers in these cases were often very cautious about coming to conclusions because of lack of information, disputed information or a refusal by doctors to commit themselves.

A worker involved in the case of the young child with retinal and brain injuries, was asked how she responded to the news that he had two injuries commonly associated with non-accidental trauma:

Well on its own um it would make me feel I need more information really and what are the medical team implying about the significance of that ...um... so it was a question of trying to make sense of the information we were being provided which was fairly scant really...um...

because it was a child who had attended a routine ophthalmology appointment in X one week and the retinal haemorrhages had been picked up on that appointment and further review organised with a more specialised medical person at Z Children's Hospital for the following week.....so there was a confusion, there was more than one hospital involved and a team of medical professionals involved (TM1)

This worker talks about *trying to make sense of the information* and assess it carefully in context despite its suggestive nature. Buckley (2003) in her study of Irish social workers noted this "sense making" response to complex information was common and ran counter to the assumptions of orderliness and predictability that lie behind the official procedures.

In the case where the worker was reasonably sure the father was the culprit complications revolved around another issue: how to act to protect the siblings? This was a feature of several cases. Were siblings at risk in situations where a child had been hurt in sometimes uncertain circumstances? What was the best way of protecting them? In one of the above cases family members were asked to look after a child, in another the authority moved quickly to take the case to court to ensure a quick decision was made.

In another case that a member of the team was already involved in there was a dreadful domestic abuse incident where a man tried to set fire to his partner and the house in front of their children.

What had happened were over a 6 hour period, and the 2 children were at home, the father was under the influence of a cocktail of drugs, alcohol, seriously assaulted the mother in front of the children, brought a can of petrol into the house, poured a can of petrol all over mum and the stairs, had a lighter, were threatening to burn her and the house down, threw some clothes into the garden and actually set them alight. (SW5)

As she rather chillingly put it:

They (the children) could have died that night

The difficulty of knowing the significance of an apparent injury or possible abuse and assessing the levels of risk was a feature of a number of other cases. In a case I observed a child returned to his mother from a period with his father with a bruise which was reported by the Health Visitor. The team took this very seriously but as further information came to light about the custody dispute between the parents, the mother's state of mind and the extent and visibility of the bruise so the nature of the situation had to be reassessed. In another there were reports concerning a family one of the team was working with of the mother's behaviour:

And there's been reports...we had an anonymous referral before I was involved about mum hitting A, the oldest one. There's this incident not long ago where the Children's Centre staff reported that she'd grabbed him by the arm and dragged him and sworn at him, so you sort of think there's a risk there perhaps from mum (SW4)

What significance is to be given to such incidents which might be observed, say, in a shop or other public space on a daily basis?

Sometimes it was not clear what, if anything had happened and, if it had, what its significance was. In one case a 2 year old child had spent a night with an uncle who it transpired was associating closely with a known paedophile. Had the child been sexually abused? Was it necessary to know when that meant putting the child through a distressing and invasive medical? In another the worker was alerted by a neighbouring authority that a man having regular overnight contact with his children was a known sex offender. Was he putting his children at risk? Could his ex-partner protect them from him?

There were cases where decisions made in the past had to be revisited. In one case the child had been removed because of neglect and parental mental health issues but had returned home and the case closed as conditions seemed to have improved. But some years later the child had talked at school about the conditions at home and his mother's erratic behaviour and it became clear on visiting that this was not a safe place for him. The authority were now in the difficult position of applying for a Care Order, having once had a Care Order discharged on the same boy.

In another a pre-birth assessment had concluded that the baby would be safe at home but it rapidly became clear after the birth that this was not the case and the family had to be reassessed.

In another case involving previous decisions – where a child had been severely injured in the past (either by the mother or father, it was not known for certain) – the mother was pregnant again and an assessment was needed to determine whether or not she would be able to care for the new child.

6.3.2 The parents

A significant proportion of the cases involved parents who used controlled drugs, drank to excess, had mental health difficulties, had been diagnosed with learning difficulties: all widely seen as issues that can seriously compromise parenting capacity (Brandon et al., 2012)

Actual or suspected domestic abuse was also present in a number of cases. Domestic abuse incidents in families with children have become a higher priority for policy makers in recent years and the legal definition of "significant harm" in the 1989 Children Act was amended in 2002 to include children witnessing such abuse. Like all local authority teams, the team received police notifications of all such incidents they attended and had a duty to follow them up in some way. The inclusion of domestic abuse into the bureaucratic processes of child protection has been criticised despite an awareness amongst social workers that domestic abuse and child mistreatment are often linked. Turning responses to domestic abuse into a bureaucratic procedure can, it has been suggested, make such responses minimalist (Rivett & Kelly, 2006)

In one of the cases a family were referred in this way, via a police notification. The manager, who had long experience in the team, recalled the name of the father from when he was a child in care and a visit by the social worker was arranged. The family at this point phoned to ask for help. This call meant that the social worker viewed them as co-operative. Yet three months later the father attempted to kill his partner by setting fire to her in the incident described above. The father, interviewed in prison, said it is was his partner's fault and the mother, having initially said she did not want the children to see their father again (a response much approved of by the social worker) began, in the social worker's words, to "minimise" and "backtrack":

> *mum were talking to me like this: "but if he'd not taken no drugs then he wouldn't have done that to us and he didn't realise what his behaviour was, he didn't ...at that time he wasn't responsible for his behaviour" and with regards to him he was basically blaming her and saying she'd pushed him to do that (SW5)*

The mother became very antagonistic towards the social worker who concluded that the parents' cooperativeness was a pretence. As a result she took a much more negative view of the mother's parenting. It has been noted that assessments of parents are often based on their degree of compliance with social workers and this compliance shapes the moral reasoning workers use to assess them (Dingwall et al., 1983; Buckley, 2000) . A number of child abuse tragedies have noted that this can distract workers from the risks to the children (Reder et al., 1993) .

In two cases negative views of parents were based on the social workers' assessments that meaningful parental cooperation could not be expected – in one case because of the mother's

mental health problems, in the other because of the mother's learning difficulties and the influence of her partner. In the latter case the social worker said:

> *And when you read the research and stuff, parents with learning difficulties - it does say that anyone with an IQ of less than about 60 will struggle with their parenting, you know, parenting capacity...(SW4)*

The worker is basing her assessment on the view, backed by research she has read, that parents with learning difficulties lack the capacity to parent their children without support and must therefore co-operate with the social worker in order to receive that support. This mother was in a relationship with a man seen as domineering, hostile to social workers and having great influence on the mother. Therefore her co-operation could not be expected.

> *Quite difficult to know whether mum is doing what he tells her to do because he is very controlling or whether she just genuinely doesn't understand the concerns herself. I do think it's probably an element of both (SW4)*

Parental co-operation was clearly advantageous to the children in several of these cases so seeing such co-operation as important is not *just* a moral issue. The parent cited above may indeed genuinely need assistance which she will not get without some co-operation with the social worker. But the moral element is closely bound up in such "co-operation" and cannot easily be separated from it (Dingwall et al., 1983)

A number of cases involved parents who had separated and were in dispute over custody of the children or, even where custody wasn't an issue, had very acrimonious relationships.

The case I observed where the mother reported a bruise on her son after he had returned from a period with his father was reassessed when it became known that the father was applying for a Residence Order. The bruise was a small and ambiguous mark on which doctors were reluctant to pronounce after the child was taken for a medical and the way in which it was viewed changed when this new information came to light:

> *so then you start questioning - is all of this part of a way of y' know discrediting one or other of the parents. (SSW1)*

Another worker involved in the case who had visited the mother said:

> *so I can't help but think, you know, this referral, you know, the suspicion that he had this hand print (bruise), is somehow understood in context of this residence dispute she wants us involved and, um, in fact at the hospital was asking oh will you remain involved, will this mean regular visits - now that's not usually the kind of question that families pose to us (SW7)*

The social worker here was suspicious at the degree to which the mother was welcoming the prospect of social work involvement, raising the suggestion that parents can seem *too* co-operative because why would they be wanting social workers involved with them....it must be for some devious reason. Yet in different circumstances such compliance would have been seen much more positively by the social worker as a sign that the parents were genuinely motivated to work with her.

These parental disputes then meant that workers were trying to balance competing stories, none of which might be true. Clearly this must have an effect on decision making. Such disputes were a regular feature of the work and have also been noted as a feature in a number of child abuse tragedies (Reder & Duncan, 1993). In one case I observed being dealt with on duty a father had given his son a mobile phone to facilitate his reporting back on his mother's activities. In the same observation another father reported his son had returned from his mother with a small scratch. The mother was interviewed and her story that it had been caused in innocent play with his brother was accepted. It was the kind of minor cut any child might be expected to have but such was the atmosphere of acrimony in the family that it had taken on a very different meaning.

6.3.3 Wider family networks

It might not just be disputes between estranged parents. There were a number of situations where grandparents now had custody of the children and this could lead to much friction. In one observation a woman reported her mother for allegedly attacking her while she was holding her baby and thus endangering the child. The grandmother had custody of her grandchild and there was a long history of disputes, allegations and counter allegations in the family. I noted in a memo on one fieldnote:

> *Each observation of duty develops into its own story with particular events/cases/themes/sub-plots: snapshots of practice. Here we have a series of referrals which revolve around allegations made in the context of custody/residence disputes: parents making allegations and counter allegations, grandmother and daughter making allegations about each other....How do the workers know which is true? Some are exaggerations, some may simply be lies: family members are giving competing versions and presenting themselves as more morally worthy that the other party (researcher memo).*

Extended family members were often important elements in the cases which were frequently characterised by complex, unstable, shifting sets of relationships. Conventional family roles were few and far between. As I have mentioned earlier, in a case discussion I observed

during a team meeting one member of a family was referred to as the *"not grandma"*: she wasn't a grandparent but had at some point pretended to the social worker that she was one and she did indeed seem to be fulfilling a grandparental role. In another case a child was removed from his parents after his baby brother was severely abused and died. The child was placed with the mother of the baby's father. This man was not the older child's father so the new carer was a step-grandparent and not a blood relative. The social worker decided she was the best person to care for the child but the arrangement caused a great deal of friction within the family as various blood relatives complained bitterly that they should have been preferred. As well as caring for the child the "step grandmother" was also asked to be present at contact sessions where the parents were allowed to see the child. This was one of a number of examples where extended family members were asked to support and monitor parents in some way. In another example a plan was made for a young couple to move in with the maternal grandmother as it was felt her support was necessary to protect the new baby from risk. Of course such examples of extended family networks providing support may be seen in many families but in these cases the support is being provided as part of a plan to protect children devised by social workers. In the above case the social worker said that grandmother had ambivalent feelings about the plan – she wanted to help prevent the baby being removed from the parents but she was angry with the social worker for not giving the parents more of a chance and judging the mother too harshly for a previous incident of abuse. In the case of the step-grandmother the woman was put under considerable stress according to the social worker:

> *if eventually the police decide to arrest her son for the murder of his son then where would that leave paternal grandma looking after this child who is not her blood child and where would the family be if that happened? So it could become quite messy and disruptive really...(SW3)*

and things did indeed become

> *quite er messy really in that relationship with grandparents, parents and paternal grandma now that her son had been released on suspicion of murder as well you can imagine both sides of the family weren't exactly gelling at this point (SW3)*

A further complication is that because she was not a blood relative the step grandmother had to be formally assessed by the social worker before she could foster him.

The stress and possible conflicts that such responsibilities place on family members who may be ambivalent to start with means that such arrangements may be unstable and require very

careful monitoring. They add to the emerging picture of complex family networks where traditional or conventional roles meant little.

6.3.4 Summary:

The families the social workers dealt with presented many problems: families with complex social problems, situations where children were seriously injured, disputes and estrangements between extended networks of adults. The significance of injuries and the degree to which families were safe places for children were not known with any certainty. It was very difficult to assess risk and make sense of the information in its context so that decisions could be made about who needed protecting. This difficulty was compounded by the dynamic, fluid nature of situations and the unavailability in many cases of optimal solutions. Sometimes the social workers faced hostility. At other times families seemed to be co-operating but it was not easy to gauge how genuine or helpful this co-operation really was.

Many cases involved disputes over the children between separated parents. It was extremely difficult to know who – if anyone – was telling the truth or how the "truth" might be recognised. Parents seemed to go to great lengths to present themselves as morally adequate (and their ex-partners as morally inadequate) and to get the social workers to accept their versions of events. Social workers found themselves having to make moral judgements about such cases, weighing up competing versions of a story in situations of considerable uncertainty.

In one of the cases cited above much of the work revolved around assessing the mother's levels of compliance, trying to decide if she was being sufficiently compliant and helpful and then – when the nature of her dispute with father came under the spotlight – if she was actually being *too* compliant in her desire to paint the father in a bad light. The seriousness of the actual injury – a small bruise spotted by a health visitor – was completely reassessed in the light of changing information. Such cases highlight the complexity and uncertainty of the work and the likelihood that moral judgements may be made which then form a "lens" through which the case is seen. In this case the child had suffered a small injury, the meaning of which could change as other information came to light: the injury *in itself* had no intrinsic meaning but was judged in the wider context of the child's family.

Extended family members could be asked to play a protective role but because this protection was part of social work planning they were often ambivalent about what they were being asked to do.

Many of the families had complex, unstable networks of relationships. Many involved situations where parents had split up and there were ongoing custody, residence and contact disputes. Such disputes also frequently existed between the child's parents and the grandparents and sometimes aunts and siblings. These roles and relationships were not conventional ones and so there was no set of social rules and expectations that the social workers (or indeed the families) could call on. Such unconventional roles do not appear in any of the theoretical texts social care and health workers study.

It could be argued that both the families and the social workers were trying to negotiate new and provisional versions of what "families" and "relationships" mean without either the families or the professionals having any stable rules and expectations about what such new relationships and social units should look like and how, within them, children were to be cared for safely. Elsewhere the relevance of Morgan's (1996) concept of "family practices" and the body of recent sociological writing and research on families inspired in part by Morgan's work and that of Giddens (1992) and others is discussed. The case cited above of the "not grandma" exemplifies Silva & Smart's (1999) point that no new vocabulary is emerging to assist in the conceptualisation of new kinds of family relationships. This body of work has made little impact on social work practice but could provide a model for better understanding the diverse ways in which families organise themselves (Saltiel, 2013).

6.4 Conclusion

The participants' working experience was dominated by the complexity and uncertainty of the cases. Lack of information, unreliable information, the sense that situations were not really known about or understood and it was important to tread carefully because they were complex and volatile were frequent themes. Dealing with these cases particularly when little was known about them raised major issues for decision making. The uncertainty was compounded by the vagueness, incompleteness and ambiguity of many referrals. Considerable time was required to complete fuller and more accurate pictures of cases but ambiguity and the difficulty of identifying abuse in complex and dynamic situations remained.

A study of situated decision making must take full account of the context within which those decisions are made and in this chapter I have tried to explore the nature of the work done by the team during the period I was carrying out my study. It seems clear that there are many complexities and uncertainties and these form a vital context which cannot be separated from the way judgements are shaped and decisions made (Atkinson 1995). Such complexity may

mean that official procedures are of limited benefit and more informal sense-making processes are relied on to evaluate a range of competing and contested narratives (Buckley, 2003; Taylor & White, 2000): processes which are embedded in and indivisible from the networks of social relations that make up the workplace. Because these practices are informal they are not made explicit or systematised. It has been argued that these “informal logics” are essential to professional practice but not well understood (Broadhurst et al., 2010a). Some examples of these informal processes in the workers’ daily activities have been given and it has also been noted how poorly, if at all, these activities and decisions are officially recorded.

Scourfield & Pithouse (2006), discussing an ethnographic study of social work practice, argue that such sense-making – informal, discretionary, flexible – is important because technical, theoretical knowledge has limitations when faced with complexity. There is a long tradition of social workers as “street level bureaucrats” (Lipsky, 1980; Evans & Harris, 2004) interpreting official rules flexibly with their clients.

Many decisions were made on referrals that were incomplete, complex and ambiguous. Moreover there were often several versions of what had happened and the social worker had to decide which version would most likely keep the child safe, rather than which version was “true” since none of them may have been. The lack of information and the contested nature of the information that *is* available make it likely that moral reasoning will be a key element in decision making (Dingwall et al., 1983; White & Stancombe, 2003). Injuries to children are seen within this complex and ambiguous context and may change in meaning over the course of the referral being dealt with. This makes a technical, forensic approach to child abuse investigations, based on the uncovering of evidence in clear-cut situations, difficult if not impossible in many cases (Buckley, 2003) whereas the “informal logics” noted above play a central role in enabling social workers to take a flexible and discretionary approach to cases – an approach that makes much more sense to practitioners than more formal responses because of the complex and uncertain nature of the referrals and which is rooted in localised team culture (Broadhurst et al., 2010a)

However it has been noted that faced with such complexity and uncertainty social workers make decisions on a case-by-case basis with relatively little attention paid to wider theoretical explanations (Benbenishty et al., 2003; Buckley, 2003) and as I noted above the recording of such decisions is often very brief and incomplete perhaps rendering important aspects of practice “invisible” (Pithouse, 1998)

In the next chapter some of the complexities of the cases and the nature of the social workers' interventions and decisions will be examined in more detail drawing on the cases the workers gave accounts of in the interviews.

CHAPTER 7: FINDINGS II - Case Decision Making in Practice

7.1 Overview

This chapter is based on data drawn from interviews with the social workers from both teams who took part in the study and in particular from the opening question in the topic guide where participants were asked to bring to the interview a case where they felt significant decisions had been made (see Appendix B). This question and its associated follow ups and probes produced a great deal of very detailed data on day-to-day decision making in practice and the contexts in which it took place.

The chapter is divided into three sections based on the themes that emerged inductively from this phase of the interviews. The first section concerns the experiences of visiting families in their homes, a theme briefly introduced in the previous chapter as it forms such a central part of the nature of the work. In the second section the social workers' experiences of assessing the children and families they work with is the focus. As much of this assessment activity took place in peoples' homes there is some overlap thematically with the previous section. The third section focuses on the experiences of working with other professionals. Child protection work almost always involves social workers working with a range of other professionals who have their own perspectives and expertise to offer though this joint working did not always proceed as the social workers wished.

In the chapter conclusion these sections are drawn together to produce a picture of social work decision making embedded in complex and often contested practice situations.

7.2 Day-to-day working with families: uncertainty, complexity and the intimacy of home visits

The home visit has a prominent place in social work practice yet remains seriously neglected in social work literature. A great deal of the social work activity described by the participants took place in families' homes: one worker stated that in cases with child protection implications

> *we would always do a home visit, absolutely....... I can't think of a situation where we wouldn't (SW1)*

It was argued in the previous chapter that having the home as a locus of activity rather than a clinical setting presented major challenges but also opportunities. Ferguson (2004; 2011) has written graphically about the home visit, of crossing a threshold into a world of dirt, smell,

contamination, even possible violence, which are encountered in a highly intimate way, but also of the value of such visits to see the family's intimate spaces and judge their ways of living. A lot of important assessment and monitoring takes place during these visits but the nature of these often chaotic and contested situations poses particular issues for decision making (van de Luitgaarden, 2009; Helm, 2011).

In their talk about home visits 3 themes emerged most strongly for the participants:

- Seeing home conditions and how families behave in their homes but not always being sure about how to judge home situations
- Encountering and trying to manage heightened emotions, notably hostility and distress,
- The complexity of relationships: both those that existed within family networks and those that developed between workers and families

7.2.1 Home conditions

Home visits gave workers the opportunity to see routines and home conditions at first hand. Seeing where and how families live was described by many of the interviewees as of great benefit.

> *because obviously we're seeing their children as well in a very different situation, the two and the three year old running around in the home environment, actually seeing where they live and how they live, you know that forms part of your assessment, umm, the set-up they've got for the child (SW1)*

The intimacy of home visits made it more likely that workers were able to observe the detail of what was going - on the actual family practices (Morgan, 1996; 2013) which help in understanding the lived experiences of families' lives. For example

> *It was when the family were discharged back to the family home and discussions were had around, um, what time was the baby last fed, when's the next feed due and they actually couldn't say when it was, um, the home conditions appeared to deteriorate, the baby would be put on the floor rather than on a blanket...I'm not saying that's a major thing but all of that indicates that they're not looking at the safety of the baby um there was some concerns about washing bottles, things being sterilised properly, and also how the parents managed um the baby waking during the night (SSW1)*

Home conditions can be poor. In one of the cases a child who had been removed from home at birth but had subsequently returned home as conditions were said to have improved, told

his teachers at school about the conditions at home which included needles left lying about. When the social worker investigated she found

> *the home was absolutely dire, there were a really strong smell of urine throughout the house, it was really cluttered, there was no food, there was cat faeces all over the bottom of the stairs, there were no bedding on D's bed...(SW6)*

But at what point poor conditions became unacceptable was less clear. Several workers commented that conditions they found unacceptable others did not. Such differences came to light when workers had to visit families on another worker's caseload. One worker described visiting a house the regular social worker had thought was untidy but acceptable:

> *the house was in an appalling state and we couldn't believe that in that week it had deteriorated to that point and so there was a real discussion with the manager as to well, where's the cut-off point, how dirty does have to be for everyone to hit that bar and say this is not good enough? (SW1)*

The same worker describing another case decided that home conditions were unacceptable and arranged for a child to move out but was conscious that others might have made a different decision:

> *at one house I had recently....really strong smell of urine, a bit, a bit dirty and quite messy but nothing that was too ingrained kind of thing and not so many possessions that you thought 'this is gonna take months to tidy up'. Bathroom not working upstairs but they did have a downstairs toilet that was dirty but useable, stagnant water in the bath upstairs, and this strong smell of urine and no food in the house, so for all those, those things together, I then made the decision that that child shouldn't be in that house and needed to get out and so arranged for her to stay with Grandma.... but I think other colleagues would've been out to that and would've looked at that situation and said 'this house needs a good clean, get on with it mum, get your shopping done in the morning and when I come back......', you know or making sure perhaps you know, 'let's go to the shop and get you enough food so you've got something for tonight, something basic and I'll come back tomorrow and see things'. I don't know which is better or which is worse for that child. (SW1)*

One worker described how conditions in a home she visited regularly were poor but the mother worked really hard and "managed really well" and conditions were interpreted in the light of the mother's hard work and commitment. The relationship between "dirt" and "mess" and moral reasoning has been noted by a number of anthropologists and recently incorporated into research on social workers' home visits (Ferguson, 2011) . More generally

there has been debate on how inquiries into practice fail to engage with the physical and emotional messiness of the work (eg Cooper, 2005).

7.2.2 Dealing with hostility and distress

Going into families' homes could be an uncertain and unnerving business. One worker describes visiting a family on her caseload to discuss the teenage son's criminal behaviour and noticing a bruise on his young sister's face asked how this had happened. This provoked a hostile response:

> *Mum just totally erupted she screamed 'oh I can't look after my children now you come into my house, I'm talking to you, get out, get out' so ....she chucked me out of house and ....she wouldn't let me back in ....you know I mean I thought she's gonna assault me...she wouldn't have I'm sure but she chased me out of house and I sat in car. ....it was quite frightening you know I was a bit shaky once I got outside (SWA1)*

The worker then had to try and go back into this frightening situation to find out more about the bruised child. Analyses of child abuse inquiries have highlighted the stress and vulnerability workers feel in peoples' homes and how this can affect decision making (Reder et al, 1993; Brandon et al., 2008) . There is the sense very strongly that the workers are on hostile ground and crossing the threshold into someone else's house is an important transitional step (Ferguson, 2011).

One worker described angry visits to a pregnant woman who is being assessed to see if she can care for her baby.

> *I was met with a barrage of insults and, you know, from (pregnant woman) saying oh you're supposed to be keeping families together not splitting us up and you seem adamant on splitting us all up and, you know, again I had to repeat how important it was for the baby to be safe and then go over what had happened with J again, again, she didn't want to hear this. So, lots and lots of upset (SW7)*

The worker commented that the grandparents and aunts in the extended family, who are being involved to provide some support to the pregnant woman are also angry with her and are not infrequently present when she visits. At one point:

> *She told me during the last session....that she wished that I'd never, ever have children because she despises me and all of this stuff. I mean how...what do you say in response to that? (SW7)*

In the face of this hostility and upset the worker must carry out an important assessment of the mother's capacity to care for an as yet unborn child.

A newly qualified worker who is still feeling inexperienced describes visiting a family with a new baby and an alcoholic mother

> *I felt quite intimidated in their house....there was me, mum...dad always hovered round which made me sometimes feel intimidated because he could never sit down and relax he was always up and down and walking round. And then a lot of the time mum's mum, the children's grandma, would be present because she provided a lot of support in terms of child care so the majority of the time she'd be present....on one occasion I was presented with verbal abuse by grandma as well because of mixed communication about smelling alcohol on breath ...grandma thought I'd reported that it was her breath I'd reported smelling alcohol on so as soon as I walked into their house I was presented with verbal abuse from grandma, swearing: why have you told the social worker this, why have you told her that, which again made me feel really uneasy....(SW9)*

When she smelled alcohol on the mother's breath during a morning visit she decided not to challenge her there and then but to go back to her office and seek advice. The unease of this worker is palpable. She describes having to prepare herself for every visit to this home and her relief when they are over but she also sees it as an important learning experience: you've got to be able to cope with this kind of thing as it's part of the job:

> *Actually approaching the house I felt nerves and anxiety but after doing it you kind of get used to it and think I've got to do this, this is my job, I'm going to approach much worse than this in the future and then after leaving the house I felt a bit more confident in myself and more ready to do the next session with them and to go back and think well yeah I can build relationships with challenging parents and that is sometimes the challenge of working with children and families, when there's issues of violence and aggression. You've got to kind of overcome it haven't you?(SW9)*

Other, more experienced, workers echoed this point that dealing with hostility and becoming stressed by it is just part of the job – you have to be able to deal with it. The newly qualified worker is well aware that she needs to be able to do so as part of gaining in authority – that process of developing one's moral career that Pithouse (1998) noted. To demonstrate confidence in the face of crisis is a key moment in a social worker's moral career. Most participants took the view that facing resistance or hostility was part of the job so they had to accept it:

It's almost, you almost come to accept and anticipate that there's going to be hostility so it's just part and parcel of our job....(SW7)

7.2.3 Complex relationships

Being hesitant in challenging family members may not be just because of the fear of what the consequences might be but in some cases due to the complexity of the relationship. The worker unnerved by the family above felt an empathy with a teenage mother she was working with who lived in extremely difficult circumstances and both she and her supervisor felt this could get in the way of focusing on the child's needs:

So I think the emotional link that I've got is just basically empathising...understanding that actually S's 16 years old, she's still a child. Being a young mum with a good family background would be hard enough in itself but the fact that she's got all these implications of domestic violence and disability involved....she's got issues with her own partner that she's now resumed her relationship with ....she's now got back with him...so there's lots of issues going on in S's life and I think that's the thing.... I think that's something I think about really, just the fact of how young she is and the things that she's got to cope with in the house. (SW9)

There are certain phrases that recur frequently in the social workers' talk – phrases which, to paraphrase Atkinson (1995) might be seen as the liturgy of the profession. One of these is about "the child's best interests" – interests which, legally, the social workers should prioritise. But in complex situations such as the one above where young and vulnerable adults are struggling to bring up children it may not be easy to isolate such "interests" from the need to support the carers and indeed a good deal of the work discussed here did involve major elements of such adult support.

One worker, talking about a case where she was working with a mother with learning difficulties and a partner who was seen by the social worker as obstructive and domineering tried to persuade the woman to access a service by telling her it was for her as an individual not as a mother:

it could mean that you would get more money because you could get DLA (Disability Living Allowance) – they might be able to come and help you with things. It's not about your kids it's about you and you know, you as an adult, you as a person and you know she'd already told me she struggles...she can't read and write very well....and so what they arranged was that the person doing the assessment would go do it at the Children's Centre so kids could be in the crèche so we got rid of that barrier in terms of you know you don't want to trail over there with the kids....(SW4)

What is notable here is the many different ways the mother is seen by the worker: an abusive parent, a possible victim of domestic abuse, someone with learning difficulties, someone who has had a terrible childhood, someone who can be told – this is for <u>you:</u> as an adult, an autonomous individual. So it is not straightforward who she is or how she should be treated.

This worker describes the way she is drawn into a complex relationship with the woman's partner - a hostile father who, for all his hostility, relies on the worker for support:

> *visits to that house are very mixed when he's there because on the one hand he'll be shouting and refusing to listen and telling you all the time I want proof, you get me proof, you get me proof and then next thing he's saying thank you 500 times because I've got the man from the Council to go round and look at the damp and sort the toilet out that wasn't working properly. And so he's very grateful for that kind of thing and can acknowledge that yeah you've done something for me (SW4)*

Questions arise as to how these complex relationships that involve both caring for and monitoring hostile or difficult clients affect decision making and fit with the more forensic, investigatory element of child protection work.

As well as hostility workers faced family members who were in distress after a child was injured or had died. One worker describes interviewing parents who had brought their child to hospital with a skull fracture:

> *...mum was almost rigid with fear...she couldn't give us eye contact, she was very very angry, she felt her baby was going to be taken away, she was really under severe stress.(TM2)*

Or in another case where a baby had died and the workers were interviewing the parents:

> *I mean at this point mum runs out into the garden screaming, you know, we give her a while, we ask him to go out and comfort her and try to talk to her...(SW3)*

In both of these cases grandparents were also present and making their distress and antagonism towards the workers plain.

This worker graphically describes feeling some of the parents' pain and distress at the death of a child whilst knowing that the actions she must take may well make them feel worse:

> *And I went to the hospital, I went with (TM1) actually, and we had to interview the parents, and at this stage the baby was very critically ill, dying probably, and the police had to be there as well and we interviewed...the police interviewed and I interviewed, (TM1) took notes, the parents and you get an idea when you're dealing with people all the time you just get an idea of who they are and what sort of people they are and both myself and (TM1) came out of*

there and said how awful, you know, they came across as caring, loving parents and how awful and, yeah, but you have to go through the process obviously.(SSW2)

Another worker hauntingly describes visiting a mother whose baby died at birth:

yesterday I visited a family who...she experienced a death...she went into labour early at 26 weeks with twins and one of those twins died so yesterday she got the memory box out, of the twin, and showed me his little tiny dummy and his little tiny nappy and photos of him....(SW9)

7.2.4 Summary

The home visit is a central aspect of social work practice and presents both unique challenges and unique opportunities. The emotional context of decision making in these situations, compounded by fear, distress and anxiety about contamination (Ferguson, 2011) may be a significant factor in the way decisions are made. Studies of child death inquiries have shown how workers become emotionally enmeshed with the families they work with and this can have serious consequences for decision making (Reder et al, 1993) . It has been observed that the focus on orderly decision making and procedures in such inquiries simply fails to recognise the importance of such factors and limits how useful they could be for practice (Cooper, 2005). Brandon et al. (2008) have described the state of helplessness workers are reduced to by some families with particularly complex and intractable problems.

There are cognitive challenges too as social workers have to form judgements and make decisions in chaotic, fast-moving situations which do not allow for more orderly forms of decision making (van de Luitgaarden, 2009; Helm, 2011).

Yet the home visit provides opportunities to see families functioning in their normal day-to-day surroundings, sometimes in poor conditions, which would not be provided by encounters in more professional or clinical surroundings.

The workers I interviewed acknowledged such issues, especially the stress of some aspects of this work, but felt that their decision making was not affected by it. Learning to cope, learning to demonstrate competence in a crisis, is, as suggested above, an important part of a social worker’s “moral career”. Yet many child abuse inquiries and reviews reveal examples of workers being refused entry to homes or to rooms within those homes and of acting in such a constrained manner when in peoples’ homes that vital evidence of child abuse has been missed.

7.3 "Building a picture": doing assessments

Assessment was an essential element of the social workers' practice. At the time of my study the government guidelines called for workers to provide an Initial Assessment and then, if deemed necessary, a more in-depth Core Assessment. Both of these assessments had strict timescales attached to them and keeping to these timescales was a major preoccupation of the participants. Initial Assessments, which had to be done within 10 days, a period of time that included contacting the family, arranging to see them, forming some kind of working relationship with sometimes very reluctant clients, trying to communicate with the children, gathering information and then completing the necessary forms, were often rushed and several participants told me that these were sometimes done in a day with just a single contact with the family. The poor quality of the work done under such conditions has been the subject of much debate and research (eg Broadhurst et al., 2010b). More detailed Core Assessments had to be done within 35 days.

Since the change in government, the publication of the Munro Review (Munro, 2011) and the redrafted *Working Together to Safeguard Children* guidelines (Dept for Education, 2013), local authorities have been given permission to vary these timescales. A single, continuous assessment is now recommended with a 45 day timescale. These changes were just beginning to be made at the time of my study but had not yet filtered into practice.

These assessment were usually carried out in peoples' homes. Family members might be reluctant, distressed or hostile and other family members might well be present and keen to contribute their own views. The views and actions of other professionals could have an important influence on the nature of the assessment. In addition these were often assessments of highly complex, ambiguous and uncertain situations where "truth" might never be established and workers were aware that optimal solutions to problems might not be available.

One worker describes trying to undertake an assessment of a teenage parent and her baby in a chaotic household. The worker has noted the young woman's "low mood":

> *She's saying it's because the sessions are taking place in the house where people are there and people are butting in on the session which is understandable so the way to get round that is we've organised sessions at the Children's Centre so that S is alone with me and her baby so it's free from interruptions. (SW9)*

They are able to do some of the assessment sessions at the local Children's Centre where the worker is able to make some observations of domestic routines that she sees as important in assessing the parent-child relationship.

> *so obviously I'm observing what's happening all the time and at the Children's Centre this week S brought BJ with her so she was in the room with us when the session was taking place. So it's obviously observing...opportunities that I've got like when BJ needs changing so I'm observing that, observing S feeding BJ, how she responds to her when she's crying, if she's trying to comfort her, if she's talking to her, if she's trying to stimulate her...so I'm observing that all the time really. (SW9)*

The same worker, visiting another family, goes at tea times in order to observe the mother managing both her children during a domestic routine. On this occasion the eldest child is refused a packet of crisps before tea and becomes very angry, leading the worker to suppose that such a refusal is not the usual practice but has been made because of her presence. She actually decides to leave to prevent the situation escalating. But this is an example of a phenomenon several participants mentioned – that families put on a show for them and tell them what they think the worker wants to hear. While a popular image of social workers is that they are gullible and naive the workers in my study were well aware of this factor.

This worker isn't taking the family member's story for granted even though she's upset and wanting to talk:

> *...and when I went down you can imagine that day she were very upset and telling me all the things, you know, that I suppose I wanted to hear (SW5)*

While there is evidence that social workers may assess parents according to their level of cooperation which can blind them to serious failings in their child care (for example Reder et al., 1993) there were instances when cooperation was viewed more suspiciously than the non-cooperation the workers expect. An example of this was given in the previous chapter where the cooperation of the mother of a child with a small bruise was seen as possibly motivated by a desire to put the blame onto the father with whom she was in dispute.

But despite all this workers need to gather relevant information and analyse it carefully. This worker describes a forensic process of information gathering which she is aware may need to be used as legal evidence:

> *I like things being very clear about the events leading...being very clear about dates and events so the events leading up to the actual investigation because potentially any situation*

we're dealing with is going to have some police involvement so we're very aware of our ability to collate information which may actually be used by the police and we may actually have to give a statement to, so particularly when there are... er..., when there's a child with an injury you need to be very clear about what the account is there at that time, because in a number of cases it can change as time passes, parents either change their story completely or remember the details and whatnot so it's very important to be very clear and consistent from the start about who's saying what and when and where, and so that, that actually is quite a difficult thing to do at times because in a way you have to interrupt parents, you have to stop them doing what they're doing, re-focus kind of a conversation. (SW1)

At the same time this worker is also wanting to find out about the family's day to day functioning

Well we'd be talking about the other children as well......kind of the way the family operates on a day to day basis really....(SW1)

As a number of the assessments took place following injuries or even deaths of children this combination of forensic, investigatory work and the more traditional social work focus on family dynamics was seen in several cases. This meant trying to undertake an assessment with distressed and angry families:

That (mother's anxiety) was in many ways made worse by maternal grandparents who kind of whipped up a bit of a frenzy against us. They were particularly antagonistic. They were very nasty, very personal and very abusive towards (SSW1: the co-assessor) and eventually made a formal complaint and dad himself, he was just beside himself, didn't know how to handle the situation. He was equally stressed and that came out in...you know he ran out of the room, he refused to talk to us, was crying...they really thought they were going to lose their baby. ......eventually they calmed down enough, they cooperated with assessment sessions.......they never stopped being distressed but they were happy to talk to...or happy enough. (TM2)

Again, as well as trying to find out what happened leading up the child's injury which had happened at the end of a family holiday the assessment looked at wider family functioning:

well, (we) did a Core Assessment which was following the Framework (see below) but in particular (we were) looking at the dynamics between the parents, you know, what was their relationship like....history of any violence....relationship with the grandparents – why was there such antagonism and anger and we looked at the specifics of what went on each day on the holiday, you know, you can walk somebody through a holiday you can get a feel as to whether there was any conflict, whether the children were left with anyone else, whether there were any other issues........It was just going into the nuts and bolts of their relationships, their day-to-day things, their background, looking for any possible indicators of risk and vulnerability.

Because we know that sometimes, well, often, in families where children are injured there are constellations of vulnerabilities that come together that, you know, erupt in this kind of incident...or possible incident...(TM2)

This worker is referring to the Framework for the Assessment of Children in Need and Their Families (Dept of Health, 2000) which social workers are required to use when undertaking assessments. They have to consider 20 "dimensions" grouped into 3 "domains" – Children's Developmental Needs, Parenting Capacity and Family & Environmental Factors – which together are intended to provide a holistic or ecological assessment. This participant, who spoke of trying to take a "systems" view of family situations, uses the image of "constellations" to suggest the putting together of these dimensions into patterns or themes.

Extended family members could be asked to participate in social work plans to support and monitor families although they might be deeply ambivalent about social workers being involved. In one case the mother of a woman undergoing a pre-birth assessment because she had abused a previous child agreed to have her daughter live with her so she could keep an eye on her parenting. This might be the kind of support many families might offer but in this case it was part of a social work plan and the woman was not necessarily in full agreement with it.

granny had come on board...granny was initially saying yes I understand that she could be a risk ....but then was saying well then I think you're being very harsh with this (SW7)

Enlisting the help of other family members may be very important in keeping children safe but it may not be clear how fully, or for how long, these family members will work cooperatively with the social workers.

More in depth Core Assessments were often seen as creating a wider, more holistic view. The phrases "building a picture", "building a bigger picture" recurred in several interviews and seemed to be a useful metaphor for several of the participants, perhaps similar to the framing process described in naturalistic decision making (Klein, 1999; O'Sullivan, 2011). Munro (1996), using a similar metaphor which has been widely taken up, suggests assessment is a jigsaw puzzle in which pieces of information, which by themselves are of uncertain meaning, have to be assembled without any guidance as to what the picture on the box might turn out to be. It has been argued that the assumption that a complete picture will ever be assembled is questionable and that the "full" picture will, in any case, mean different things to different people (K. Thompson, 2012). The participant cited above who spoke of "constellations of

vulnerabilities" later used the image of a kaleidoscope – an object designed to create shifting patterns and views.

The ambiguity, complexity and uncertainty of many cases meant that many of the participants mentioned having "niggles", intuitive feelings that things weren't right or needed further investigating:

> *…, there was something that didn't quite settle in the back of my mind, it was like there was something niggling at me that this just wasn't quite right. (SW2)*

or:

> *I suppose you get that little niggle and think that's not quite right.... I don't know I can't describe it.....I don't know, I don't know, just a niggle, just like a feeling that something's not right. I don't know I can't describe it to be honest. (SWA1)*

These comments suggest that intuitive reasoning, tacit knowledge and practice wisdom were important elements in enabling the social workers to respond flexibly to complex, uncertain and dynamic situations. Assessments were rarely straightforward or obvious and when they appeared to be so the workers were very conscious that this was quite unusual. As one manager described an assessment

> *it's like an unfolding story really. (TM1)*

suggesting that decision making becomes a complex sense-making process rather than an orderly and linear one.

7.3.1 Summary

Undertaking assessments of children and families is another crucial aspect of social work practice and featured in many of the participants' accounts. These assessments presented significant challenges to decision making.

They often took place in peoples' homes where routines and activities could be observed but they often took place with reluctant, hostile or distressed family members. Members of extended family networks might be present and they could offer valuable information or become involved in the social workers' plans to support the family but they could also be a further source of hostility and add to the complex of differing family perspectives and relationships which the social workers had to consider. It has been suggested that the post-modern complexity and diversity of family relationships, some of which we do not have a

vocabulary for, was not well understood by professionals whose knowledge was based on more conventional or traditional models (Silva & Smart, 1999; Saltiel, 2013).

The complex, uncertain and dynamic nature of many situations meant that the social workers needed to respond flexibly and quickly to a large number of environmental cues which were often disputed and fallible: building pictures and making sense of unfolding stories rather than weighing each factor in an orderly and sequential fashion. Building pictures, constructing jigsaws, images of constellations and kaleidoscopes were all metaphors the participants used to describe a process of trying to put these cues together into coherent patterns that began to make some sense to them.

7.4 Working with other professionals

Child protection work takes place in inter professional contexts and it has increasingly been shown that failures of communication and cooperation between professionals lie at the heart of many tragedies (Manthorpe & Stanley, 2004; Corby et al., 2012) . Indeed, hardly a review or inquiry into a child death concludes without pinpointing failures in professional communication. There is something of a "solid" and "liquid" (Ferguson, 2004) dichotomy here too: on the one hand the official view is that inter professional communication is an unalloyed good thing and usually works well and a much more mixed perspective from researchers and practitioners. An overview of this research has been presented in chapter 3.

Government policy - as in the *Working Together to Safeguard Children* guidelines (Dept for Education, 2013) - and legislation (the 2004 Children Act) define child protection as an inter professional project and these participants worked alongside other professionals as a matter of course. While I did not ask any questions specifically about this topic it emerged as a theme in 75% of the interviews.

In my observations of duty sessions I observed workers almost as a matter of course referring cases involving teenage children to their schools for advice and intervention. On some occasions workers argued that as schools were universal services their input would be less stigmatising than that of social workers. The social workers' awareness of the unpopular nature of their work and the frequent lack of an optimal solution to problems seemed to lie behind this but I also observed quite complex cases being referred to schools which made me wonder how appropriate these referrals were. In other situations health visitors and midwives were asked to monitor situations. So the social workers seemed to use referrals to other professionals as part of gatekeeping. How satisfied they were with these professionals

seemed to some degree to depend on their willingness to take on these cases. Some schools for example were seen as willing to take cases on and not to panic about them others were less willing and quick to refer cases back.

The child protection referral I observed being dealt with began with a referral from a Health Visitor who had visited a parent who pointed out a bruise on her child who had just returned from contact with his father. While the incident was being treated seriously the workers spoke of the Health Visitor with respect as an experienced colleague but an inconclusive medical and the discovery that the allegation from the mother seemed to be part of a custody dispute changed this. When the social worker returned from visiting the family I noted this conversation:

> *Social Worker: I couldn't see much of a bruise. I had to take him into the light to see it.*
>
> *Manager: Sometimes it's (the Health Visitor's) vivid imagination. She gets carried away (observation field note).*

The Health Visitor's expertise was now openly questioned. Throughout my study participants were careful not to blame colleagues in the team for mistakes or suggest they lacked competence although it was clear that errors and mistakes did get made: Pithouse's (1998) theory of an "assumption of collegial competence" (p.55) has been discussed earlier. Other professionals, outsiders to the team, do not have this assumption extended to them.

In this same case it was necessary to have the (alleged) bruise seen by medical experts who could determine whether or not the injury was non-accidental. The workers expected this would be inconclusive, that doctors would be reluctant to state the nature and time of the bruising and in this they were correct. The child protection medical is an essential part of many investigations yet when medicals were discussed by participants it was usually to say how inconclusive they were even in cases of serious injury. In one case a child was hospitalised with retinal haemorrhages and sub-dural haematomae – life threatening injuries strongly suggestive of non-accidental injury by violent shaking but in this case the child had been born with severe disabilities.

> *So, the difficulty was that medical professionals were saying 'we don't know how these are being caused, one potential explanation is non-accidental injury' and then as time went on they started putting forward these hypothetical situations that could have caused them but at the same time they'd never seen them before (SW1).*

In the end no conclusions were drawn and it was never certain how the injuries had occurred. A similar case involved a child taken to hospital with a skull fracture. The family said they thought the child's sibling had thrown a toy at him and the police decided there was no action for them to take. Again a medical did not provide a conclusive answer:

> *and the radiologist....felt that he couldn't rule out that the toy may have caused this injury - it's extremely unlikely, he'd not experienced it in his professional background but couldn't entirely rule it out.(TM2)*

Again there is a sense here that medical examinations are often not conclusive but part of a complex unfolding story and just as ambiguous as other elements of that story might be. The doctors were often very reluctant to commit themselves and for the social workers there was a sense of a group of professionals who were clearly highly respected in the courts and whose opinions were vital for decision making on cases – the social workers depended on them heavily – but who often turned out to be less than reliable colleagues.

In another case a small child was medically examined to see if he had been sexually abused by a relative with whom he had spent a weekend. The social worker, with some misgivings, as she knew how distressing the experience would be, persuaded the family to give permission for the examination:

> *and it's very distressing listening to a little child really screaming and sobbing and you know really, really distressing.....and I don't know how much of that is the examination itself or just the fact that he's in a strange place with strange people and his mum and his grandma were there but I'm sure it's still very disturbing for a small child to be in that environment....So we did that, and obviously grandmother and mother were very distressed as well...and I think C (the other social worker) and myself were quite distressed as well...um, so, once that had concluded they...the doctors sat down, sat them down, and said actually I can't see anything to suggest he's been abused. Everything looks pretty normal. (SSW2)*

Here at least the medical exam has had a positive outcome in putting the family's minds at rest but it was an unpleasant experience.

In this case suspicions had been aroused because the relative was acquainted with a known local paedophile who was the subject of a major police investigation. The police had given the social worker some information which she was told not to pass on to the family and she clearly felt constrained by the police and had some anxiety that she might say the wrong thing and compromise their investigation. While the social worker felt that getting the child

examined was worthwhile she was influenced by the police need for possible forensic evidence.

> *So, we were really debating whether or not we needed to have D medicalled to see whether he had been sexually abused and obviously that's quite a difficult decision because it's an invasive procedure in itself and very distressing for the child also....he was so little anyway that he wasn't going to be able to substantiate anything verbally, he's only got a few words and.....so we ummed and aahed and I said well I'll discuss it further in the morning when we'll see where we go, so then I had discussions with the consultant paediatrician, Dr P, and obviously gave him the scenario, the background, the information we'd got (SSW2)*

The decision was only reached after consulting the police and medical staff but the possibility that some forensic evidence might be found was clearly a factor in the decision.

In another case a child suffered serious injuries and the police begin an investigation. The social worker felt that this investigation powerfully shaped her work – she said she felt led by the police, constrained by what information she could and could not give to the family and constrained as to what decisions she could make.

> *....I really felt that we were being restrained by what the police were doing and it drifted because of that (SW3)*

The child died and the police were now investigating a possible murder. Because of the high profile of the case senior management became involved and took over some of the decision making about the future of the dead child's sibling. She did not agree with all of the decisions made because she felt that focused on the short term rather than the longer term needs of the child.

> *Everything I believe we did properly but we could have done things better. (SW3)*

The social worker felt that the serious nature of the police investigation and the involvement of senior managers profoundly affected decision making. While the decisions made were "proper" they could have been better geared to the long term needs of the dead baby's brother.

In another case where a child had died and senior managers became involved the social worker assessing the family made a decision about the parents' contact with their children which was countermanded by senior management and she drew a distinction between a "safe" and an optimal decision:

I made the right decision. Service level made the safest decision, I think...is the best way of putting it...but mine was right (laughs).......(SSW2)

Police actions in another case of an injured child were quite different. In this instance parents took their child to hospital having noticed some swelling in his head and a fracture was diagnosed. The family seemed respectable and the police quickly decided to take no action. The worker felt there was

....some collusion between the police and the family ....the police officer had done some informal interviews, literally 10 minute chats, with people and decided that, you know...shrugged his shoulders basically. We don't know what's happened to this baby but, you know, these people seem to be alright kind of thing.(TM2)

The family were then extremely aggrieved that the social workers continued to assess the situation. The social workers involved found themselves trying to steer a middle course between police inaction and a team of colleagues who wanted to immediately remove the child under a Care Order:

. we'd got three different perspectives: the police were quite clearly saying, which shocked me rigid really, but this didn't meet their threshold to investigate so therefore we're not going to interview the parents or anybody. The (longer term child care) team were saying this is a really serious injury to a very small child and we need to start Care proceedings and maybe ask a Court to make a Finding of Fact and there was (SSW1) and myself saying we need to do an assessment....(TM2)

The "Working Together" procedures (Dept for Education, 2013) require a range of interprofessional meetings and case conferences to take place at which important decisions are made about safeguarding children. Such meetings can be productive but can also cause major disagreements in which professional differences come to the fore . One worker faced strong disagreement at a Case Conference from other professionals regarding a plan she was suggesting to protect a child. To some degree her past experience had led her to half expect this:

Quite often what happens at conferences is that it's like us against everyone else including the professionals (SW7)

In this case she was annoyed because she felt some professional colleagues had agreed with her prior to the Conference but were now disputing her plan and this continued into subsequent meetings:

> *and so at the core group the family and also the midwife and the Children's Centre worker they all kind of ganged up on me...(SW7)*

However despite such disagreements it was necessary to try to maintain harmonious relationships albeit with some difficulty

> *because you've got to sustain some sort of, maintain a relationship with them because of course the following week you could be working with them on a different case, so yeah that was particularly difficult......(SW7)*

There is evidence that such meetings can be prone to a range of group dynamics such as groupthink which can compound some of the errors and biases to which decision making is prone (Munro 2008).

It seems clear that decision making by social workers must be seen in the context of inter professional collaborations which can be prone to problems of poor communication and information sharing in which "atrocity stories" (Dingwall 1977; White & Featherstone, 2005) about other professionals (such as some of the accounts cited above) can thrive. The social workers in my study worked closely alongside health visitors, nurses, doctors, schools, the police and other professions and at times their work and the decisions they made were enmeshed in those inter professional relationships.

7.4.1 Summary

Inter professional working is an inescapable aspect of child protection work. Official guidance demands it take place according to certain procedures and it is a common feature of daily practice. Social workers routinely worked alongside doctors and other health professionals, health visitors, schools and the police and these collaborations significantly shaped the way they practised. While the social workers depended on the expertise of these professionals inter professional relationships were not always experienced as helpful or useful. One example of this was the carrying out of medicals where children had been abused. These medicals are a crucial element of many child protection investigations yet they are often inconclusive and fail to provide definitive answers. Another was the way social work decisions were affected by the need to cooperate with police inquiries.

In a number of serious cases senior managers who would not normally become involved in such work intervened and made key decisions that the social workers felt were not necessarily in the best interests of the children and families.

Decisions in the cases discussed in this chapter were rarely taken by social workers acting alone. But in both daily practice and in the more official meetings where child protection cases were processed decision making could become a contested matter with inter professional differences coming to the fore.

7.5 Conclusion

In this chapter three themes have been identified as characterising the social workers' daily work with families: home visiting, undertaking assessments and working with other professionals. All three suggest a practice world of considerable complexity, very different from more straightforward technical and legalistic accounts. Information and knowledge required for decision making is almost invariably contested, complex, emotionally and cognitively demanding and is usually contingent upon and constructed within the contexts of daily practice rather than appearing as "fact".

But social workers have to make vital decisions, sometimes very quickly, about protecting children and these accounts of practice often try to strike a balance between "traditional" social work values and more forensic, investigatory approaches. There is a tension between what Platt (2006a; 2006b) describes as an "events-focused....incident driven culture" (2006a, p. 275) which has quite a narrow focus on risk factors and a more wide ranging engagement with and assessment of families' practices and interpersonal dynamics. Holland (1999; 2004) suggests that there are two discourses of decision making in social work assessment – a "scientific" approach that emphasises gathering facts and listing risk factors and a more "reflective" model that emphasises an in-depth assessment. The suggestion is that workers follow one or the other model but the participants here seemed often to be trying to follow both, reflecting the complexity of their relationships with family members: a complexity that involves elements of caring and controlling and where many family members are, at different times, seen in different ways: as parent, teenager, victim, perpetrator or abuser and as self-actualising adult.

The encounters, visits and other activities that make up the participant accounts in this chapter exemplify Ferguson's (2004) concept of the liquid and Pithouse's (1998) of invisibility: much information gathering and decision making took place in fleeting, transient moments, in private, intimate places, rendering crucial elements of practice difficult to see and to analyse.

This practice world was characterised by complex, uncertain and dynamic situations that required complex sense-making. The cases discussed here had a number of key features that

made gathering undisputed information about them difficult because of complex family relationships, problematic and contested situations where levels of risk could be hard to ascertain, disagreements between professionals and a lack of clearly articulated professional knowledge about the diversity of family practices in a post-modern society.

Such a world may be best suited to intuitive reasoning based on experience and practice wisdom (Hammond, 1996; Hackett & Taylor, forthcoming). Some social workers talked about assessments as "building a picture" or creating a kaleidoscope and this may suggest they were creating mental representations as suggested by naturalistic models of decision making such as Klein's Recognition Primed model (Klein, 1993) and Brunswik's judgement analysis (Hammond, 1993; Thompson & Dowding, 2009) where experience and professional cultures create a "lens" through which situations are judged. In such models creating a coherent picture or narrative is important in making sense of complexity. As has been argued, intuitive and naturalistic models have considerable strengths and may be best suited to the realities of daily practice but they are not infallible and are open to a variety of errors .Models of analytical decision making which consider factors sequentially may be important in uncovering and correcting these biases. However there was little evidence that in daily practice the social workers were incorporating the tools of analytical decision making such as risk assessment or Structured Decision Making schedules in their assessments or making explicit use of research- and theory-based evidence.

Formal management practices such as supervision are, it is often suggested, the best place to employ more analytical reasoning. These are also the practices within which social workers account for – or as Pihouse (1998) puts it – render visible – their actions. This area of practice is the subject of the next chapter.

CHAPTER 8: FINDINGS III – Management and Supervision

8.1 Overview

It was anticipated from the literature review that management and supervision would be a key theme. Poor supervision and poor management have frequently been identified in inquiries and reviews into child deaths and since the 1970s social work, like other health and social care professions, has experienced increasingly directive management (McDonald, 2006; Alcock, 2008; Harris & White, 2009).

Questions on supervision and management were included in my interview topic guide and participants also discussed their experiences and perceptions of supervision at other points in the interviews – particularly when discussing in detail the case I had asked them to bring to the interview. It was, then, one of their major preoccupations. In addition, when observing both teams at work and in team meetings, I saw a good deal of informal team talk in which cases and workers' experiences were discussed and this seemed such a feature of the work that I included a question on this in my interview schedule. I had planned to observe some supervisions. I observed two but it was so clear I was disturbing the setting that I did no more. I did use some of this observational data to inform my subsequent interview questions.

This chapter is divided into three sub-sections. The first section is drawn from participants' talk about their experiences of being supervised. The managers, who acted as supervisors, were also being supervised by more senior managers, so their experiences and perceptions of being supervised are included here. The second section draws on the accounts of those who managed and supervised others. The third section draws on observations and interview accounts of the more informal team talk.

Supervision is widely seen within social work as an essential tool for ensuring good practice, professional judgement and decision making (Hughes & Pengelly, 1997; Morrison & Wonnacott, 2010; Wonnacott, 2012) It can be of poor quality and is no panacea (Helm, 2011) but the ideal is regarded as indispensible to good practice. In this chapter participants give accounts of what they saw as both good and bad supervision - supervision that helped in the making of decisions that protected children and supervision that failed to pick up and correct errors. A feature that emerges in all the accounts concerns the complexity of supervision as a social encounter. The selectivity and artfulness of workers in presenting accounts of their work in supervision, the variable skills of the managers in addressing these accounts and the

importance of supervision in sustaining team identity and morale are all significant themes. These complexities may not be easily captured in official accounts of supervision yet played a very important part in participants' talk.

8.2 The social workers and supervision.

While a number of the social workers pointed to problems and shortcomings in their supervision they all said that they found it extremely useful. No-one complained that they did not get much supervision and there seemed to be a culture within the team and the wider organisation whereby supervision was valued and took place regularly.

> *I've always felt that (Banksfield)has always protected workers, protected social workers, always protected newly qualified social workers. We hear horror stories in other authorities that newly qualified workers are thrown straight to the lions, into child protection, into court when they shouldn't be there, and I think that's why people've stayed in (Banksfield) because they have been protected, they have been nurtured. (SW3)*

Workers often said that they valued being able to talk over cases and the issues the cases raised. Being able to just talk over situations, to bounce ideas around, to reflect were all mentioned.

> *...just talking about that case and talking about what plans I feel we should be doing...what things in the case I should be doing and just bouncing that off your manager and getting their feedback or something else to try or another suggestion that you might not have thought about before. (SW6)*

Here advice from the manager is not seen necessarily as the correct answer but as another possibility, something different to try or to think about. The idea of "reflection" was used by a number of workers to describe this process

> *Interviewer: so what would you say were the most useful things about supervision?*
>
> *SW9: I think just reflecting on your own practice really....*
>
> *Interviewer : and what does that mean, reflecting....?.*
>
> *SW9: well, looking at what I've done and looking if anything could have been done differently, any ways that I can improve on things.............*

Another worker uses the term:

> *I mean reflecting on cases is always really good. (SW1)*

This worker gave the *caveat* that there was not always enough time for this reflection – if your manager was in a rush or busy: in that case you might dispense with reflective discussion and come to a decision quickly:

> *I guess it's dependent on how much time that manager's got that morning and sometimes that can be quite a bit of time so that you can have in-depth discussions about the cases really, and other times...umm... it's not so much reflecting it's more about your views, and coming to a decision with your manager about, about how that case should proceed (SW1)*

Where there was not enough time the more analytical sequential discussion of evidence that is recommended (Munro, 2008) did not occur and supervision became much more like the quick-moving intuitive decision-making of practice: supervision mirroring practical decision-making rather than reviewing it. Asked if she was able to use supervision for reviewing decisions one worker commented:

> *we don't get a massive amount of opportunity to do that because it's like a conveyor belt – one in, one out, one in, one out...that's what it feels like. (SW6)*

Another worker said that:

> *supervision for me is really useful to discuss case by case, share my... what's happening in my case, what I think should happen in my case and where we're at and then to get that feedback from whoever my supervisor is then, see if they agree with me or what they think and it's sometimes useful for someone else to look at it from outside that's not involved in it and sometimes you know they can pick up things, not that you've missed but that you could do differently. (SW3)*

Again the worker is emphasising the value of discussion and of getting some feedback or advice which may not be the "right" answer but which offers another perspective. But again there isn't always enough time for this:

> *I try to be organised in supervision but in this team things move that quickly and sometimes our caseloads are quite high. I sometimes...you go into supervision where you've got lots of cases and if you're not organised it is really difficult sometimes to remember everything. (SW3)*

Having some space to think and reflect with the supervisor, then, is important – sometimes having the space itself is enough:

> *supervision's good to be able to sit and have someone else's whole attention for an hour (SW5)*

but in a busy work environment that space is at a premium.

As we have seen some workers emphasise the importance of discussion and reflection – getting different perspectives that may not be the "right" answer but which offer the opportunity to think differently about a case. "Reflection" is the term a number of workers used to describe this process whereby practice is deconstructed and considered from different perspectives. Morrison and Wonnacott (2010) define "reflective supervision" as being about the "exploration of practice" (p.3) rather than checking that procedures and targets are being complied with.

However social work takes place within bureaucratic organisations where a plethora of local and national procedures, guidelines and laws have to be complied with and the workers were well aware of this. They were careful to distinguish decisions they could not make themselves, such as instigating legal proceedings or using expensive resources, which managers had to make. They were also clear on the importance of keeping managers informed about what was going on so that the manager was part of any decision and would, presumably, back the worker up. Asked what she found most useful about supervision one worker said

> *well to make sure I'm doing things right to be honest, you know, to have that support and run things by....making the right decisions on what I'm doing I suppose, you know - is this right that this case closes or is it right that it transfers to another social worker ?(SWA1)*

Several of the cases workers described involved child deaths and serious injuries and in these cases workers felt that managers were very clearly making the decisions:

> *well we had formal supervision and obviously informal supervision because obviously this were a daily thing – either seeing the child, seeing the parents, liaising with police and we would feed back a lot of that to our manager and have debates about where we would go next really, step by step really, so that everyone were clear about what our plan were. (SW3)*

In this case the worker felt that by keeping a tight grip on what decisions were made the senior managers prevented the social worker feeling isolated and ensured she did not make serious decisions without backup or support.

Several workers described different experiences with supervisors over decision making: some supervisors simply telling them what was going to happen next and others being prepared to discuss and negotiate:

> *.....I think with some managers you can have....you know they all operate differently so some managers allow you to go in...are much more receptive to you going in with what you think should happen and then negotiating that. Other managers have a firm idea about particular*

cases and about what should happen. (SW7)

One worker said of a previous manager:

> *I tend to find that supervision with X was very thorough but I kind of felt I came out at the end of that supervision with a list of things to do that had been decided by X primarily. I didn't ever feel as though I had a lot of input into making decisions about what we did with cases and I was able to say what I thought but it always sort of felt like I was waiting for X to say right, you need to do this or you need to do that and even though I knew some of those things....(SW4)*

Another worker describes a similar process:

> *we explain what's gone off, what I think, she chews it over and she'll make that decision (SWA1)*

Some workers were happy for decisions to be made by the manager in this way while others felt frustrated that their opinions and expertise were not being taken into account. Less experienced and less confident workers tended, perhaps unsurprisingly, to be in the former group. For them, feeling protected was very important. One worker describes a supervision when she was new to the work and of being told what to do very directly

> *I think.... I mean when I first started in the team when, you'd do an assessment and then you'd think you'd finished it, you'd think you'd spoken to everybody and then (the supervisor)'d say "well, have you spoken to this person and have you shared information with this person?" And you'd say "No I haven't" "well you need to go and do that and I'll not close it until you've done it." and then you'd think "Oh God, you know, that's gonna be another piece of work and it's gonna be open for another week", and then you'd done it and then you'd think "well actually, that's, that's the right thing to do because....." (SW2)*

As workers became more experienced they wanted to be consulted more closely. Several workers described using supervision strategically to present a case in a more confident manner that will have an effect on the supervisor:

> *we're choosing to tell (the supervisor) the information we want to tell her about a case, which will in effect, and we're presenting it in a certain way which will affect the decision making, so for example I could sit here and say Oh you know, Dad's still drinking, and I'm worried about this and ooh, you know whatever, or I could say Dad's had a couple of drinks but actually on the whole he's doing really well and that immediately creates a different kind of attitude (SW1)*

The suggestion here is that as a worker becomes more experienced they take more control, overtly or covertly, of the decision making. Managers, as we shall see, were often aware that they depended on the supervisee for information about a case and learning to explore or challenge that information was an essential element in becoming a more experienced

supervisor. It becomes clear that the relationships within a supervisory relationship are complex and change as both sides become more experienced and perhaps more strategic about how to present material, present themselves and negotiate with the other party. White (White, 2003), discussing social work, and Atkinson (1995), referring to medicine, have argued that decisions do not speak for themselves but must be "sold" and this process of "case formulation" has to be negotiated with colleagues.

Social workers often knew that they would be questioned and challenged, being made to justify their work:

> *(The supervisor) would ask "What do you think should happen? What do you think the outcome of the assessment will be?" so she was very good at putting it back on...very good at putting it back on us to think about what we should do and why we were doing things rather than "well this is what you...this is how you do it and this is my take on it." (SW2)*

or, as one describes it, "being put on the spot":

> *being put on the spot.... she's very like that and will, you know, put her pen down and say 'go on then,' and expect you to do all of that and I think that's really good and really important because it's really making you think through everything. (SW1)*

There is a sense here that being challenged, being put on the spot and made to justify your decisions means the supervisor is not just challenging you but acknowledging your ability to argue your case. Another worker suggested it showed the supervisor is prepared to spend time on you through discussion. This suggests that the relationship between supervisor and supervisee, their "rapport", is an important aspect of supervision. In both cases this approach is contrasted with the supervisor who tells you bluntly what is to be done.

Out of this dialogue some workers described gaining clarity in their thinking, getting useful guidance or fresh ideas, of working out priorities:

> *supervision always gives us a to-do list which is really good and because it's, it's monthly it means you're keeping on top of everything basically, nothing's drifting. (SW1)*

Workers said that they saw supervision as a place where anxieties about cases could be vented and reassurance sought. One worker recalled that when she first came into the work she found its demands overwhelming and supervision became something of a safe haven

> *So supervision for me at that time were invaluable really because it gave me the opportunity to have a cry and stuff because it were really really hard to fit in just because it was so fast paced (SW5)*

As I have argued, learning to cope with the demands of the work, to prove one's ability to deal with difficult situations, is a key element in the worker's "moral career" (Goffman, 1961; Pithouse, 1998). Supervision, for this worker, played an important role in helping her develop coping strategies. Without a sympathetic supervisor she might well have left the profession. Another worker who was newly qualified said that her supervisor accompanied her on home visits that she felt anxious about.

Workers appreciated managers who were calm and approachable, who didn't give vent to their own personal needs or anxieties but focused on their requirements as supervisees. Some participants gave accounts of previous supervisors who had been preoccupied with their own problems.

More negative comments were made by some workers. One of the most common was, as suggested earlier, lack of time because of the pressures of the work. Lack of time also became an issue when workers were unable to carry out all the tasks they had been given in supervision before the next meeting.

One criticism of managers who make the final decision on cases is that they do not have the actual experience of meeting the families

> *because you know seeing things in black and white, on paper, is very different from meeting the family and having a relationship with them and understanding all of these family dynamics. (SW7)*

The suggestion here is that the worker gains a unique insight from the intimacy of the face-to-face work and this should be listened to. On the other hand one of the points several workers made was that supervisors were able, because of their distance, to provide a fresh perspective.

Another theme that emerged from several interviews was that as managers set the "tone" of the team and established what the thresholds for intervention were, it could be difficult when changing managers or speaking to a different manager because their thresholds would differ: they didn't all have the same expectations or standards:

> *there's things now that...you know, decisions that were made on duty, when I've been duty officer....and before I went on leave: "(the former supervisor) would never have done that" (laughs) so... that's going to take some time to get used to isn't it? (SW5)*

they've all got different styles, how they work and how they make decisions but I think it's all about thresholds – where they are, some managers' thresholds can be a lot wider than others. (SW3)

Finally, for some workers there were limits to what supervision could achieve – that in some respects it was not very relevant to the pressures of the work. For one worker it could be a waste of time, an exercise that needed to be performed:

we have supervision because we're supposed to have supervision, you know, so sometimes I know what the hell is going to happen on a case but yet we've got to go through the whole rigmarole again and discussing it over again for the purpose of it being within the ....supervision arena , you know? (SW7)

or it could simply be overtaken by fast-moving events:

...things you've got on your supervision list do not happen, and then they do not happen the following week either.....because by this point you might have another two cases, new ones, or you might be preparing another case for a legal meeting or you might be preparing another case for conference so that phone call or that... whatever... thing that's been suggested doesn't always necessarily happen so the following supervision session can be a little bit kind of.....sometimes I sit and cringe and think oh gosh I hope she doesn't remember we had this very same discussion last month (laughs).(SW7)

For another worker simply talking about what makes a family's home feel unsafe to visit doesn't help to build confidence for the next visit: only experience and a determination to cope with the stress of the work can do that.

8.2.1 Summary

Unlike social workers in some areas, the Banksfield workers felt they got supervision regularly and that it served a number of positive functions for them. At a bureaucratic and managerial level it provided a place where workers could apprise managers of difficult or worrying situations and get the managers either to make difficult decisions or put a stamp of official approval on the decisions they had made themselves. At a more developmental level it provided a space for reflective thinking where ideas about cases could be bounced around and considered. Decisions made quickly and intuitively could be revisited and reconsidered. More experienced workers appreciated being challenged to justify their work and to think about options they may not have considered. In these cases supervision may be seen as performing the vital function of providing a more analytical and deliberative complement to quickly made, heuristic decisions. Sometimes these fresh ideas were presented prescriptively but at other times they were seen as options, alternatives, not necessarily more "right" but

other ways of making sense of complex situations. This only happened when there was enough time and in a busy, fast-moving work environment supervision could be rushed and simply mirror the quick decisions workers had already made. At other times discussions and decisions made in supervision were simply overtaken by the speed and unpredictability of events leading some workers to question its usefulness.

The social workers appreciated the distance their managers had from cases so they could provide fresh perspectives and present a range of options that the workers themselves had not considered previously although this distance also meant the managers did not have the intimate knowledge of the families that the workers had.

There was a strong sense of supervision as a complex social encounter. Less experienced workers appreciated more directive supervision – and with very stressful cases even very experienced workers could appreciate having decision-making taken out of their hands – and the support and rapport built up between supervisors and workers, especially novice workers, could play a significant role in developing the worker's confidence and professional identity: this emotional and professional support was another level on which supervision functioned. As workers became more experienced they appreciated being treated more as equal partners in the process, having their views listened to and considered seriously and they also became more skilled, more artful, at the ways in which they presented their work – rendered it visible as Pithouse (1998) says – and used supervision as a place where their actions and decisions could be "sold".

8.3 The managers' perspectives

Of the participants in the interviews six held managerial responsibilities and supervised staff (though they were themselves supervised by more senior managers). These six all supervised front-line social workers.

Managers saw themselves as responsible for setting the tone in the team – being calm, approachable and consistent were attributes they felt were important.

> *you have to feel quite confident that you are making decisions on a daily basis that are consistent. If you're not consistent it creates anxieties I think for the rest of the staff team because if you know where your manager's levels are that helps you filter out stuff in duty, it helps you make decisions. (SSW1)*

The consistency (or lack of consistency) of "levels" – where thresholds for intervention are determined - between managers was something several of the social workers commented on

and for the managers it was important that their thresholds, their standards, were adopted by the team and seen as consistent. I observed managers trying to do this though it was also clear that managers did not have the same standards and their thresholds for intervention varied to a degree: perhaps inevitably given the nature of child abuse as a social problem.

A key theme for the supervisors was how to enable workers to reflect upon and analyse their work. Intrinsic to this was being able to assess the quality of the work from the accounts workers brought to supervision for discussion – there was little mention of looking at the quality of the workers' written work such as reports in computerised case files and reports for meetings. Less experienced managers felt that this was a difficult area on which to make judgements. One less experienced manager discussed a case where she felt she had not sufficiently challenged the social worker's account. The worker had undertaken a pre-birth assessment, had concluded that there were no problems, and the case had been closed, leaving some health professionals to monitor the new baby's health and development. Following the birth the case had quickly been re-referred to the team because of concerns that the parents were not caring for the child well. She felt now that the social worker had relied too much on "anecdotal" evidence from the family and had not tested this out by, for example, gathering sufficient information from other professionals. And she herself had not challenged this in supervision.

> *I hadn't explored things enough in supervision.... I hadn't checked the case recording, asked more questions...um...and ultimately it was you know it was me that said ok this case can close ...so again it's my decision making so you get worried about it and it does.... certainly for me it's been a massive learning curve. I would never close a case just before a baby's born...um... which is I think the basics - you know if there's concerns up til eight month let's monitor a bit longer and see how things go after the baby's born. (SSW1)*

The supervisor is concerned that she accepted the worker's account to the point where she failed to make a "basic" decision – that the case should remain open after the birth to monitor the situation whatever the pre-birth assessment concluded. She then faced having to discuss with the social worker the poor quality of her work.

it was quite difficult because obviously you don't want to cause anxiety to social workers but it's also about a learning curve and that's the way that we looked at it. It was "what have you learned from this?" and you know I was honest about the things I felt as though I'd learned ... and I think that helped them to say maybe they could have done things differently without saying you know oh this was all wrong because there's no right and wrong - that's one of the difficulties I suppose in this job and it's always easier to look at things in hindsight (SSW1)

The worker was angry and defensive and the supervisor found that the most comfortable approach was to see this as a learning experience from which they could both learn from their mistakes while asserting the intrinsic difficulty of making judgements in child protection work. Facing a colleague with the suggestion that they had made a mistake was a difficult one and the supervisor tried hard to reframe it in a way that she and the supervisee found least uncomfortable.

Pithouse(1998) identified a powerful "assumption of collegial competence" (p.55) in his study in which team harmony, autonomy and self-regulation are emphasised and scrutiny of colleagues' work is minimised in order to strengthen team identity. He noted a belief that as the work is difficult workers should be allowed discretion in how they manage their work. Supervision is a mechanism for opening "invisible" work to scrutiny – a scrutiny that does not undermine the team identity because it takes place in private – but even there the supervisor must continue to show loyalty to the team and take the path least likely to disrupt the assumption that all are equally competent.

This supervisor suggests that the major problem is having to rely on the social worker's information and this can be difficult to judge especially as you don't have time to read up on the case thoroughly:

sometimes you wish you could sit and look at every case and read the case events to get a very good picture, a good clear picture of what's happening in the household...you don't physically have time to do that so you're very dependent on information that's given to you and I think that maybe previously I haven't encouraged the social worker to explore other things maybe not playing devil's advocate enough within supervision so I suppose it's you know that situation also makes you question, it makes you anxious around your own judgements particularly when you're supporting members of staff. I think sometimes it's easier to manage a case if you're the case holder, you know that situation and you know it's your own judgement whereas as a supervisor it becomes third party you know information, you're relying on somebody else's judgement. (SSW1)

But this supervisor is also suggesting that she has not done enough to question and challenge the information the worker brought to supervision. Because a third-party referral has necessitated the reopening of the case she is having to question the quality of her supervision: the case went outside the team and so the team's internal mechanisms for maintaining harmony and morale were undermined.

Other supervisors raised the problem of having to rely on others' information and judgement. Another fairly inexperienced manager:

> *I think managing and supervising are really difficult because you're dependent on whoever is coming in for supervision, you're dependent on them, their understanding, their views, their thresholds...and then you make a decision about what needs to happen and I think that is quite scary..... I've had you know a couple of times I've thought oh dear that was a bad, that was a close call...(SSW2)*

This supervisor is recalling a similar situation to her colleague: a case that she accepted could be closed from the social worker's account turned out to be subject to numerous concerns from other professionals. And again this supervisor is faced with reviewing what has happened with the social worker. She said that she had taken the line that there was now new information that changed the nature of the assessment, thus avoiding a criticism of the worker.

> *so I don't think she felt undermined in any way – I hope that the way I said it was you know, you'd got the information you'd got, unfortunately they came with extra information that we hadn't got....is the way I played it, and it seems to have been ok – we've still got a very good working relationship. (SSW2)*

The supervisor is very conscious of using a strategy that will not undermine the worker or their relationship. It may be argued that the strategies adopted by these supervisors enabled learning to take place without workers feeling blamed or undermined but it might also be argued that the desire to maintain team harmony and morale meant that decisions were not reviewed and explored as thoroughly as they might have been. A factor in this may be because there is a sense shared by several of the managers that the work is difficult, mistakes are easily made and difficult to admit to and their responses should be guided by this awareness:

> *....it never feels an easy thing to say "maybe I didn't get that right" but I would much rather be able to have that opportunity to think it through because that's where the learning comes from .... I do have an idealistic view that most of us at some time have done something that wasn't*

the best decision but to be able to admit to that and not be in a situation where you feel judged. There needs to be a relationship between supervisor and worker. (TM3)

More experienced managers were also aware of the problem of relying on others' accounts but were more confident about how to assess the status of these accounts:

well obviously I can't meet every service user, every child, it would be impossible so people are going out and doing an assessment and coming back and talking to me about what they've seen, what they've observed, what they've heard, what thoughts they have about something and...so you've got a different level in there haven't you? You've got me trying to make sense of this family through this social worker's eyes and to be able to think well why do you think that and what leads you to believe that and why do you think that's true or what evidence have you got for that? (TM2)

This manager talks about getting to know the strengths and weaknesses of each team member and of taking a questioning approach to the accounts they bring, taking nothing at face value. The comment about making sense of this family through the social worker's eyes suggests a process of assessing the strengths and weaknesses of the assessing worker, their interpretations of events and the fallibility of the evidence indicators – a highly sophisticated cognitive process which would require considerable expertise – not to mention the skills of an experienced social researcher: such a cognitive process, of interpreting others' interpretations, is described by Smith & Osborn (2008) discussing interpretative phenomenological research, as a "double hermeneutic":

...a double hermeneutic is involved. The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world. (Smith & Osborn, 2008, p.53)

This same manager gave an example of visiting a family so she was not just relying on her assessment of the worker's account:

I really like to meet people myself as well and...because it's really hard to make decisions through other people's eyes (TM2)

However, the example she gives is of a very serious case where a child had been taken to hospital with a fractured skull. She herself says, as do the other managers, that normally they do not have time to do this.

The supervisors presented similar views on the value of supervision to those of the social workers. It was a reflective space to explore cases, to bounce ideas around, to ask searching questions so that workers had to justify their views, to provide support given the emotional

demands of the work and what one manager described as the "awful" responsibility of making decisions about vulnerable lives. As with the worker accounts there was less a sense that the managers saw themselves as experts, able to provide the "right" answer and more a belief that by challenging and suggesting other perspectives they could move workers into fresh ways of thinking:

> *social workers should be able to voice when they're stuck and a team manager's no different to anyone else and I'm no different, I don't have all of the answers and I've said that to staff, you know, "it's your case, you've worked with this family, you tell me, then I'll be a devil's advocate and maybe come at it from a different angle" (SM1)*

One manager sums up why she thinks supervision is important:

> *....it's about safe decision making, it's about practitioners being able to reflect on their assessment and think about things, being able to pose questions and say well have you thought about this? Have you considered that? It does generate ideas, people can get stuck with cases, people can get locked into particular ways of thinking so it opens up channels, it poses difficult questions, things that you might not ask yourself. (TM2)*

Again, there is no sense here that the manager is an expert but a facilitator of reflective thinking, asking questions and encouraging new perspectives to be considered. Behind this is the assumption that this is difficult, complicated work that often doesn't have "right" answers. But while there seemed little sense of having expertise in terms of knowing the right answer to a problem with a case, the right way to intervene, there was expertise suggested in the ways in which supervisors asked questions and encouraged workers to think along different lines. The main difference between the less experienced and more experienced managers seemed to be that the latter had developed expertise and strategies in this area.

This manager seems to be clearly drawing a distinction between these two possible areas of expertise and making it clear which she sees as the key skill for a supervisor:

> *being open to doing things better rather than thinking you know it all which I don't and never will. So yeah being open to other people's ideas and getting social workers to have the confidence to say what they feel, to get them to make decisions because I think there's certainly a culture that needs to shift whereby the team manager is seen as the decision maker and actually they're professionally accountable as well. So I have to be aware of that as well because I can ....I think I have to be aware to give them the space to actually say what they feel the decision should be and also encourage them to use their assessment skills, to have the confidence to say what they think those decisions should be and if we have a disagreement to be able to talk that through and come to some...solution (TM1)*

She discusses the importance of making workers analyse rather than just describe:

> *because I think they all know what the word "analysis" means and it isn't just again describing what you've done, it isn't again just repeating what you've just described earlier on in the assessment. It's...."what does this mean?"..(TM1)*

Another manager suggested that more her job is not to take workers' accounts as facts upon which she will make a decision but accounts that will only be accepted if they can be demonstrated to be well thought through and well evidenced:

> *I think more often than not they are presenting their view and this is what they - speaking from their point of view - this is what I think should happen. So it's not that they're giving me a load of information and expecting me to process it and say this is what you should do, they're much more competent professionals than that – they've done the assessment, they've made that judgement, this is what they think should happen and providing I think that that's been well thought through, it's been thoroughly evidenced and it's safe then we would agree a course of action on that basis (TM2)*

Some of the more experienced managers cited above are talking about improving workers' analytical skills, their ability to construct a clear argument and back it up with empirical evidence the status of which they have made a firm judgement about. Another spoke of encouraging a worker to project her argument into the future – a family may be able to cope with their baby now but will they still be able to do so when he gets older and his needs become more demanding of them? Benbenishty et al. (2003) argue that social workers are able to use "basic" arguments but not more extended complementary arguments in which theory and evidence are applied critically to specific situations – qualifying claims, searching for disconfirming evidence, considering alternatives - and other authors such as Buckley (2003) have argued that social workers do not use theory and empirical evidence in an informed way. These managers suggest they are trying to use their positions as supervisors to remedy these shortcomings.

Several managers spoke of the way social work has changed and the need to encourage a more forensic approach amongst workers that makes them look more carefully for evidence:

> *we have an investigative role, almost a forensic role these days ...(and)... you've got to be challenging, you've got to look for other evidence (SM1)*

This emphasis on constructing clear arguments, of searching for and critically applying evidence, of reflecting on work done and thinking of possible alternatives can be seen as a process of making sense of the difficulty, uncertainty and complexity of the work, the fallibility

of the evidence indicators. This suggests a discussion about what counts as evidence and how decisions are made about it. This will be explored more fully in the next chapter but in this section it is suggested that, through developing supervisory skills and strategies, these managers are playing a pivotal role in the construction of knowledge for practice, a construction that, because of the centrality of multiple fallible indicators (Hammond, 2006), is a discursive process, a search for meaning (Helm, 2011).

> *...it's interactive but it's much more from them in a sense and they're checking it out with me and I'm checking it out with them so it's a process. (TM2)*

8.3.1 Summary

The managers and supervisors included in this study shared some of the views of supervision expressed by the social workers. They saw supervision as a way of supporting the workers with the heavy responsibilities for protecting children that they bore. They saw their roles as both bureaucratic and managerial, so that practice could be officially accounted for and where necessary decisions made at a more senior level, and in the more developmental sense of encouraging reflection, fresh thinking, the consideration of alternatives that that the workers might not have thought of but which were seen as other options for discussion rather than the "right" or "expert" answer.

For all the managers there was the question of what status to ascribe to workers' accounts and assessments. As they gained experience they developed strategies for questioning and assessing these accounts but more novice managers could take these accounts too readily at face value. It might take a concern raised by someone outside the team and not bound by considerations of collegial competence to prompt a re-evaluation.

The managers' accounts emphasised the nature of supervision as a complex social encounter. Challenging workers' accounts was not straightforward as these were colleagues and it was seen as important to maintain their (and the team's) morale and sense of competence. Managers had to think carefully about how to frame these challenges as learning experiences. There could be a danger that supervisors' feelings of discomfort at challenging accounts might lead them to avoid such challenges.

The managers were aware that workers' accounts might be fallible and as they gained experience they learned ways of, as they put it, "seeing through the worker's eyes" or asking "what does this mean?" Interpreting and evaluating a worker's account of that worker's own evaluation and interpretation of a case is a complex cognitive and interpretive process of

sense-making. An essential element of this was prompting workers to provide more evidence of their thinking by trying to make them analyse rather than describe their practice, by encouraging skills in mounting arguments and considering disconfirming evidence, by improving the clarity and precision of the workers' practices as social work becomes more and more investigatory and forensic.

How easily can such processes be audited? This is a pertinent question given that the authority within which this study was carried out has been criticised in a recent Ofsted report for its staff supervision:

> *Staff within children's safeguarding services express a high degree of confidence in their managers and feel well supported. Newly qualified social workers receive individual support which they value highly. Supervision is regular but records show little evidence of challenge, reflection and information to assist worker's development. In a number of records there is inadequate evidence of managerial involvement in or oversight of decisions. (Ofsted, 2012)*

It may be that such complex and socially negotiated processes are not easily captured by official reports like so much day-to-day practice. But it may also be that it takes considerable skill and experience to supervise in this way and some supervisors did not manage to do this.

8.4 Team talk and informal supervision

During the observation phase of the study I noted that there was a good deal of informal team talk and that the seating arrangements of the team seemed to facilitate this. Given that informal or peer supervision is often a valued feature of team cultures (Phillipson, 2009) I incorporated a question on this into my interview schedule.

Several people talked about how this informal talk created a team culture, a bond, which they felt was needed given the difficulty of the work.

> *I don't think you can work in isolation, I think it's dangerous, I think you need the support of your colleagues and you need to feel safe in your team and with your colleagues. (TM1)*

The team talk was seen as making team members feel safe, having a base to return to after potentially difficult or stressful visits and meetings. One worker went so far as to talk about coming back to the office as like coming home:

> *sometimes when it gets difficult we talk to one another – if it's particularly difficult we might discuss it in supervision but usually everyone in the team is quite supportive and we have similar experiences so you know we talk to one another and when you're in a difficult situation you look forward to the drive home – you know, home being work – and being back with your*

colleagues, familiarity, and being in a position to then talk about what's happened, have a bit of a laugh if it's appropriate, you know, just sound off...(SW7)

One of the managers saw the informal talk as providing this kind of support but also a forum for discussion of ideas about the work that was different – looser, more relaxed – than formal supervision

You need to be able to talk, you need to be able to offload and all of those things and share ideas and generate ideas...(TM2)

There seems a strong sense in these quotes of drawing a boundary around the team within which there is a sense of safety and support. It was also seen as a source of support and advice for individual team members, a place where ideas, thoughts and feelings could be aired:

People tend to bounce things off, you know, different people. Different people have different views...you tend to find the less experienced or more anxious staff will talk to a number of people and sometimes it's just around clarifying that what you're thinking is right. I think that's quite beneficial not only on duty but with cases in general...um... there's a lot of communication between staff (SSW1)

One worker draws a distinction between the formal and informal kinds of supervision:

I think, you know, we're talking all the time about cases, we're not saying actually can we sit down and have some supervision here...we're not doing that. On an informal basis, daily, we're saying so-and-so said this, so-and-so said that blah, blah....what do you think? And really what you're doing is getting some informal supervision from a colleague and I think we're always testing...are we doing the right thing, you know, would somebody else do it differently, why would they do it differently? (SSW2)

So here the informal talk is seen as a looser, more experimental way of testing out ideas and considering other ways of thinking about cases. Helm (2011) suggests that at times this more informal talk may be a better way of clarifying the intuitive judgement-making of practice than a more formal and deliberative supervision.

Some workers did voice some dissatisfaction with this team talk: it could be noisy, distracting, frustrating. Discussing a case in this informal setting meant that anyone in earshot could contribute their views and this could feel undermining and intrusive at times. Managers felt they needed to keep some control over this talk especially if someone was making a suggestion about a case that they thought was wrong or inappropriate but at the same time they felt it was an aspect of team culture and cohesiveness that they wanted to foster. I

observed workers withdraw from such discussions and give the impression that they did not want to be disturbed.

From my observations it seemed that the informal talk functioned as gossip – reinforcing relationships and boundaries, creating a sense of cohesiveness for some but leaving others feeling marginalised at times. On another level it was another way in which knowledge was tested out and constructed, in a looser manner than in supervision and feelings and emotions were also tested out and communicated. Both professional knowledge and professional identities were being constructed and reconstructed through this informal talk and the team culture it represented.

8.4.1 Summary

The informal talk in the team could act as a kind of informal supervision in which ideas, thoughts and anxieties were tested out perhaps in a more experimental way than in the more formal confines of supervision. This could pose dilemmas for managers who worried that advice they considered wrong or inappropriate might be given. The talk had the social effect of creating bonds within the team and of drawing a boundary around the team within which its identity could be sustained. It created a sense of security which the social workers were able to draw upon particularly on their return from difficult situations. However some workers engaged more fully in this talk than others and there was the risk that some team members could feel marginalised.

8.5 Conclusion

Supervision is widely seen as essential to good practice in social work as in many other professions and it holds a significant place in the professional culture of social work. Poor quality or lack of supervision has been identified as an important factor in a number of inquiries and reviews into child deaths. In the main the managers and social workers in this study saw supervision as important although there was some scepticism about its usefulness. They saw supervision operating on three levels:

- A bureaucratic/managerial function where decisions could be made or approved and work accounted for.
- A developmental function where space was provided to rethink decisions – sometimes by presenting options sequentially but often through a reflective bouncing around of ideas and possible other options for understanding complex and fast-moving situations.

- An emotional and professional support function where workers were enabled to develop confidence in their professional identity and given support with managing difficult cases.

This is a quite conventional typology: Hughes & Pengelly (1997), for example, in a widely used text on supervision, conceive of it as having a triangle of functions: a bureaucratic service-delivery function, a managerial focus on the work the practitioners are doing through which that work can be accounted for and a professional development function. The social workers and managers in the study talked about supervision on all these levels.

In terms of decision making, an ideal that emerges from participants' accounts would be a supervision in which an expert manager made decisions where appropriate but also listened carefully to the worker's intimate knowledge of the family and through skilled challenging encouraged the worker to think analytically about the case, consider the available evidence and options carefully and revisit decisions already made to see if they needed changing. This ideal could provide an analytical complement to the more heuristic decision making workers tend to make in the complex and fast-moving situations of their practice. Supervision could provide the space for all options to be sequentially considered as in classical decision theory but it could also provide a space for sense-making reflection on complex and uncertain information where the utility values of classical decision making are much less identifiable (O' Sullivan, 2011; Munro, 2008; Taylor, 2012).

This is an ideal and both social workers and managers were well aware that despite a commitment within the organisation to regular supervision the reality could fall far short of this. Lack of time and lack of supervisory skills could result in supervisions where social workers' decisions were not adequately explored and where the supervision simply mirrored the quick, heuristic decisions made in daily practice. Errors and biases in heuristic reasoning could then be compounded rather than identified and rectified. The skills identified by experienced managers that were required to interpret and challenge workers' accounts – to see the families through the workers' eyes and make meaning out of this - were sophisticated and complex and it seems likely that many supervisors will not become expert in them. If worker accounts are not adequately interrogated then, again, errors and biases will not be uncovered.

Supervision could also be seen as a place where social encounters and practices (Lofland et al., 2006) were enacted. Seeing supervision from this more interactionist perspective suggests a number of social complexities which formal or bureaucratic models of supervision

may fail to take account of. Pithouse (1998), drawing on interactionist perspectives, argues that a prime function of supervision is to maintain the assumption of collegial competence and thus maintain team harmony and cohesion. When it was necessary to challenge workers' practice less experienced managers found this difficult and felt they had to reframe their challenges in various ways in order not to antagonise or undermine the worker/colleague. At the same time social workers learned to present cases artfully so that their accounts were more likely to be accepted or "sold". Supervision, then, could be seen as a complex negotiation between workers and their supervisors about what would be dealt with and how and where unspoken rules about team culture and cohesion were enacted. The social, cognitive and affective complexities of these negotiations are not easily captured officially yet were central to the way supervision was done.

Alongside the more formal, officially-sanctioned supervision was team talk and discussion which could act as a sort of informal supervision, providing workers with emotional support and the opportunity to discuss cases. This too seemed to have an important social function – sustaining bonds between team members and asserting the team's identity. This function seemed to include some team members more than others.

As the social workers and managers negotiated what they would talk about and how they would talk about it, it could be argued that they were engaging in a process of constructing and reconstructing the knowledge of the workplace. It is argued that professional knowledge is constructed through the activities in the workplace (Atkinson, 1995; Scourfield, 2003; Scourfield & Pithouse, 2006) and in particular though heavily routinised and even ritualised practices – like supervision – that occur frequently, are taken for granted and become important ways in which social actors perform social life and construct their cultures and identities (Lofland et al., 2006; Hammersley & Atkinson, 2007). The nature of the knowledge the social workers drew on to make decisions is the subject of the next chapter.

CHAPTER 9: FINDINGS IV - The Nature and Construction of Knowledge for Social Work Practice

9.1 Overview

This chapter presents data on the knowledge social workers used to make decisions and carry out the activities which have been discussed in the previous three chapters. As a result there may in places seem to be some overlap with those chapters though every effort has been made to keep this to a minimum.

The chapter was designed to address the nature of the knowledge the social workers used to make decisions: where it came from, how it was constructed in practice and how it might have influenced the decision making process/

The data were drawn from several sources. A question was included in the interview topic guide on the knowledge participants used in their work. They were asked what sources it was derived from: their training, knowledge of research, practical knowledge, experience, the views of managers and colleagues (see Appendix B). In addition to this participants often referred to the knowledge they used in response to questions on managing their cases and on supervision. Several questions in the topic guide elicited responses about the degree to which the knowledge participants used was enmeshed in work with other professionals, a theme that had not been anticipated when the interview schedule was designed.

The first section looks at the diverse and contested nature of much of the knowledge social workers drew upon in their practice to assess families. Information came from other professionals, from family members, from anonymous sources, from casefiles: all of which, it will be argued, were troublesome and fallible sources which required careful evaluation A significant element of this information came from home visits which as previously discussed are particular complex practice situations. A focus on the sources of the knowledge as well as on the knowledge itself suggests that this knowledge is not neutral or disinterested but intimately bound up in, shaped, constructed by the nature of day-to-day practice.

The second section looks at participants' perspectives on the importance of experiential knowledge or practice wisdom and the degree to which they used other forms of knowledge which are more widely accepted as "evidence" – that is knowledge based on research and academic theories.

The third section looks at the conditions of uncertainty within which social workers used their knowledge to make decisions. This uncertainty applied to the social workers' cases but also to the socially constructed nature of child abuse and the changing culture of social work practice away from more traditional approaches and to a more investigatory way of working. This addresses certain tensions in the ways social work and its knowledge base are understood.

9.2 Building the bigger picture: synthesising and evaluating information about cases

Knowledge was drawn from a wide variety of sources which reflected the diversity of the social work knowledge base (Pawson et al., 2003). However some of these sources were problematic. A good deal of knowledge, like a good deal of the work, was closely enmeshed in working relations with other professionals which, as previously suggested, could be difficult.

An example is the child protection investigation which I observed and about which I subsequently interviewed the workers involved. Following the referral two of the social workers visited the home and found a small mark. The home visit was seen as important because this gave the workers the chance both to examine the child and listen to the mother's account and thus form a judgement about her reliability. They decided to have the child medically examined and this meant that the expertise of the examining doctor became crucial. The doctors couldn't give a definitive diagnosis:

> *they were basically sitting on the fence about how it may have been caused. (SW7)*

So the assessment drew on a variety of sources, none of them definitive:

> *based on my visit, based on some previous information, based on discussions with the health visitor, shared information with the police, obviously had discussed with the medics at the hospital and looked at old files, also consulted with the previous worker who is still attached to this team so we were able to quickly access previous assessments that were completed, previous decisions that were made....so all of that yeah feeds into current assessments. (SW7)*

Thus to make decision on the child's safety the social workers had to balance and evaluate information from a number of sources – the separated parents, the Health Visitor, the indecisive doctors, colleagues, old case files – some of which (the parents were locked in a custody dispute, the Health Visitor's expertise was being questioned, the doctors couldn't decide) were likely to be highly fallible.

As with the above case many of the examples which were observed or which workers brought to interviews involved other professionals and these other professionals might be quite

powerful and have a significant effect on the way the work was shaped: most notably, and reflecting the generally accepted hierarchy of professions (Hudson, 2002), legal and medical experts but also the police, other health professionals and experts in specific areas of the work such as with adults with learning difficulties.

> *Discussion going on between SSW1 and SW4 about the need to medical a child in a case SW4 is dealing with. SSW1 predicts that the doctors will not be able to "time" the bruise and will sit on the fence. However the medical needs to take place and SW4 leaves office to accompany family to hospital.....(later) I ask SW4 what happened at the hospital and she says that the doctor said there was no evidence that it was non-accidental. Such a long and laborious process she says with no definite outcome but we have to do it (field note extracts)*

In deciding whether a case should go to legal proceedings workers and their managers would meet with the authority's legal representatives in a Public Law Outline meeting in which decisions are made about the suitability of a case for legal proceedings and what needs to be done to prepare the case for court. Several workers mentioned attending PLO meetings and talked about legal representatives being present at case conferences and other child protection meetings. A senior manager I interviewed talked about the knowledge of legislation and case law she needed to advise social workers. She described debating with a social worker the pros and cons of Care Orders and Supervision Orders, a debate that required knowledge of, for example, the case law around courts' powers to impose conditions on Care Orders (Dewar, 1995; Hayes, 1996). Such knowledge has an important role in determining how cases will be dealt with.

In several cases the police were heavily involved because they were investigating crimes committed against children and this affected how workers managed their involvement with families. In a case previously discussed a social worker had to decide whether or not to have a small child who may have been sexually abused put through an invasive and distressing medical. She needed to balance the effect of the procedure on the child, the views of the family, the police desire for possible forensic evidence and the opinions of the doctor. She discussed the matter with the doctor.

> *...I think it was a joint decision you know, I gave him the situation, he has the expertise about the medical and whether it's really necessary to put a child through that and he said I think that under the situation that you've talked about, the information that you've given me, then I would say that it's necessary in this case. (SSW2)*

So the process of making a decision here is closely enmeshed with inter professional

processes – it is not a decision the social worker makes alone and, in this and other cases, she was not sure that from her point of view the right decision had been made.

There were other cases discussed in this study where the police decision to investigate – or not investigate – a case affected the way the social workers proceeded. Sometimes the police would refer a case but provide only partial information and the gaps had to be painstakingly filled:

> *Police contacted office as Tamara (a teenage girl) has been trashing her house. Tamara lost her mother at an early age and Molly (aunt) has been her guardian but she has another aunt, Sophie, where she sleeps sometimes. It's not clear from the police report if they are referring to Molly's or Sophie's house and the police provide no telephone numbers so SW5 has to contact School Health to see if they have any contact details or, failing that, check council tax records (field note extract – all names changed)*

It is not surprising that if basic information sharing is so difficult that when social workers and other professionals meet in official multi professional meetings frictions and difficulties can arise so the sharing and synthesising of different professional knowledge-claims is not straightforward:

> *Quite often what happens at conferences is that it's like us against everyone else including the professionals. (SW7)*

Getting information from professionals is not straightforward and neither is balancing and evaluating information from professionals and from family members. One supervisor described how a worker overlooked key points in an assessment:

> *there was an over reliance on family members, on listening to what family members were saying rather than maybe getting information from professionals and I think that's...you know, you think shouldn't have done that, um, yes, you use anecdotal evidence from family members but if you're looking at parenting a baby professional information would be more appropriate (SSW1)*

Perhaps even more complex and contested is eliciting and evaluating the intimate knowledge of family members. Social workers have been criticised for uncritical reliance on the views of family members but to discount them would raise many ethical and professional issues as their perspective is unique in making sense of complex situations: the "bigger picture" that a number of participants referred to. It is clear from the following that the nature of this family information is multi-faceted and requires considerable skill to evaluate:

> *when you visit a family you get a very small snapshot of what is happening at this time, how*

people interact with each other and also about what the parents are saying... um... which can be very different from... um... I suppose the bigger picture is around what experience has this person had of being parented, what's their past experience, what are they bringing to being a parent...um... what's the situation now regarding that individual... um... do they have supports, are they honest with family members, are they accepted in the community, what's that person's relationship with, like, with their partner? Is there any domestic abuse, do they talk to each other, do they support each other, which one's the strongest person...um.... and who takes control of finance, are they looking forward to this baby you know have there been any previous so it's about the functioning of families and also the history of what they bring to...um... that relationship and also their ability to parent and function – you know, maintain a family home, pay bills, all of those things so all of that information is the bigger picture of what sort of family this baby will be moving in to when it's born. (SSW1)

Children are also valuable sources of knowledge and can be directly consulted once they are old enough. Yet this too raises issues about how knowledge is to be balanced and evaluated against other sources. One worker described attempts to rehabilitate a teenage girl with her mother who had drug and alcohol problems.

the girl had... she'd raised something, some issue about that she felt that her mum....she felt that her mum wasn't keeping to parts of the agreement that had been made and I think it was again, for the worker, that was largely about the young person's understanding of how substance misuse and alcohol services would work with mum and that they would work with mum with her consent really. So I think it was about explaining that process that (the girl) might not actually see anything significantly different or significantly changing but it may well be that things were happening within sessions or the alcohol was being, you know, the level of alcohol that mum was drinking was actually being monitored by substance misuse workers but the (girl) might not be seeing that. (TM3)

In this case the girl has unique knowledge about whether or not her mother is keeping to the agreement she had made with the social worker but it has to be balanced against a belief that the girl does not have enough adult, mature knowledge to fully understand the situation. And yet she is seeing things the professionals are not seeing. Evaluating and judging evidence such as this is extremely tricky.

Another contentious area is the weight to be placed on calls from members of the public which may be made anonymously.

we had an anonymous one which must have come from a neighbour because they said they'd seen S in the garden crying and then S had been seen outside hitting A, A had been seen putting a cigarette butt in his mouth while unsupervised outside...while I've not actually spoken to any neighbours this is the information that's either been referred to us as an

anonymous referral or come to us via the Children's Centre so it could be quite unreliable information. (SW4)

In this case the social worker balances it against other information she has:

However when you look at the big picture of this family, what goes on, suspicions and background etcetera it's more than likely that it is actually happening. And then, you know, that's from neighbours.(SW4)

Again, constructing "the bigger picture" means synthesising and evaluating information from a range of sources which may all be fallible

9.2.1 Constructing knowledge from home visits

Another important source of knowledge is home visits. As previously discussed home visits are an important site of social work practice and a great deal of the information social workers gather comes from home visits which present very particular challenges and opportunities: they give unique opportunities to observe families in their most intimate spaces but they can be chaotic, stressful and difficult to manage. They are central to social work practice – in the child protection investigation discussed above the social workers considered it essential that they visit to see the child and interview and assess the mother before taking further steps and this is common practice. Helm (2011) argues that home visits are situations where large numbers of fallible cues are presented simultaneously and orderly decision making according to the explicit rules of decision theory is impossible.

A newly qualified worker described how she has struggled to cope with the demands and anxieties of home visits and gather the information she needs. Something unexpected can derail her plans:

you have got to make those decisions on the spot haven't you? Nothing can be planned you've got to decide at the time. (SW9)

Faced with aggressive behaviour she decides not to ask pertinent but difficult questions

so I was assessing the situation in my own head thinking she's not in the right frame of mind, I'm aware there's been violence and aggression to professionals, I'm sat next to her....I made that decision at that time not to challenge her on the alcohol I could smell on her breath because I was aware of my own safety that if I challenged her about that...(SW9)

She was not satisfied with what she had done and felt she would have to learn to be more confident in future. Following Helm above, this would suggest she feels she needs to learn to develop the skills of quick, heuristic decision making which tend to come with experience. She

also felt she needed more experience and confidence: the challenge of gathering sensitive information in such situations is obvious. An experienced manager described supervising an inexperienced worker with the same difficulties:

> *you're doing a core assessment you find there are risk factors. Well for example does she misuse alcohol?*
>
> *"No".*
>
> *How do you know that?*
>
> *"Cause she says so. I asked her did she drink?"*
>
> *Well is she going to tell you? Is she really going to tell you, a social worker with all the powers she thinks you've got and when you're investigating the quality of parenting to her child, is she actually going to say to you "yes I do drink 2 or 3 bottles a night love" ? No, she's probably not as you probably wouldn't tell somebody the truth. This was all at the time (the) Baby Peter (case) was around and I was saying you've got to be challenging, you've got to look for other evidence so is there any evidence that school have ever had a concern about her smelling of alcohol or being under the influence of alcohol when she drops the child off? Were there lots of bottles all around the room using skills...powers of observation... were there half filled glasses? did the room smell of alcohol which sometimes it does if you, if you go in the next morning and there's been a heavy drinking session? What about the recycle bin on the doorstep – is that overflowing or is it empty? (SM1)*

The manager is describing the skills required to gather evidence from a home visit without which the social worker risks gathering only very partial information. Clearly it is possible to uncover evidence of someone's drinking habits from such a visit that could be much more difficult or impossible to obtain from a visit to a clinic or a doctor's surgery but doing so is far from straightforward.

Another, experienced, worker describes another obstacle to gathering information:

> *and, it was very, it was difficult in a way and also what you find in those situations inevitably it's very hard just to have a conversation with the one person or the two people, i.e. the parents or primary carers about the situation because you've got grandma and uncle shouting in and wanting to ask questions. (SW1)*

But experience has taught her to be more confident in controlling these variables and getting the information she wants

> *you might go round lots of other things and let the interview kind of go wherever whereas actually from our point of view this is an interview to be very clear about why this child in front of me has these injuries and what your account is now because either we're going to be in*

> *court, we may be in court, or the police may be involved and either way what we say here and now will be produced. (SW1)*

and to act decisively:

> *I actually didn't even ring my manager while I was there I just saw the situation, knew what needed to be done, did it, came back to the office and said 'right, this is what's happened and this is what's done' and that was absolutely fine with my manager and kind of...but I guess I'd made all those decisions by myself there because I just knew that that was the right thing to do. (SW1)*

The picture this participant paints of herself as confident and decisive contrasts with the accounts of less experienced workers still at an early stage of their moral careers (Pithouse, 1998).

But sometimes there is no easy way of resolving "grey" areas:

> *a lot of the cases I think.... whether that's acceptable, because we have this, you know, "good enough" don't we? Well, what is good enough....? What's good enough when I look in a house and go "is that good enough? No" another social worker will go in and go yeah that's good enough...it's very difficult and I think situations where I've gone oh dear why do they think that was alright have been those sort of situations, you know, the ones that are a bit grey. (SSW2)*

The importance of experience in learning to control and judge the many factors jostling for attention is made clear here. Another experienced worker said:

> *...I'm quite comfortable with challenging people about things you know. Obviously you don't argue with people do you but I can make sure I get my point across and if they don't agree with me, they don't agree with me... if I felt a child was at any risk there's no way I'm going to back down and not do anything or not sort of challenge them about what I've seen....(but)....you can't go in and sort of be "alright you're going to do this, you're going to do that", you've got to sort of try and build up some kind of relationship with the person, with the family, parents whoever, but then there's times when it's quite clear that you're not going to be able to do that, you're not going to be able to have a working relationship with them but that doesn't mean...there's some people as well we have to be quite direct with that you couldn't pussy-foot round them as it were, you've got to say things how they are. (SW4)*

Here another experienced worker presents a picture of herself as confident to challenge people and not back away from confrontations but stresses that, if at all possible, it has to be done in a certain way: within a working relationship. This requires a complex balancing of skills and introduces the idea that it is not enough to *do* something, it has to be done in a

certain way, in accordance with certain values, that are important to social workers' sense of professional identity. This point is discussed in more detail later in the chapter.

9.2.2 Knowledge from case files

Case notes are now kept on centralised computer systems and workers spend a good deal of their time entering their notes onto the computer. As I have suggested gathering information on incomplete or contested referrals and trying to make sense of the case in discussions with colleagues is time-consuming, painstaking work: work which may be only very briefly mentioned, if at all, in the case notes. In chapter 6 I noted one duty worker's difficulty in choosing what to type up from a long and perhaps incoherent story (especially when the keys on her keyboard didn't work properly!). Another worker I was observing reading through some computerised notes on a case said to me how useful detail was often missing:

> *she says when you read your own assessment you recall lots of detail that didn't go into the assessment form so you can give a more detailed account – you aren't limited to the information in the form as you would be with someone else's assessment. However, she says, in a stable team you can ask the colleague who wrote it to give you more detail. (observation field note of SW7)*

This exemplifies the distinction Gobo (2008) makes between "thick" and "thin" descriptions in ethnographic field notes which has already been discussed. Here, the worker suggests, they are either lost or retrievable only by speaking directly to the previous worker – if they are still in the team – and tapping into their personally held store of knowledge.

> *I think when you're typing things you tend to reduce it, certainly I do. It takes, because it takes longer you try to think okay how can I condense this into something I can type in the next ten minutes so you greatly reduce the information that you put on I suppose. (SSW1)*

Workers who hope to refer to "thin" casenotes like this to add to the information they have on a case may find little of use to them. Hunches and thoughts so central to the process of discursively analysing a case are often missing. One worker, searching through the files in another authority for information about a father, told me that the author of the file had noted that the mother had "failed to protect" the child without giving any further details as if this piece of commonly used social work language was enough by itself: a complex sequence of behaviours reduced to a few words of short-hand jargon. The same worker emphasised that for her (and she was not alone in this) case notes were about accountability rather than providing help to subsequent readers:

because at the end of the day I'm gonna write an assessment, and that's gonna have my name on it and I know when we have an inspection somebody's gonna ask me....(SW2)

Another worker, recounting the language she had found in a casefile dating back some years laughed at the thought of writing "what I really thought". So case notes tend to be bland, short, written hastily, written for a specific audience who might hold the author accountable and so they rarely hold the complexity of the situations they are referring to – indeed the author may actively seek to omit such detail for fear of being questioned about it. Some workers who had used paper files in the past said they preferred them because they were more like "working tools" that could be read and considered whereas computer files tended to be much thinner. This may be because these workers were unused to the technology but it might also be because of the "database culture" (Aas, 2004) which, it has been observed, we increasingly inhabit: the tendency for computer systems and electronic forms to require information stripped of the meaning and context required to turn "information" into "knowledge" (Aas, 2004; Parton). White et al. (2009) observed the ways in which practitioners attempted to tell a coherent narrative using assessment forms that seemed designed to prevent this. Yet for some of the workers trawling through old casefiles was a valuable experience as they found details of family backgrounds and previous involvements with social care, which added to their store of information.

Casefiles are clearly another important source of information but the conditions under which they are written shapes the nature of the information which they contain – and that which they omit. Casenotes are not neutral carriers of information but artfully produced "texts" which need to be read in particular ways. As with other forms of knowledge they need to be interpreted and evaluated thoughtfully before being synthesised with other forms of knowledge to build the "big picture".

Other research has suggested that case notes are artfully produced and of contested status. Pithouse (1998) saw them as incomplete and carefully managed accounts which are used selectively by others. Hall et al. (2006, chapter 6) see them as rhetorical devices for displaying and reproducing social work practices. Hayes & Devaney (2004) argue that accessing such confidential material for research involves complex ethical issues.

9.2.3 Summary

In this section it can be seen that social workers draw on knowledge and information from a wide range of sources in building the pictures of families upon which decisions are based.

This is to be expected given social work's very diverse knowledge base (Pawson et al., 2003). This diversity means that the quality of some forms of knowledge are more contested than others so for the social workers evaluating this knowledge involved balancing different and often fallible indicators. Considerable skills were required to make sense and meaning from this knowledge and the often difficult situations from which it was drawn such as home visits and the sometimes problematic interactions with other professionals.

While there is a body of literature on the nature of social work knowledge less consideration has been given to the practice situations from which that knowledge is drawn. Yet knowledge is intimately embedded in and shaped by practice. Home visits, uneasy consultations with other professionals, written casenotes: these were all vital sources of information but all produced knowledge that could be described as "troublesome" and fallible – needing careful evaluation both in terms of the information itself and the circumstances in which it was produced.

Less experienced workers felt that developing these skills was an essential part of their development and some of the more experienced workers suggested they had developed skills and strategies that enabled them to confidently frame and manage the many cues and difficulties these situations presented. These were skills that could not be taught – one inexperienced worker dismissed her supervisor's attempts to teach them – but came with growing experience and confidence.

9.3 The importance of experiential knowledge: practice wisdom and tacit knowledge

The value of experience was a consistent theme in participants' responses. As one manager, asked to rank the key factors in her decision making said:

> *I'd say experience, common sense and research (TM1)*

....with the research there to "back up" the other two:

> *you can find whatever you want can't you really, to back up whatever argument you want to make (TM1)*

As previously discussed a key element of naturalistic decision making is the framing of situations, based on prior experience, so that they can be evaluated swiftly. As one participant said:

> *it's always there in the back of your mind when you're presented with a similar situation in the future. (SW6)*

Some workers were aware that experience had advantages and disadvantages:

> *well, there's two sides of it isn't there then, becoming more experienced you could be very focused on the issue and know exactly what it is, what information you need and to deal with that in a timely fashion with as less disruption and upset for the family and fair enough. But then if you've worked here for 20 years maybe you just want to be in and out...so there's two sides to that isn't there? (SW5)*

For the more inexperienced workers gaining practical experience of, for example, difficult home visits, was more important in building confidence than learning more technical or theoretical knowledge .For experienced workers the benefits that experience brings are summed up by a participant describing a home visit:

> *then everything just falls into place – this has to happen and that has to happen and that doesn't need to happen and you know you do that very quickly in your own head....(SSW2)*

For this worker and for other experienced practitioners experiential knowledge becomes "common sense":

> *I think you just do things that are a lot of common sense: you look at a situation and you work out a way to try and make that situation better and I don't think you sit down and go: what theory will I put to this situation. (SSW2)*

Another experienced worker puts it like this:

> *there is that sense of like making a good educated guess and some of that is common sense isn't it, you know, how likely is this event to happen again? (SM1)*

What this participant calls "common sense" and "educated" guesswork seems to be a description of the intuitive, heuristic thinking discussed in chapter 3: the process of simplifying complexities and probabilities to reach a quick decision based on consideration of a limited range of cues. For this worker it has become "common sense" because this way of thinking has become so habitual after much experience. Earlier another practitioner, an experienced manager, was cited putting experience and common sense side-by-side when describing her decision making. The danger, perhaps, is that if this complex process of sense-making becomes transformed into common sense it becomes taken for granted and unexamined and its strengths and shortcomings are not consciously understood. However, it does not necessarily follow that those using the term "common sense" do not think about what it means:

Maybe it isn't common sense because maybe it's all the information and all the knowledge we've got that makes it seem like it's common sense. But to me...common sense...you just look at a situation and go, well it's obvious that needs to happen. But it's a funny...what does common sense mean, it's very hard to define, isn't it, yeah. I don't know, maybe it just seems straightforward to us because we have all that knowledge and information stored away somewhere that makes things seem like, oh of course, that's what you do – it's common sense ! (laughs)......I don't know. (SSW2)

This is a description of common sense as tacit knowledge or intuition: experiences become routinised, self-consciousness diminishes and the knowledge becomes something that the practitioner cannot articulate to others or themselves (Eraut, 1994). Most skilled practitioners have large amounts of tacit knowledge, or practice wisdom, and it is invaluable in helping them to make rapid decisions but its nature means it may well be unexamined and this means its advantages and disadvantages are not open to scrutiny. Again, some practitioners were well aware that this could be problematic:

I think sometimes it's almost unconscious it's kind of ingrained and....I think the danger though is to become robotic and that's something else I'm always conscious of and I guess hypothesising about situations because some of them on the surface can seem quite similar and you say oh I've seen this before, do this, this and this and I'm very conscious of that really and try to see children and put them in a context and see them as individuals really, not as cases that, you know, that we've managed in this way two weeks ago. So I'm quite aware of that, cause I think there's a danger of becoming quite automatic in your responses when you've been doing the job for a long time and hopefully I haven't slipped into that trap really. (TM1)

One worker, discussing the nature of tacit knowledge made the link to "who you are" as if the knowledge is so deeply ingrained and personal it becomes part of your sense of identity and this can make it less "knowable" to others:

so it's about how much experience you've had of different things and all that forms part of your judgement as well as you and who you are and what you bring and, and to some extent they're things that you, I suppose you're never really gonna know about in a way because they're such personal things to people that people wouldn't admit to, d'you know what I mean? (SW1)

Others spoke of the importance of who you are in a personal sense:

I suppose it depends on your own personality, your own character and you know whether you're...and experience as well I suppose as well...I think most of it's down to you as an individual person, how you deal with things. (SSW2)

Deeply ingrained intuitive or unarticulated knowledge may give rise to the feeling that things aren't right - to "niggles" or gut feelings:

> *you know I suppose you get that little niggle and think that's not quite right ...I think it's intuition isn't it?(SWA1)*
>
> *I mean I guess just every day you know, when we get cases referred to us and you can have the feeling about a case...(SW7)*
>
> *but you sort of, when you're experienced and you've done similar stuff, you get a gut feeling sometimes (SW3)*

Another worker described having the feeling that something wasn't right about the discussion she had with a mother whose former partner, who still had regular contact with the children, was suspected of sexually abusing another child. She then made the link to her recollection of similar cases where mothers had, in social work language, "failed to protect" the children because of their partner's domestic abuse. "Niggles" or gut feelings, then, may be the intuitive sense that something about a case fits the "frame" of similar cases even though there is little or nothing ostensibly amiss: these practitioners' experience and tacit knowledge is issuing some sort of warning. Of course they may be wrong. But it is noteworthy that all the social workers who mentioned having such gut feelings did not dismiss them but talked them over with colleagues or supervisors. This is an indication of the importance of unspoken, experiential knowledge which can so easily be undervalued or dismissed as Pawson et al. (2003) suggest.

9.3.1 Using theory and research

It has been noted by a number of studies (eg Buckley, 2000) that social workers' knowledge tends to be very case specific and that as a consequence workers do not use theoretical and research-based knowledge in an informed way. This affects the quality of the workers' decision making with little evidence that social workers are able to limit and qualify knowledge claims, search for disconfirming evidence and consider alternatives (Benbenishty et al 2003).

Earlier a manager was cited who put research knowledge behind experience and common sense in order of priority and suggested that you could find research to back up any argument you cared to make. Another worker made a similar point when discussing a dispute she had had with some other professionals:

> *And (they) quoted some research and I said well actually I could quote some research to counter whatever you're quoting. (SW7)*

I was not sure whether or not this worker actually had such research available but these views about research suggest a lack of understanding of the standdards of quality that apply to academic research despite the fact that such standards are well established (Pawson et al., 2003).

Workers were aware that they were expected to provide sound evidence to support their assessments:

> *there's quite a drive I think for us to get involved in evidence-based research, and include theories and kind of case-law and what-not in our assessments which is all well and good and we should be doing that, and, and the new core assessments that we've got are very guided towards focussing on what the issues are and how they're going to be managed so there's kind of no escape, you can't really...I think previously assessments were more general and you could almost skirt around something whereas now you absolutely can't, you need to be very focussed on what the issues are and how you propose they're to be managed and what the consequences are....however in the assessments there's no, there's no space for a bibliography or anything, so it's almost like they're asking for you, but they don't ask you what tools you have used you know, umm, or when you've used them. (SW1)*

This worker said that she had included a bibliography in a recent assessment though she had had to think carefully about where to put it as none of the boxes asked for one. She raised another issue in that there was no-one available with the expertise to check her bibliography and assess its quality.

The most important guide to assessment is the government's Framework for the Assessment of Children in Need and Their Families (Dept of Health, 2000). Workers' responses in the interviews suggested that all their assessments are based on this Framework and the various electronic forms they used were structured around the assessment criteria the Framework recommends. The Framework is explicitly "evidence-based" though the collection of studies which informs it was published separately (Seden et al., 2001) so those using the Framework may well not be aware of them.

Another worker talked about using research-based evidence:

> *I mean in my conference report, I don't always do this, but in this case in my conference report I've sort of quoted a bit of research – I've put in a few things about child development and what's expected of a three and a half year old, a two year old, a one year old...this is not what we're seeing with this family (SW4)*

Another worker who is doing a Masters degree part time and is carrying out some research herself showed some frustration with the lack of research evidence in reports:

> *you know, what we need is, we need to be going into court and saying this is what we're recommending and this is why. Previously we've gone in and said (puts on a silly voice) "ooh well, we'll recommend this" and we haven't wanted to say why because then you're citing research and then the solicitors will cite another research that's contrary to that research and then you get into this whole battle of which research is the most appropriate so we've always been told really, when you're doing your statements to just avoid it, avoid it altogether and put in what you think from your understanding of this case (SSW2)*

She is suggesting that social workers have been told to avoid citing research because solicitors will always being able to counter it with a contradictory study. However she could clearly see the advantages of a more research-based approach:

> *so I think that's certainly coming out of my (research), just talking to social workers what they're saying is they want to be able to go in to a court and say I want 2 contacts a week for this baby and this is why. And I don't want to barter... because it is a bit like a bartering system where you go in and the solicitors say "four!" and you go "three!" and there's no real reason why. So I think that's come out...so far that's what I'm finding. (SSW2)*

Much has been written on the troublesome relationship between theory and practice (Eraut, 1994; White & Stancombe, 2003). Research tends to produce nomothetic knowledge whereas practice-based knowledge is much more idiographic raising the question of how research can be applied to *this* family in *this* situation. One worker summed this up thus:

> *I've just put in (a report) the research that tells us that anybody with an IQ under 60, it's going to impact on their parenting capacity and they would struggle with that without support. However you've got to be mindful that everybody's individual and you know if we had a mum there who was willing to work with other services that would be changing the situation. You know, we've got to think right, this is the situation we've got, this is what research tells us, this is what we observe, this is what I see going out every week to see that family, this is what Children Centre staff see, this what the Health Visitor sees and knows from her observations. You put all that together and see what the outcome is for that child and that the likely outcome for those children at this moment in time isn't very good because of x, y and z and we know this from research, we know this from observations we've seen of parents, we know this from delving into the background and I guess it's a mixture isn't it that informs your judgements and your decisions.(SW4)*

Another said:

> *I don't think you sit down and go: what theory will I put to this situation. I think you work out a*

plan of action and then probably if you look that would fit a theory, you know, in hindsight but I don't think you think to yourself ooh what theory am I going to use here. I think it works the other way. You can probably plan or plot theories on to actions that we've taken. (SSW2)

What these extracts suggest is that those workers who said they valued and used research-based knowledge found it as troublesome as the many other knowledge forms they used. It had to be interpreted, evaluated, balanced against other knowledge that they have about a family and they then made judgements about how useful it was for them. Another issue was their access to such research. There are a number of reputable websites that give access to research studies and digests of research relevant to social work, some of which are free and some require subscriptions but none of the participants mentioned using them. Several comments suggested that participants did not necessarily have the skills to appraise and interpret research studies even if they could access them.

Some of the participants recalled academic work that had had an influence on them: one cited Dingwall et al.'s work on the Rule of Optimism (Dingwall et al 1983) , another Reder et al.'s study of the lessons to be learned from child abuse inquiries (Reder et al 1993) . Other workers mentioned research that had helped them think about children's attachments, parents with learning difficulties, the knowledge of risk assessments stemming from having worked in the Youth Justice field, a knowledge of how to work directly with children drawn from one participant's training and experience as a nursery nurse. It suggested that all workers have a "tool box" of theories and other studies which they have selected because they have found them useful. These tool-boxes are likely to be as unspoken and private as much tacit knowledge, suggesting that - to be relevant to them - academic knowledge has to be converted into something more idiographic and practice-based. There was a theme that such theories will need to be adapted to practice situations or they will either be of little use or encourage an automatic "tick box" approach.

9.3.2 Summary

The participants identified the importance of experience-based knowledge in their work. It enabled them to judge situations quickly and gave them confidence in carrying out their work in difficult situations using skills and strategies that were built up through experience rather than other sources. This fits with literature on naturalistic decision making reviewed in this study. To be able, one inexperienced participant said, to challenge family members yet build relationships with them as well was a skill that could be learned only through experience. Much of the reasoning they identified as being at the heart of their practice wisdom fits the

model of rapid, heuristic decision making and the ability to frame situations based on previous experience. The knowledge underpinning this is largely tacit and many participants found it difficult to articulate: it was common sense, a part of who they were. Experienced workers were conscious of having a great store of knowledge which they could draw upon and they felt they instinctively knew when it was right to use it. But participants were also conscious of the dangers of working "robotically" and simply acting automatically on the basis of familiarity without considering the uniqueness of every situation. "Gut feelings" or instincts that things "just weren't right" were valued because they gave important clues to what was going on even if they were difficult to articulate. As with heuristic reasoning these feelings lie at the intuitive rather than the analytic end of the cognitive continuum of human reasoning (Hammond, 1996).

Some participants were also conscious of the need to use more analytic, articulated research-based evidence, particularly when compiling reports and giving evidence in court. They talked about finding evidence to back up a decision already made rather than reviewing the available evidence and adjusting decisions accordingly. This suggests research evidence was sought retrospectively when its use was considered important to justify a decision rather than being used to shape and inform actual practice. Some were citing evidence in their reports but felt they were not encouraged to do this either by their employing organisations or by the nature of the forms they used. The degree to which participants had the knowledge and skills to access, interpret and appraise academic evidence was open to question. This also limited their ability to discriminate between different research studies which might be cited by other professionals.

The mix of knowledge workers drew on was largely idiosyncratic and personal: a tool box of resources they could utilise when they felt that situations called for some element of it. Some research and academic knowledge was in there along with their accumulated store of practice wisdom but what research and theoretical knowledge they considered significant or useful seemed to be largely a matter of personal choice about what stood out for them in their training and practical experience.

9.4 The uncertain nature of knowledge: making decisions in conditions of uncertainty

Perhaps because the work is full of uncertainty and complexity, and because much practitioner knowledge is tacit and experiential, knowledge about cases was rarely seen as definitive or certain. Instead it was seen as discursive – in the sense that it required

discussion and reflection. Helm (2011) suggests that, because the work involves consideration of large numbers of fallible indicators, cases could be seen in a number of ways so there needs to be a careful search for meaning:

> *I can walk into some family homes and think "this is ok". Somebody else would walk in and say no this is not good enough. Those kind of things are difficult. Those kind of things need to be talked through....(TM3)*

One manager talked about a complex case full of uncertainty being like an "unfolding story" which required thought and reflection rather than a process of "fact finding" and this emphasis on the need to reflect, to consider, to search for meaning emerged from a number of participants. But the time to do this thinking may not be available:

> *right when I've done that I've got to do that, when I've done that I've got to do that and you don't necessarily have the time to actually sit back and think ok I've done that what does that piece of information mean (TM3)*

This need for reflective space was, as previously discussed, in tension with their heavy caseloads and fast-moving, busy working lives.

Many participants talked about the irreducible conditions of uncertainty surrounding decision making. One element of this uncertainty was that they simply didn't know what they were walking into – that, as one worker put it, an apparently simple visit could turn into "a can of worms".

> *things can constantly change, as well as the snippets of information that we're getting on duty that we go out on, for example an anonymous referrer, guy's living here and he's been accused of rape in Z-- just thought I'd let you know, we go out and actually he could turn out to be any of awhole host of different things, we don't know what the set-up is in that family home, so actually then it's kind of those constant calls back to the office, clarifying bits of information, trying to make decisions on that. (SW1)*

Information is often incomplete and further information may not resolve the uncertainty as this may also be incomplete or of questionable quality. As the cases discussed here show even when there is a specific event it is hard to know exactly what happened and it is not easy to arrive at the truth.

sometimes we can have injuries that we feel could be non accidental but we have a child making disclosures and a parent who has a different story about how this happened and we have a child protection medical and then we have a doctor telling us, if you like, sitting on the fence a little bit, can't tell us: "it could have happened like that, could have happened like this".. (SW3)

Cases involving neglect and poor home conditions are difficult because of differing standards of what is "good enough" – what meaning different social workers and other professionals put upon a dirty home.

The combination of complexity and uncertainty in many situations means that workers must make judgements about the information they gather or which is communicated to them and meaning will rarely be unambiguous. And they have to make them quickly:

you have to make decisions on the run, on the foot, all the time I think. (SSW2)

Social workers are required not just to assess the present but to predict the future – to consider section 31 of the Children Act which sets the legal criteria as to whether or not a child *is* suffering or *is likely to suffer* significant harm. One manager talked about helping a social worker who was preparing a case for a court appearance. She asked if the worker had

Tak(en) into account the future, asking the question not just about the now, the here-and-now but the future.....because a child's at risk or a child's needs are so complex and are just not being met to the extent that if it's not a risk now it's going to become a risk in the future ....I think she was saying "these are nice parents and they probably can do it now" but she wasn't projecting into the future to say "but can they do it through this child's childhood?" given the child has additional special health needs and she said well you mean you want me to predict the future? And I said "yes" because that's what social workers have to do.(SM1)

She felt this was an inherently uncertain process:

Well, we can only use evidence to make our best judgement on that. We can't actually completely predict the future (SM1)

but that it was a factor in all decision making about children:

I think that it's what is asked of us every time we make a judgement, we are mostly predicting. Even if a child has suffered significant harm we have to make a judgement: is that likely to happen again (SM1)

There were examples of cases where decisions were made that were adequate to safeguard a child in the short term but were seen by the social worker as much more problematic in the longer term. An example was the case where a child had died and his brother moved to stay

with the stepfather's mother. This worked in the short term but created a series of family conflicts which in the longer term might well, according to the social worker, affect the child's future development.

But how apparent was this at the time? Social workers must make decisions based on the evidence available at the time and later this may be seen as inadequate or wrong. Munro (1996, 1999) in her study of 45 child abuse inquiry reports found that in a significant number of cases the decisions made were reasonable based on the information available at the time. Hindsight bias is a frequently cited error of reasoning when reviewing decisions which subsequent events showed to be wrong (Munro, 2008; O'Sullivan, 2011). Unsurprisingly the social workers were well aware of this as the profession has been publicly criticised for decisions that subsequently proved to be wrong:

> *I mean hindsight is a wonderful thing isn't it? I mean I can sit here and say "this went wrong, this went wrong, this went wrong...(SW6)*

But sometimes cases that had been closed came back to the team and this could be very uncomfortable for the workers involved in the original decision:

> *"Oh you had this 2 months ago and you were saying that everything was all fine" and so that can make you question your judgements, your assessments, in full view of everybody else (SW7)*

So it may be that this awareness of "hindsight error" can act as a way of excusing workers for mistakes made and maintain the assumption of collegial competence (Pithouse 1998) that is important for team identity and morale.

One worker said that a case she took on had been closed prematurely and looking back there were clearly warning signs. She seemed to feel very clearly that a mistake had been made. In the interview she said:

> *so, what I'm saying, with hindsight, is it's easy for me to go back and say well it were going wrong there, it were going wrong there but I weren't the worker at the time and I don't know why it's been let go, why it were just sort of...managed, I don't know......(SW6)*

However:

> *After I turned the tape off she said "that was a right fuck up" (field note extract)*

To return to section 31 of the Children Act: another difficulty it creates is that the legal test is not "harm" but "*significant* harm". How do social workers distinguish between the two? The

responses to my asking this in interviews suggested that they found the distinction difficult. Some forms of abuse are unambiguously significantly harmful but others are much less clear and the context of the mistreatment can be important: the risk to the child, the level of emotional impact, whether the mistreatment came from a close relative or a relative stranger, the likely effect on future development: all of these factors had to be considered.

One worker talking about a child with a bruised ear said:

> *well I mean if.....it's over chastisement I guess. I mean, I don't know that she has grabbed him by the ear or that dad did, we don't know that either parent did this but in a "what if" scenario, if mum...well it's not appropriate and if he's been left with a bruise on his ear because he's been pulled by the ear well then that's significant harm. The emotional abuse, being sworn at, shouted at.....is significant harm in a different way because that's emotional. The fact that there's no stimulation is another side of the risks to them because of their development. (SW4)*

In considering the available options workers were often aware that optimal solutions were not available This worker's assessment of the services available to a child is very bleak (and also refers back to the theme about the difficulty of predicting the future):

> *And I think the difficulty for me has been whether or not we...by the time we finish Care Proceedings D will be 8 so the chances of him being adopted by somebody are narrowed given his age and that he's a boy and the odds are against him and then he's got to spend the next 10 years in long term foster care and will that provide better care for him than his mum will ? (SW6)*

This dramatically exemplifies the description of social workers as "brokers in lesser evils" (Hardiker & Barker, 2007, p.48). Another participant, considering options for a child, argued that it was more about managing risk than finding a perfect solution:

> *you know something, you have to consider that you may not find the perfect risk-free answer in any of these (possible) solutions.... (SM1)*

Given the complexity, uncertainty and incompleteness of the information social workers had available to them, and the rapidity with which they had to make decisions, it is not surprising that mistakes were made. Indeed it has been argued (Munro, 1996) that mistakes are unavoidable.

9.4.1 The changing nature of the work

> *I think that sometimes we delay making decisions about those sort of cases because we want to see the best in people – that old thing of Rule of Optimism...(SM1)*

This participant, an experienced manager, is referring to the landmark study by Dingwall et al. (1983), discussed in more detail elsewhere, that found evidence in social work settings of a "Rule of Optimism" which allowed professionals to take a flexible view of child abuse. The work was both popularised and misconstrued by the public inquiry into the death of Jasmine Beckford (London Borough of Brent, 1985), since when this "Rule" has been taken to mean that social workers are too gullible, too naive, too prone to believing scheming and dishonest parents rather than the institutional device it was originally conceived as.

A number of participants contrasted social work as it used to be with what it is now. A senior manager commented:

> *I think in the past a lot of people who came into social work were very much you know "I've come to help people", we were a helping profession, and certainly I've trained a lot of students and newly qualified social workers who've started their careers with me and I think I always try and give students the impression that we have an investigative role, almost a forensic role these days (SM1)*

Another very experienced worker summed up the changes in social work over the years:

> *I think we've all become more sort of aware, things like Climbie and Baby P that, I think personally when we go to people's houses I think we need to start to look wider, at wider issues, not just...years ago I think social workers didn't think if it were a routine call wouldn't look at the house, wouldn't go upstairs, look at wider issues for this family...there were no initial assessments in them days. The initial assessment that we do is quite, although it's supposedly a snapshot of that family's life I think they're quite thorough assessments. We do cover a lot of things now. We always make sure we see the child's bedroom, the child's bed, cot, we ask more questions, we do more networking with all professionals, as part of that we're now checking with GPs. (SW3)*

The suggestion is that social work has become more investigatory, more concerned with gathering evidence, more aware that children are to be protected. There is a greater awareness that cases may end up in court and this affects the way the work is done.

Another worker described what she saw as the way relationships with families have changed:

> *I've only been qualified for 4 years I don't know what social work was like other than what I've read and what I've heard 20 years ago or whatever but I kind of think: oh I don't really think*

this is what it is, you know, this is what it was like where you had more involvement with families perhaps and you spent more time with them or you were able to do more. (SW4)

Parton (2008) and others have argued that social work has become, over the past few decades, much less about building relationships and much more about distanced surveillance and the monitoring of risk.

But, as suggested earlier in this chapter, many participants argued that it is important that the work is carried out according to certain values which are central to social workers' sense of professional identity and which are firmly enshrined in the ways social work students are trained and assessed. Discussions of practice involved certain ways of talking about the work:

you have to be open and honest but that is your job, you know, you're investigating things and I think that to gather evidence you have to be cynical and challenging..... Yeah, it's about being inquisitive and challenging....appropriately.....there's a nice way of challenging somebody and behaving with people that doesn't make you oppressive but you have got to be able to appropriately challenge (SM1)

Being "open", "honest", "appropriate", these words were central to the professional identities of social workers, they marked them out from others:

That's the difference I think between perhaps another professional and a social worker....there's no wagging finger. (SM1)

Another worker uses very similar language to describe her demeanour when undertaking a home visit:

I think I'm quite approachable, I think I'm quite open with families , I don't use a lot of jargon...we've got to be open and honest with them from the beginning. (SW5)

These approaches have to be used in potentially difficult situations:

somebody has given me some information which raised some concern and I have to believe that to be true until kind of proved otherwise, I still would be respectful and be considerate to that family and also that's part of engaging them as well, you know and so in that situation all I could do was be very honest with them (SW1)

Another says that she can quite understand that people might get angry:

So I think it's just about being honest and quite open and I understand when people are going to get angry and I think there's situations where people have got a right to be angry so should be allowed to have a bit (of a) rant (SSW1)

So the social workers espoused a firm belief in a set of values about being open, honest, approachable and tolerant of a certain level of hostility and these beliefs were central to how they saw themselves professionally. Yet at the same time they understood quite clearly that their work involved a significant degree of forensic, investigatory work in which they were required to take a sceptical view of parental accounts and this way of working contrasted sharply with the way things used to be done. Several workers gave accounts of older former colleagues who could no longer cope with these newer ways of working and whose practices could, at times, endanger children and render them liable to professional sanctions.

9.4.2 Summary

The knowledge social workers produced and used was often uncertain and incomplete. It often had several possible meanings which needed to be discussed and reflected upon (a theme which also arose when participants discussed their expectations of supervision). Social workers were required to decide not just on what has happened or is happening now – challenging enough – but on what might happen in the future. Trying to predict what might happen was an important element of the work and added to its uncertainty, especially as there were rarely optimal solutions to be had. Decisions had to be made in conditions of fluidity and uncertainty and errors were not uncommon. The participants had many examples of mistakes or questionable decisions though they recognised that some of these erroneous decisions were justifiable at the time they were made.

The meaning to be made of ambiguous information was accentuated by changes in the professional and public cultures within which social work is practised. There has been a significant shift towards a more sceptical, forensic, investigatory form of working and the participants were not fundamentally critical of this turn – regarding older ways of working as naive luxuries belonging to a different time. At the same time they continued to hold on to certain values that have long been associated with more traditional forms of social work practice.

9.5 Conclusion

The knowledge the social workers talked about was difficult and complex. It had to be assembled – often rapidly – from a range of sources all of which were problematic and all of which offered information that had to be interpreted and applied to the specific situations the social workers were assessing. It was highly case-specific, thoroughly enmeshed in the complexities and experiences of professional practice and drawn from many sources.

Different sources of knowledge, some of more contested status than others (Pawson et al., 2003) had to be balanced and evaluated against each other. It was saturated in different meanings, values and moral standards and easy to misunderstand. It rarely produced definitive answers. It was, as Scourfield & Pithouse (2006) argue, often conceived of as common sense.

If knowledge is constructed in situations of complexity and uncertainty then the conditions in which that knowledge is produced are as important as the knowledge itself as they shape it so profoundly. Writing about the production of medical knowledge Atkinson (1995) argued that "social exchange of talk, the social distribution of knowledge and the everyday ceremonies of medical work" (p. 59) were indivisible. Knowledge produced in, for example, the particular conditions of home visits will be profoundly shaped by those conditions. Another example of this process is seen in the construction of casenotes whose thin and abbreviated qualities were a product of the circumstances in which they were written and their anticipated audience. Workers took care to omit the hunches, possibilities and ambiguities which elsewhere they saw as important areas for discussion in supervision and informal team talk.

Workers valued experience-based knowledge and there is, as has been discussed, considerable evidence that such knowledge and the more intuitive and heuristic forms of reasoning on which it is based are extremely useful and well suited to the conditions of social work practice. There was some use of and valuing of more analytical forms of research and theory based evidence but these tended to be used, if at all, to retrospectively justify decisions rather than inform current practice. Even if participants had wanted to use these forms of knowledge more often they lacked access to them and to the skills needed to appraise them. So the workers' knowledge base was heavily weighted towards the more intuitive end of the cognitive continuum and so prone to the errors such forms of reasoning can give rise to.

The nature of the work meant that errors did occur. Munro (1996) has argued that the nature of the work makes such errors unavoidable. A number of studies (eg Reder et al., 1993, 1999) have highlighted the problem that quickly made decisions can lead to fixed perspectives, impervious to change. New information is either disregarded or re-interpreted to fit with the existing view of the situation. Ideally, social workers can revisit and rethink decisions but as previously argued supervision does not always provide a space for this as it ideally should.

Child abuse is a socially constructed category and values and beliefs play a part in understanding and assessing it (Hardiker & Barker, 2007). These change over time and

debates about the Rule of Optimism which took place in the 1980s still have currency. A more detailed discussion of the changing culture within which child protection social work takes place is given in chapter 2. For the workers in this study there was some tension between the forensic, investigatory (perhaps one might say "post-Rule of Optimism") nature of the work and the more traditional values associated with social work. This tension is perhaps unavoidable, rooted in what Parton & O'Byrne (2000) argue are two conceptions of social work and its knowledge base – one technical, rational and objectivist, the other practical, moral and interpretivist. As social work cultures and practices change so theories, values and beliefs about the work change. Social workers do not have a completely free choice of theories to draw on as some are preferred to others (Hardiker & Barker, 2007), sometimes to the point of having a hegemonic sway over the knowledge base (White, 1997). Changes in the way social work is practised are accompanied by changes in which theories and knowledge-claims are preferred.

The social workers had a fundamental dilemma. On the one hand they were expected to provide definitive solutions to very grave social problems which were sufficiently certain and robust to stand up in court but on the other they had to work in uncertain, ambiguous situations with family members whose understandings of those situations were often very different from their own. There may have been a rhetorical quality to participants' insistence that "open-ness", "honesty" and "approachability" were central to their practice but such words also arise, Jordan (cited in Parton & O'Byrne, 2000) argues, from an understanding that social workers work with people to negotiate situations of complex and contested meaning. Others (Scourfield, 2003; Hardiker & Barker, 2007) have argued that such words are part of a professional ideology that leaves unexamined crucial assumptions about social work practice. The choices and dilemmas the social workers faced as to what does and does not count as good knowledge and how that knowledge should then be used in practice are not made easier by the contested and shifting ground inhabited by the profession as a whole.

CHAPTER 10: DISCUSSION

10.1 Overview

In this section the four chapters of empirical findings are recapitulated with the aim of capturing overarching themes that recur across the data. Three such thematic categories emerge:

- The nature of the dominant forms of decision making in social work practice
- The centrality of uncertainty and complexity in child protection social work.
- The complex and localised social processes whereby knowledge is gathered from a range of fallible sources and then reconstructed through workplace practices to provide the knowledge for decision making.

These categories are set out in more detail in Table 7. They may be seen as higher order concepts which can be used to suggest hypotheses and substantive theories: to produce an account which will provide the framework for analysis (Dey, 1993).

The picture that emerges is one of system complexity that reflects the complexity of child abuse as a social problem. This forms the context within which knowledge is produced and reconstructed and decisions made. It is suggested in this chapter that activities which are deeply enmeshed in social work's culture and daily practices such as home visiting and professional supervision can be seen not as neutral producers of knowledge for assessment and decision making but as complex processes of social interaction which profoundly shape the nature of the knowledge social workers produce and which can be troublesome and fallible as sources of knowledge. It is also suggested that insufficient attention has been paid to the contexts within which knowledge is produced and used resulting in a lack of research into these intimate and complex activities which constitute daily social work practice.

An attempt is made to synthesise these understandings and suggest that future research should take a systemic view of these complex processes through which knowledge is produced and decisions made. Recent sociological work on family lives, notably Morgan's work on "family practices" (1996) is useful not only in understanding the complex nature of many of the families social workers deal with – which, it is suggested, contributes significantly to the uncertainty of the work – but his emphasis on "practices" more generally suggests that research could profitably focus on "social work practices" and attempt to identify the fluid, complex and diverse ways in which social workers actually "do" social work. The chapter

concludes by suggesting that this detailed examination of local contexts and practices could be a profitable way of understanding how and why errors in decision making arise.

10.2 Recapitulating and synthesising the empirical findings

The first empirical chapter explored the day-to-day context of the work the social workers did, seeking to provide an understanding of the nature of their work and the conditions under which they made decisions about cases.

The chapter examined the work with families that the social workers did within their office – looking at the duty system where new referrals were processed – and outside the office in families' homes. Many of the day-to-day decisions were made in these situations and the picture was of complex cases involving both incomplete and contested information requiring the social workers to make decisions quickly based on evaluating multiple fallible indicators. The work was often unpredictable and uncontrollable. Both these areas of work were stressful and both emotionally and cognitively demanding. The findings lend support to the evidence from previous studies that in such fluid, uncertain and ambiguous situations there are severe limits to the usefulness of official procedures and of more orderly, analytical reasoning.

More informal or unofficial processes featured significantly in the work. These processes were visible in the routines of the work: the ways in which practitioners conceptualised and evaluated cases, the ways in which they talked about them to each other and to the researcher, the ways in which practical tasks were carried out. Trying to gather enough information to construct as complete and coherent a narrative as possible about a case took up quite a lot of the workers' time and because these narratives remained contested or ambiguous there was a good deal of collegial discussion about them. The ways in which these tasks and interactions were undertaken created a distinct culture in the team, a set of unwritten rules, which had a powerful effect on the way the work was done and decisions made. Again this tended to support the findings of previous empirical studies which identified the importance of unofficial, local rationalities in shaping the way the work was done.

A key way of making these processes more official and auditable was by recording them. Recording practices varied. Sometimes case recordings were made carefully but often they were brief, abbreviated, "thin" descriptions which provided very few or no indicators of the author's thinking in evaluating complex and fallible indicators. In part this was due to lack of time to write full recordings but it was also seen as a way of limiting those elements of day-to-day practice that would enter the official domain of audit and procedure. A number of studies

have argued that social work cannot be understood only in terms of the official versions of the work and this study's findings served to emphasise that social workers' actual practice can only be fully understood through close examination of their day-to-day actions.

The families who made up the social workers' workloads overwhelmingly presented complex and demanding issues. Children were often at risk, families could be difficult and stressful to manage and the social workers often found themselves juggling competing stories of events with no idea which, if any, were true.

In such fluid and contested situations moral judgements were often made as part of the workers' sense-making. Social work assessments, as previous studies have noted, ascribe meaning to injuries and other concerns by setting them in a social and moral context rather than taking a purely clinical approach. This was graphically seen in a number of cases in this study.

Dingwall et al. (1983) referred to this reasoning in elaborating their concept of The Rule of Optimism. It might be argued that cases were seen through a "moral lens", drawing on Brunswik's concept of a sense-making lens comprised of professional and personal knowledge, beliefs and experiences through which people make sense of the world and decide which environmental cues are more or less significant (Thompson & Dowding, 2009; Hammond, 1996). Graham argues that there is a particular "welfare model" (Graham, 2011, p.1544) based on traditional psychological and sociological theories which is central to social workers' views and this may play a central part in determining the nature of this moral lens. Graham argues that this model is based on certain assumptions about stable parenting and family structure which may not accord with the diverse worlds which many families inhabit.

Many of the families the social workers dealt with had shifting, complex structures that included estranged parents, step parents, step grandparents and friends whose status and connection to the child were uncertain. More recent sociological approaches to families' lives and practices, notably Morgan's work on "family practices" (Morgan, 1996; 1999; 2013), may be useful in helping social workers understand such families and in helping to analyse the nature of this moral lens. I will return to these approaches later.

The second chapter of empirical findings sought to build a detailed picture of social workers' practice with families. Three areas of practice emerged as sub-themes: home visiting, doing assessments and working with other professionals. The information the social workers

obtained in their day-to-day practice came from these three sites so they might be seen as important sources of social work knowledge in practice. All three were far from straightforward and so echoed the picture of complexity and uncertainty emerging from the previous theme.

Home visits occupy a central place in social work practice and present very particular challenges and opportunities. They are a quintessential representation of social work's "invisibility" (Pithouse, 1998) yet remarkably little has been written about them. They can be stressful, chaotic, difficult, even threatening situations where practitioners are drawn into intense relationships with often angry and distressed families and many of the participants' most vivid stories were about such visits. Learning to cope with the challenges such visits present are important rites of passage for social workers yet even experienced workers accepted that they sometimes struggled to assess situations because there were few unambiguous indicators.

Because assessments are often carried out during home visits there is an overlap between the first two sub-themes. While some participants describe trying to adopt precise, forensic investigatory techniques others describe more uncertain and ambiguous processes of trying to engage families with complex problems. Some workers clearly moved between these positions. Certain terms recurred in participants' narratives: about building a picture, identifying constellations of factors, thinking in terms of kaleidoscopes and jigsaw puzzles. These suggest the sense-making processes of naturalistic decision making: constructing "frames" in order to produce coherent narratives that placed abuse within social contexts (eg Sullivan, 2011; Thompson & Dowding, 2009). Because reasoning was largely heuristic and practitioners' experience was highly prized "niggles" and "gut feelings" were not dismissed as irrelevant but incorporated into assessments and collegial discussions. There was a distinct moral element to these assessments with practitioners seeking to evaluate contested information and competing stories and family members trying to establish their moral credentials. So a significant element of the frames workers were constructing was shaped by the moral lens suggested earlier.

The social workers routinely worked alongside other professionals and frequently found these collaborations frustrating or counter-productive. The participants complained that other professionals often made poorly thought out referrals, medicals were inconclusive, the police often took very different positions about families and could compromise social workers' activities, schools avoided working with difficult parents, health visitors skills were questioned.

Professionals are required to work closely together in child protection work and a number of examples of disagreements over professional boundaries were reported. Dingwall (1977) argues that professionals tell "atrocity stories" about each other to defend their professional identities and illegitimise the claims of other professionals who might be rivals for the same professional space. The evidence from previous research that inter professional collaboration can be hard to achieve was supported with particular detail emerging about issues over medicals and over police involvement in social work cases. Although the use of specialist professional expertise is regarded as an important way of introducing more analytic methods into decision making in social work (Hackett & Taylor, forthcoming) the participants often doubted the usefulness of the information they got from other professionals.

It may be suggested that all three sources of information and knowledge production for the social workers were troublesome and the information not infrequently regarded as unreliable, contested or of uncertain status.

The third empirical chapter focused on one of the central activities of social work: supervision of practitioners by their managers.

Both supervisors and supervisees valued supervision as a place where cases could be reflected upon, ideas bounced around and alternative possibilities considered. This was valued above having an expert supervisor who had the right answers: social work knowledge is often complex and full of uncertainty and it needs to be made sense of and given meaning rather than there being a single "right" answer (Buckley, 2003; Helm, 2011). At the same time it was accepted that supervision was a place where practitioner accounts should be questioned and challenged and the evidence for them clearly argued. Supervisors and supervisees argued that as social work becomes more forensic and investigatory, and evidence needs to be found that can be used in courts of law it was necessary to be able to develop and sustain such arguments. Some studies have found that social workers are not always able to argue their case clearly (Benbenishty et al., 2003; Buckley, 2003) and it is argued that supervision, as a controlled situation where environmental indicators can be considered sequentially, offers the possibility of providing a more analytical complement to the heuristic reasoning of daily practice by weighing up options in an orderly manner by, for example, using decision trees (Munro, 2008; O'Sullivan, 2011). Ideally, decisions made rapidly on the basis of incomplete and contested information can be rethought. This requires time which is not always available in a busy office. Perfunctory supervision can very easily

mirror rather than complement heuristic thinking, with options not fully considered and decisions made quickly and mechanically. Many participants suggested this happened not infrequently despite a commitment to supervision within the agency and the local team.

However, it is also a matter of supervisors possessing the required skills and experience to be able to challenge social worker accounts and not take them at face value. Less experienced supervisors could struggle with this even if they had doubts about these accounts because they did not want to undermine the harmonious relationships and morale in the team. More experienced supervisors seemed more confident at managing these different functions and attendant expectations. They learned to develop skills in challenging accounts in a way that sought to facilitate in the supervisees more analytical and critical thinking and the ability to construct clear evidence-based arguments. Again, this was valued more highly than the supervisor knowing all the answers and again this reflects the sense that social work knowledge is full of uncertainty. One manager characterised this process as "trying to make sense of this family through this social worker's eyes" – a process requiring complex interpretive skills and one that contrasts with the less experienced supervisors' struggles with having to rely on practitioner accounts of families they themselves had little knowledge of. Learning to become an expert supervisor seemed to require learning these complex cognitive skills and balancing the different functions of supervision within the team. It would seem likely that not all managers and supervisors would become expert in these skills.

Participants generally had a good understanding of the espoused functions of supervision but what also emerged from their accounts was the degree to which, particularly as they gained experience, they learned to manage the process artfully – sometimes choosing what to discuss and what to omit but also *how* they would discuss a case in order to "sell" the version they wanted to be accepted. This highlights the social aspect of supervision, with skilled actors negotiating new ways of presenting material for discussion and decision making.

Alongside more formal supervision there existed more informal team discussions which could act as a kind of informal supervision, enabling team members to discuss and reflect on cases. Like formal supervision this informal talk had a social function, cementing relationships and sustaining team identity and morale.

The fourth empirical chapter concerned the nature of the knowledge the social workers used in their activities and decision making. There is a degree of overlap with other themes as a

discussion of the sources of knowledge the social workers used meant revisiting previous sections on such topics as home visits and case recording.

Social work has a diverse and often contested knowledge base. Cases in this study often involved social workers drawing on information from a range of sources – warring parents, other professionals and agencies, old case files – none of which provided definitive information and all of which were regarded by the social workers as fallible. To make a decision on how to proceed all these sources had to be balanced against each other, synthesised and evaluated.

Participants expressed an acute awareness of the unpredictable, uncertain nature of the work, the possibility of making mistakes, of making decisions quickly that worked for now but might be counter-productive in the longer term, of the lack of optimal solutions to entrenched problems. Against this context knowledge was rarely certain and definitive. It was contingent and needed to be evaluated, discussed and reflected upon......if there was time to do so.

In their daily practice social workers drew on information from other professionals, from family members, from children, from the public, from case files and found all of them to be troublesome. Professional collaboration was often affected by conflict and poor communication; family members and members of the public might give false or unreliable information for many reasons; children might not fully understand the situations they were talking about; case files were often brief and selective, written for audit purposes and so likely to be incomplete or even incoherent (Hall et al., 2006; Pithouse, 1998).

A potent source of information was home visits and, as has been noted earlier, these could provide unique insights into families' lives but also posed major cognitive and affective challenges for social workers who had to evaluate information from multiple fallible indicators in complex and often chaotic contexts. Such was the importance, and the challenges, of home visiting that for less experienced workers gaining experience and confidence in managing them was perhaps the most highly prized of skills and, as has been argued previously, a marker of their "moral career" (Pithouse, 1998). Yet even experienced practitioners found home visits problematic and evaluating home conditions difficult. Balancing the forensic element of the visit with the need to engage in often complex relationships with family members was one of the key challenges.

What is striking is that many of these troublesome sources are both fallible *and* provide potentially unique and intimate insights, making evaluating their worth highly problematic. Practitioners had to makes sense and meaning from them to build the “bigger picture” many of them talked about: the production of a probabilistic picture based on an evaluation of multiple fallible indicators.

Building such a picture is a key aspect of naturalistic decision making which is based largely on experiential, intuitive reasoning (Klein, 2000; Hammond, 1996) and the literature reviewed earlier suggests strongly that social workers rely heavily on this form of reasoning in daily practice. So it is not surprising that the participants valued experience most highly and less experienced workers valued building experience above other forms of knowledge. Experience and confidence in dealing with practice situations is seen as a mark of expertise (Fook, Ryan & Hawkins, 1997; Pithouse, 1998). For more experienced workers this experiential knowledge became tacit knowledge or common sense and might not be easy to articulate or interrogate: as one participant put it :“then everything just falls into place – this has to happen and that has to happen and that doesn’t need to happen and you know you do that very quickly in your own head”. It is a defining feature of intuitive knowledge that it does not have a step-by-step logic to it (Hammond, 1996). Broadhurst et al. (2010a, p.1046) refer to practitioners’ “informal logic”. Such knowledge became for experienced practitioners, part of who they were and was inextricably linked to their values, beliefs and identity. Many participants referred to the importance of certain values such as openness, honesty, approachability and being non-judgemental in marking out their work from that of other professionals. It was suggested that this may be a recognition of the socially constructed nature of social problems and the need to negotiate multiple realities but that it may also be a professional ideology that does not interrogate crucial elements of the work.

More abstract knowledge based on research and academic theory was less valued. There is evidence that social workers do not use such knowledge much in their practice and there may be considerable barriers to practitioners accessing, appraising and using such knowledge (Gray et al., 2013; Thompson et al., 2005). The view that you can find research to back up anything you want – making it therefore largely worthless except as a way of retrospectively backing up a decision already made – was voiced by several participants. The value of research to justify decisions and provide evidence was recognised by some who made some efforts to incorporate it into their reports but even then it was seen as a limited resource. Making generalised or nomothetic academic knowledge relevant to specific client situations

was not easy and such knowledge was only valuable when seen alongside other sources of information. There are well established criteria for judging research-based knowledge, more so than for more intuitive forms of knowledge (Pawson et al., 2003), but in practice it was as troublesome as all the other sources of knowledge the social workers drew upon and needed to be just as carefully evaluated.

10.3 Developing overarching themes

A number of themes recur across the four Findings chapters and these may be grouped into three categories as the table below suggests:

Themes	Categories
Unpredictability and uncertainty of the work Need to make decisions rapidly based on fallible information Informal sense-making process embedded in the routines of the work Extent of use of more analytical reasoning The value placed on experiential knowledge and reasoning The value placed on more abstract knowledge drawn from theory and research The importance of values and beliefs – "who we are" The moral lens	**The nature of the dominant forms of decision making in practice**
Uncertain, complex, contested work: the complex and intractable problem of child abuse The complexity of families: their relationships, their contested narratives Setting abuse in social and moral contexts: the use of moral judgements as part of decision making The contexts in which knowledge is produced and used The importance of values and beliefs – "who we are" The nature of supervision	**The centrality of uncertainty and complexity**
The nature of home visits The nature of assessments Inter professional working The nature of case recordings The diverse and contested nature of the social workers' knowledge base and the contexts in which it is produced and used Supervision	**The construction of knowledge in the workplace** **Fallible sources of knowledge**

Table 7 Grouping inductive themes into categories

It is not suggested that each theme fits into a single category or that the categories are entirely discrete. Some themes clearly occupy more than one category as might be expected when analysing a study of a complex social setting where the researcher is seeking sensitising concepts rather than discrete variables (Blumer, 1954, 1956). So, for example, supervision fits into the category of the construction of knowledge in the workplace but also into the category of context and situated complexity as it has many functions, only some of

which are its espoused, official functions. Another example is the theme of values and beliefs and their importance to social workers' sense-making. This fits into the theme of context and situated complexity as it is an essential element of the team culture but it also plays a crucial role in decision making and in the nature of the moral lens which it has been suggested shapes the way social workers make sense of the world and evaluate environmental cues. And the recurrent themes of uncertainty and complexity which stem from the complex nature of child abuse run across all three categories.

The inter-relationships between the three categories may be represented as in the diagram below:

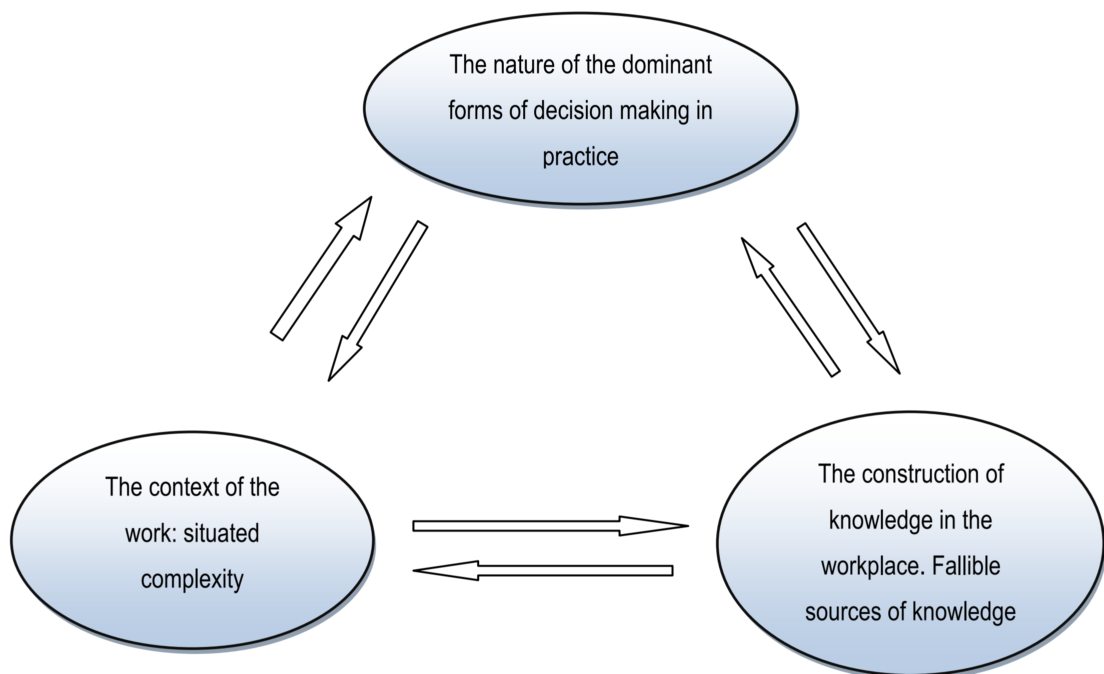

Figure 3 Inter-relationships between the three categories

10.4 Generating ideas and substantive theory

The usefulness of the above table and diagram is to further develop analysis of the data by suggesting higher order categories. These may generate substantive theory that seeks to explain the nature of the phenomena under study. Of course this is a small study of limited scope and any theoretical suggestions must be made cautiously. It is helpful to use Coffey & Atkinson's (1996) definition of theory as the generation of ideas about the data which may be then be related to other ideas. The aim is to propose substantive theory which could provide ideas and hypotheses for future research. Substantive theory is theory that is drawn from, and

firmly grounded in, data generated in a particular context and which tries to make sense of that context (Coffey & Atkinson, 1996; Glaser & Strauss, 1967) or, as Birks & Mills put it "it is produced for the purpose of understanding a tangible phenomenon in a clearly defined situation" (2011, p.156). Any ideas generated by this study would need to be further researched across different contexts, involving a wider range of stakeholders.

10.5 The overarching themes: introduction

The following discussion is subdivided as follows:

1. The nature of the dominant forms of decision making in practice
2. The centrality of uncertainty and complexity
   - (i) Complexity of function: supervision
   - (ii) Making sense of complexity: home visits
   - (iii) Understanding family complexity
3. The construction and ecology of knowledge from fallible sources

10.6 The nature of the dominant forms of decision making

The findings in this study support evidence from previous studies that social workers largely use heuristic, naturalistic reasoning because of the complex and uncertain conditions of practice. It is suggested that the task characteristics of social work heavily favour this kind of decision making.

Key task characteristics of social work practice favouring intuitive or naturalistic decision making
Poorly defined problems
Uncertain, dynamic situations
Large numbers of cues presented simultaneously or very rapidly
Cues difficult to measure reliably or objectively: high levels of potential fallibility
Action -feedback loops rather than linear cause-and-effect
Time stress: need to make decisions quickly

Table 8 Task characteristics of social work practice

(Orasanu & Connolly, 1993; van de Luitgaarden, 2009; Helm, 2011)

Strategies for introducing more analytical decision making rely on clearly defined and orderly situations where cues or indicators can be considered sequentially and systematically and measured according to agreed standards of utility. Such conditions rarely existed in the practice examined in this study. The most likely situations for using analytical methods were in supervision, in working with specialist professionals and in using structured decision aids. However, as discussed, these can all be problematic in practice and cannot be regarded as panaceas. Supervision could be effective but could also be rushed and poorly managed. Work

with specialist professionals could be riven with inter professional conflicts. No participants mentioned using structured decision aids which are seen as a key way of introducing more analytic thinking into practice reasoning. It must be acknowledged that such a question was absent from the interview schedule - an oversight which future research would need to rectify. However there is persistent evidence that such aids are rarely used, are problematic in practice and when they are used they may be used in a mechanistic way that does not improve decision skills although there may be evidence that aids structured in accordance with more naturalistic models may be a more useful way forward than actuarial models based on purely rational-choice thinking (Schwalbe, 2004; Shlonsky & Wagner, 2005; Barlow & Scott, 2010; Gillingham & Humphreys, 2010; Gillingham, 2011).

It is accepted that intuitive thinking often works well but the problem is that its known tendencies towards certain kinds of error and bias are difficult to address because intuitive thinking is characterised by an absence of explicit models of reasoning and an emphasis on tacit knowledge (Hammond, 1996). For many of the participants in this study what they knew was intimately bound up in their values and beliefs – their sense of who they were. But explicit models of naturalistic decision making do exist. As discussed the models which seem most closely to fit the ways practitioners think are Klein's Recognition-Primed model or RPD (Klein, 1993; 1999) and Brunswik's "lens" theory (Hammond, 1993; 1996; Thompson & Dowding, 2009). The RPD model underpins some non-actuarial decision aids (Schwalbe, 2004; van de Luitgaarden, 2009). Making explicit use of such models to examine decision making could be a very useful focus for supervision for example.

In addition it has been suggested that insufficient attention has been paid to the contexts in which knowledge is produced and used (Gray & Schubert, 2013; Osmond & O'Connor, 2006; Sheppard, 1995; Sheppard & Ryan, 2003). The lack of attention in previous research to what goes on in home visits suggests there is a significant gap in the knowledge base about how this kind of reasoning operates in such contexts.

Trying to impose linear rational-choice models of thinking on social workers as a corrective to the errors inherent in intuitive thinking is unlikely to be successful because of the task characteristics of the work. More explicit use of models of experiential and naturalistic decision making and more research on how such thinking operates in the specific contexts of social work practice may be a much more fruitful direction. Two of those contexts – home visits and supervision – are considered in more detail later.

10.7 The centrality of uncertainty and complexity

Devaney & Spratt (2009) argue that a complex problem such as child abuse has a number of key characteristics. It has no definitive formulation but is composed of a complex set of interweaving problems whose meanings vary and which are so interlocked that change to one area may cause unexpected and undesirable consequences elsewhere. Solutions will not be universally right or wrong but will, at best, provide improvements in local situations under certain conditions. Those improvements may be limited ones – many of the participants were well aware of the lack of optimal solutions to entrenched problems. For example, taking protective measures by placing a child out of home could, as some of the participants suggested, have poor long term outcomes. It was noted in chapter 2 that in the majority of cases resulting in Serious Case Reviews one or more of three factors – domestic abuse, mental ill-health and drug- and/or alcohol-abuse – co-existed, with all three present in nearly a quarter of cases (Brandon et al., 2012). A straightforward, linear solution to address one element of this complex of issues may have negative consequences for another element. Munro (2010) argues that child protection work is located in complex systems and changing one part of that system will affect other parts in an unintended way. It is suggested (eg Buckley,2003; Spratt, 2001; Broadhurst et al., 2010a, 2010b) that an increase in administrative procedures to make child protection work more standardised and auditable resulted in rushed, poor quality work as social workers and their managers sought to meet targets. Yet those procedures arose in response to evidence that insufficient procedures existed to ensure professionals worked together to safeguard children. It has been argued that an understanding of theories of complexity is important to understanding the complex non-linear causality found in child protection systems (Hood, 2012; Stevens & Cox, 2008).

It is suggested then that the systems designed to intervene in child abuse situations come to reflect the complexity of the problem they are design to counter. As previously discussed, official responses to child abuse tragedies tend to take a prescriptive approach to problem-solving that assumes that the complexities and uncertainties of daily practice are resolvable in a linear fashion (Cooper, 2005; Reder & Duncan, 1993). Social workers find themselves struggling with rigid official systems which do not reflect the ambiguous and uncertain cases with which they work and the complex sense-making required to understand them (Broadhurst et al., 2010a; Buckley, 2003). So the complexity is largely unofficial, unaudited, “invisible” (Pithouse, 1998). Of course, as has been argued, this is not unique to social work: all jobs have an unofficial, hidden complex of unwritten rules – a culture – that differ considerably

from the ostensible role and function of the work but the nature of child abuse as a social problem and the demands it places upon practitioners make this a particularly acute issue for social work.

In the following sections complex aspects of the work which have figured significantly in this study, and which are central to knowledge production and decision making, are discussed: supervision, home visiting and the complexity of the families.

10.7.1 Complexity of function: the case of supervision

Much has been written about supervision in social work and it is not the intention to review the literature comprehensively but to argue that the *social* function of supervision which has been suggested in this study is a crucial but overlooked aspect and one which fundamentally shapes the meaning supervision has within the local context.

Supervision has long been regarded as central to good social work practice. Phillipson argues that it is "a fundamental plank in ensuring social work's focus and effectiveness" (2009, p. 188) and has remained so despite social work's many changes and crises. It is seen as providing a space for developing critical reasoning skills and in managing the affective demands of the work: working with families with complex and enduring problems can be emotionally draining and often feels thankless as change is so hard to achieve so supervision can provide crucial emotional support and encourage fresh thinking (Brandon et al., 2008; Barlow & Scott, 2010; Munro, 2008). It is not easy to provide such cognitive and emotional support and development and there has often been a gap between the expectations of supervision and what actually happens in reality (O'Sullivan, 2011). The lack of good supervision has been highlighted in a number of inquiries and reviews (Reder & Duncan, 1993; 1999). Supervision is often conceived as having a triangle of functions. O'Sullivan (2011) suggests these are administrative, educative and supportive. Hughes & Pengelly (1998) suggest a triangle of managing service delivery, examining the practitioner's work and facilitating the practitioner's professional development. Munro (2008) argues that an increasing focus on supervision as a form of managerial oversight has compromised the ability or willingness of supervisors to encourage good critical thinking skills. Jones (2004) argues that as supervision is embedded in organisational contexts the more hierarchical the organisation the more supervision becomes an unequal partnership between supervisor/manager and supervisee: an inequality that may compromise some of supervision's support and learning functions.

Pithouse (1998) has argued, as we have seen, that building a set of social relations in the team founded on an assumption of collegial competence is important in helping social workers manage the uncertainty of their work. Supervisors, he suggested, are very aware of this assumption and are faced with the dilemma of how to critique supervisees' work without undermining that assumption. This was, as discussed, an important preoccupation of the less experienced supervisors in this study who sought to reframe any criticisms they had in ways that did not leave supervisees feeling undermined. This could leave supervisees' accounts uninterrogated and leave errors and oversights unexamined.

Supervision performs a complex of functions: managerial, cognitive and social. It is a central routine of social work practice and such social routines can be seen as complex and significant social practices that construct and reconstruct the rules by which social order is maintained (Silverman, 2011; Hammersley & Atkinson, 2007). In official versions of the work supervision has a number of functions which are well documented and understood but it also has a number of unofficial functions which are less well understood and do not feature in official accounts and audits but which profoundly shape the way supervisors and supervisees "do" supervision.

Using the typology of social units suggested by Lofland et al. (2006) supervision can be seen in a way that examines its social function. Supervision might be seen as a hierarchy in which there is an inequality of power between the participating actors – an element of supervision that has received a good deal of attention (Jones, 2004; Hawkins & Shohet, 2006; Phillipson, 2009). It might be seen as what Lofland et al. define as a practice – a recurrent social category whose routine nature renders it unremarkable – or as an encounter – in which a "tiny social system (is) formed when two or more persons are in one another's immediate physical presence and strive to maintain a single....focus of mutual involvement" (Lofland et al., 2006, p. 124). Seeing supervision in these ways allows the activity to be conceived of in different ways. So the struggles of some supervisors to learn the skills of challenging practitioner accounts, the artfulness with which supervisees and supervisors negotiate what they will discuss, and how they will discuss it, the ways in which they negotiate their relationship and the ways in which that relationship changes as practitioners become more experienced, a preoccupation for a number of the participants in this study, are saturated in social meaning drawn from the context in which they work and are crucial to how supervision is done.

As I have suggested a study of some of the routines of the workplace was important in answering the research question because a study of routines can uncover the ways in which social order in the context studied is sustained. In this context how routines play a part in constructing the knowledge that informs social workers' actions and decisions is a fruitful area for study (Scourfield & Pithouse, 2006). Supervision plays an important part in this process. To understand how supervision operates within its social context, how it maintains or challenges social rules and expectations, how it plays a part in the construction of social workers' knowledge and decision making, it must be closely examined within its social context. Some time after the field work phase of this study had been completed the local authority was inspected and the rigour of its supervision processes questioned. I was asked to speak to the senior management team about my findings and I argued that to make supervision into a more narrowly managerial, auditable process could have a deleterious effect on the social functions of supervision in maintaining team morale and identity. Of course this should not mean that supervisors do not challenge practitioner accounts for fear of undermining team relationships but that any changes should seek to balance both the official and the unofficial functions of the activity. The lessons of complexity theory (Stevens & Cox, 2008), that any change will have unexpected consequences elsewhere in the system, are very relevant here.

10.7.2 Making sense of complexity: home visits

The social work home visit has been a recurrent theme throughout this study and this reflects the central place that activity has in daily social work practice. One of the key findings of this study has been that the conditions of the home visit exemplify the uncertain, fluid, poorly defined and stressful task characteristics of social work practice and much more attention needs to be paid to the nature of such visits and the processes of knowledge production and decision making they give rise to.

Ferguson (2011) argues that we need a new theory of intimate social work practice:

> *To properly capture what social work and child protection involve doing....we must follow the....practitioner as they leave the office, make a journey by car or on foot, walk to the doorstep and (try to) gain access to the service user's home, walk into and within the home, and then make the return journey (Ferguson, 2011, pp. 41-42)*

Whilst I was undertaking the fieldwork in both sites there was a constant coming and going as social workers went out to visit families and returned, often with a story to tell or seeking a

discussion with the available manager. Every participant talked about them and there are many accounts of difficult visits throughout this study.

Ferguson (2004) argues that the social work visit has been a central part of social work practice since the early days of the NSPCC in the 1890s and from the start was complex and contested: many of the problems he describes NSPCC inspectors grappling with were similar to the dilemmas participants in this study discussed. Ferguson sees the home visit as a crossing-over into others' intimate spaces and notes the profound effect this can have on the social worker and their interactions with family members. Yet, as he and others have noted, within the general lack of detailed research into the daily activities of practice, the absence of research into home visiting stands out. A recently published short text (Nicolas, 2012) contains a single page of references, eleven sources in total, of which only two – one a web-based guide – are specifically about the home visit. Another recently published edited text on social work with children and families (Davies, 2012), designed as a core academic text, contains a single page on home visiting. This is clearly a seriously under researched and under theorised area despite its importance.

It is also one of the most private: Hall et al. argue that home visits are "the least public arenas in social work" (2006, p.71). But, in some ways, it is also one of the most public as some of the most vivid and distressing episodes described in inquiries and reviews are about visits which missed apparently important signs or which did not take place as they should – where the child was not "seen" (see chapter 2). There is a good deal of evidence from inquiries and reviews concerning the difficulties of visiting chaotic or hostile families without being overwhelmed by the problems they pose. Brandon et al. (2008) describe two thirds of the families subject to a Serious Case Review as uncooperative, a definition that includes "hostility, avoidance of contact, many missed appointments, disguised or partial compliance, ambivalent or selective cooperation" (p.89). As discussed, these authors describe some social workers being frozen or paralysed by such families. Inquiries often recommend that home visits be conducted in a more rigorous, inquisitorial manner but Hall et al. (2006) argue the home visit has many functions and vividly exemplifies the tension between the forensic, investigatory role of social work and the more traditional close engagement with family members: one participant, for example, talked about the father who shouted at her in child protection meetings yet was humbly grateful when she organised some home improvements. Other participants described being drawn into intense relationships with family members and being concerned that this might affect their judgement. Hall et al. argue that there is a certain lack of direction to home

visits but, rather than being evidence of social workers' incompetence or naivety, this apparent lack of direction purposefully provides space for them to engage with families, hear their stories and take time to listen and respond.

The home visit offers both unique opportunities and unique challenges. Visits are fast-moving, fluid, often chaotic events in which the social worker is faced with a large number of environmental indicators and, to make sense of them rapidly, must think heuristically, using experiential knowledge to frame situations and quickly identify key elements of the situation (Helm, 2011; Klein, 2000) just as experienced nurses do in crisis situations (Benner, 1984). It is, I have suggested, a key site where social workers' knowledge is produced. It has been argued that not enough attention is paid to studying the contexts in which social work knowledge is produced and used and the home visit is one of those contexts – a particularly important one given the amount of time social workers spend visiting families' homes and making assessments there.

The social workers in this study have given powerful accounts of home visits yet when such visits are highlighted in inquiries and reviews, usually in the context of something having gone wrong, the voices of social workers are almost invariably absent (Gray & Schubert, 2013). Ferguson's suggestion of a theory of intimate social work would pay close attention to these visits and to what they mean to all those involved in them. As Hall et al.(2006) argue a great range of activities goes on in a home visit and close study of these interactions would provide invaluable information about the role of intuitive reasoning in making sense of visits, about the meanings they have for those involved in them and the nature of the intimate but often ambiguous, incomplete and sometimes inaccurate information they produce which contributes to social workers' knowledge.

Like supervision, the home visit is a routine deeply embedded in social work cultures and practices through which knowledge is constructed in workplace contexts (Scourfield & Pithouse, 2006). Studying it as a social unit of interaction in itself rather than simply as a means to the production of an assessment could produce invaluable data on how social workers' reasoning and decision making are shaped.

10.7.3 Understanding family complexity: the "not grandma"

Much of the discussion in this chapter focuses on processes of knowledge production and reproduction rather than specific areas of knowledge. In this section a substantive area of knowledge is discussed – that of new sociological approaches to the study of families' lives

and the contribution this might make to the social workers' understandings of the families they worked with. However, this section does link conceptually with the discussions of knowledge production processes in that, like them, it is an approach to understanding complexity and through a focus on "family practices" (Morgan, 1996) it examines complex and fluid processes of human interaction rather than institutional forms. I have also suggested that the nature of the families the social workers dealt with and the contested narratives of their members contributed significantly to the uncertainty of the work.

A key moment during the research occurred for me when a team meeting I was observing turned to a discussion of a family where a woman who was caring for a child turned out not to be the blood relative she had claimed she was. The social workers, unclear as to what her relation to the child was or what meaning it might have, referred to her as *the not-grandma*. By this time it was becoming increasingly clear that very few – if any – of the families the social workers dealt with fitted the traditional welfare model (Graham, 2011) based on certain assumptions about stable parenting and relatively fixed family roles and structures which I suggested earlier helped constitute the social workers' "moral lens". Silva & Smart (1999) point out that we do not have names for many of these new relationships and as a result we lack scripts to guide us in understanding them.

The majority of the families in the study had extended networks of family members and friends which existed across different households and which had developed as a result of parental separations and re-partnerings. The conventional model of "co resident, lifelong, romantic heterosexual love relationships" (Williams, 2004, p. 48), which continues to act as a "theoretical blueprint" (Chambers et al., 2009, p.4) was hardly to be seen. Many of the parental separations had not been managed in a co-operative way and there was a great deal of conflict, a consequence of which was that different members of these networks had competing stories to tell and it was extremely difficult for the social workers to make sense of them or to decide which, if any, of these stories was, more or less, "true". In mapping the factors that created uncertainty in the work the complexity of these family relationships loomed large and the traditional welfare model provided little help in making sense of them and determining whether or not children were safe in these family arrangements. Ferguson (2004) argues that new forms of living, new forms of relationship, pose sharp problems for social workers when they are required to pass judgement on them.

Families' lives have changed greatly since the 1970s, becoming more fluid, more diverse, less

predictable and less uniform – in other words less *knowable* (Chambers et al., 2009; Williams, 2004). There has been, as Giddens (1992) argues, a transformation in intimate relations and the lived experiences of many families bear little relationship to more traditional, normative family structures (Williams, 2004). While Giddens' work is not universally accepted, his insights have proved important in the development of a new sociology of families' lives which has attempted to understand the ways in which traditional family roles and structures have changed (Smart & Neale, 1999; Williams, 2004). Morgan (Morgan, 1996; 1999; 2013) has developed the concept of "family practices" to examine the ways in which these changes have occurred and continue to occur as ways of living and caring are continually renegotiated by families. Morgan argues that studies should move away from considering "the family" –which he describes as "a thing-like object of detached social investigation" (1999, p. 16) to a focus on the rich and diverse processes of interaction within and around families – to what families actually *do* when eating, watching television, rearing children, dividing up domestic labour, negotiating responsibilities and so on.

I have suggested (Saltiel, 2013) that such an approach could be helpful in understanding some of the practices the social workers in this study worked with: how the parents of a severely impaired child managed looking after him in all its messiness and emotional difficulty rather than using generalised terms about meeting the child's needs, for example, or how social workers attempted to manage the complexities of involving grandparents, step-grandparents (and, of course, *not*- grandparents) in providing care for children. The concept of family practices has started to be employed in a range of social work writings to discuss such areas as work with grandparents (Mitchell, 2007), troubled families (Morris, 2012), adoptive families (Jones & Hackett, 2011; 2012) and the narratives and experiences of children in the care system (Rees et al., 2012; Holland & Crowley, 2013; Biehal, forthcoming). The emphasis in all these studies is on the complexity and diversity of the ways people "do" family and while some of the ways the families in this study were "doing" family were resulting in children being assessed as in need or at risk, a focus on family practices provides a model for recognising the diverse ways people can negotiate roles and responsibilities, sometimes in very difficult circumstances. As I have suggested (Saltiel, 2013) the home visit, despite its many cognitive and emotional challenges, can – and did for many participants in this study – offer uniquely rich and intimate portraits of families' practices in which such diverse practices can be uncovered – provided sense can be made of such diversity. The new directions in

family sociology may help in understanding but too often practitioners do not engage with families in sufficient depth to enable this to happen (Morris, 2012).

10.8 The construction and ecology of social work knowledge from fallible sources

I have suggested that key areas in which the social workers' knowledge was produced, discussed and reconstructed can be understood as complex social interactions with a range of official and unofficial functions rather than as procedural means to the end of producing an assessment and a decision. This complexity is a reflection of the complexity and intractability of child abuse as a social problem full of uncertainty and ambiguity but it is not unique to social work.

In his study of haematologists, Atkinson (1995) draws on the concept of an ecology of knowledge. He argues that the model of decision making where a single practitioner makes a single decision in a particular time and place, a model that implicitly lies behind theories of rational, analytic decision making, does not represent the reality of decision making in a complex organisation such as a clinic - or a social work child protection team. He argues that knowledge is drawn from different occupational groups in different contexts and the experiences, identities and status of these groups defines the kind of knowledge they produce and how it is treated by others. Atkinson's doctors do not take this knowledge at face value: for example discounting some information because it came from a particular lab technician. In the same way participants in this study openly questioned the expertise of health visitors, school staff and the police and treated their information sceptically. In addition, the social workers had to evaluate potentially vital information from non-professional sources which could be very difficult to evaluate and certainly could not be taken at face value.

Atkinson emphasises that the actions of individuals and the interactions between small groups of professionals where this knowledge is produced and reproduced only make sense when seen as embedded in the networks of "socially shared discursive resources" (p.54). Atkinson's argument that decisions are not single events but that in complex professional settings they take place across time and space as different professionals become involved was also supported by this study. A social worker might make a decision based on an interview with a family but rethink it after consulting a doctor and again in supervision and again during multi professional conferences or the Public Law Outline meetings where cases were considered for legal action. One of the reasons, he suggests, that it is so difficult to "see" decisions is that they do not take place in a single place at a single point in time. Once decisions are seen

within the social contexts in which they are made, negotiated and re-made it can be seen that they and the knowledge on which they are based are profoundly shaped by social influences. Atkinson's work lies within a sociological tradition of workplace studies that have highlighted the way that the official activities are closely enmeshed in the web of informal social actions and settings that make up the working context (Orasanu & Connolly, 1993; Wikstrom & Larsson, 2003) – a tradition that, as we have seen, has extended to some *in situ* studies of social work practice. In Figure 4, below, the processes by which the social workers produced and reproduced knowledge about the world for making decisions are represented diagrammatically at the risk of imposing too linear a structure on a complex set of processes:

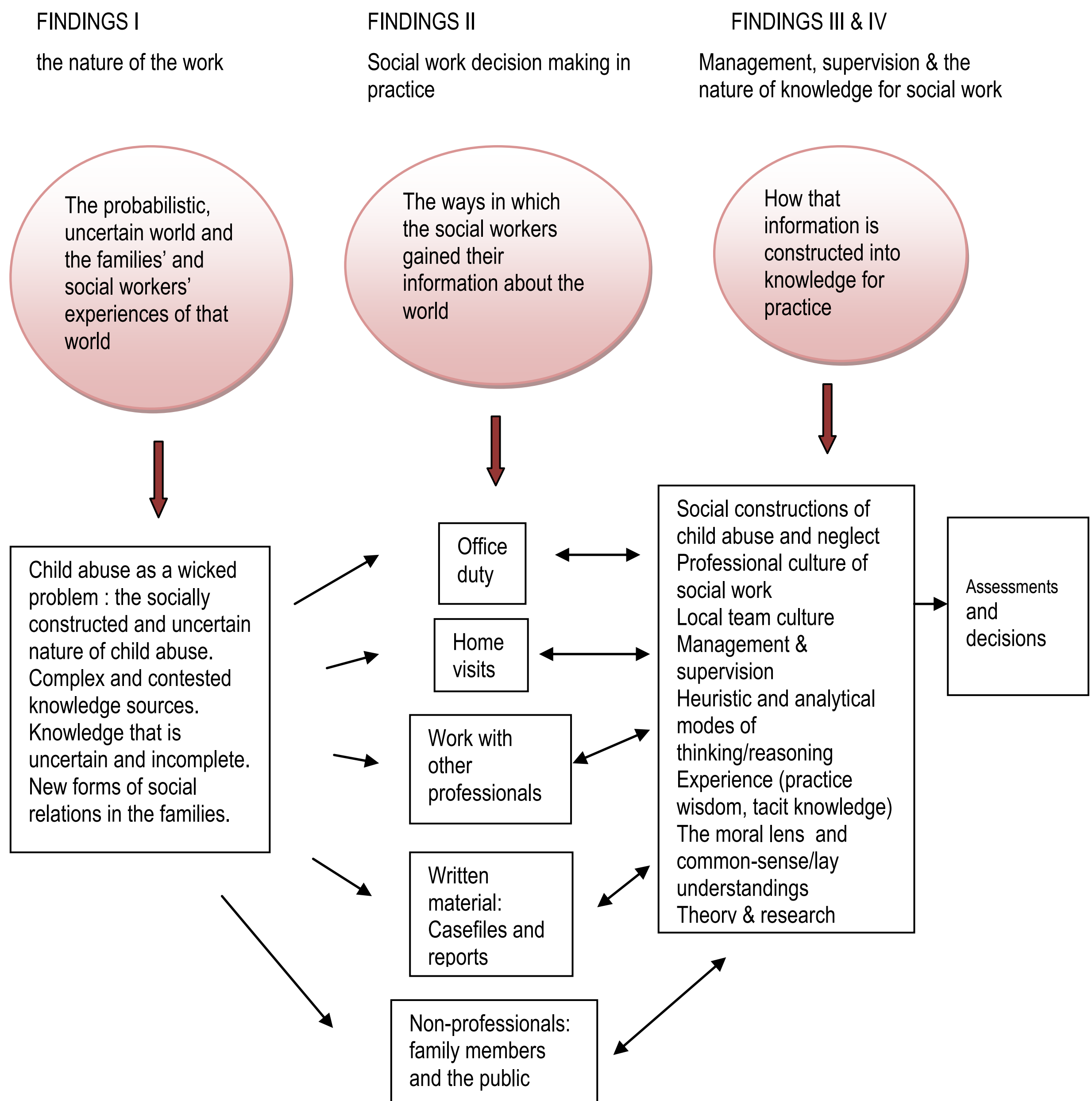

Figure 4 Processes of knowledge production and reproduction

The social workers in this study inhabited an inherently probabilistic world full of multiple fallible indicators (Hammond, 1996). For the purposes of their work there were particular areas of uncertainty: the very nature of child abuse as a problem characterised by a wealth of uncertain, contested and ambiguous meanings and definitions, the incomplete and contested nature of information about individual cases and the nature of their client families with their complex, shifting networks of relationships that were often very difficult to understand. The sources of knowledge they drew on to try and make sense of these cases were all to a degree troublesome or contested. Five such sources have been identified, all of which presented problems in terms of what status should be given to the knowledge produced from them:

Office duty	Rapid throughput of work Unknown or little known cases Incomplete information Referrals of varying status, priority and complexity
Home visits	Potentially invaluable source of intimate knowledge Often chaotic, stressful and riddled with contested definitions Social workers drawn into complex relationships which had to be balanced against investigatory/forensic requirements Many fallible indicators presented simultaneously Need to make quick, heuristic decisions which could contain errors
Work with other professionals	Potential source of expertise but often seen in the context of inter professional conflict and miscommunication. Professionals seeing cases through different "lenses" may disagree on nature of problem and what is to be done
Written material	Casefiles written for a particular purpose and audience: often have only brief, selective accounts. Little or no details of what author's reasoning processes were
Non-professionals: family members and the public	Information of a potentially unreliable or contested nature which needed to be carefully evaluated and never taken at face value

Table 9 Five fallible sources of knowledge

Having to make quick decisions often based on incomplete knowledge, having to make sense of a multitude of fallible indicators containing a great deal of complex information, having to deal with professionals and non professionals whose knowledge could not be taken uncritically all contributed to this troublesome-ness, leaving the social workers to try and balance, evaluate and synthesise these pieces of uncertain knowledge in order to make sense of the cases. This knowledge was then reconstructed, discussed, reviewed, reflected upon. The key processes whereby this process of reconstruction happened, such as supervision and team talk, were routines and interactions deeply embedded in the complex set of social relations that made up the culture and context of their workplace. Heuristic reasoning was the dominant mode of rationality based on tacit, experiential knowledge reconfigured as common sense. These common-sense understandings combined with social workers' professional and personal values created a moral element (Scourfield & Pithouse, 2006) – a moral lens (Brunswik in Hammond, 1993, 1996) through which the cases were seen. The result is a knowledge production process for decision making that is intimately bound up in the local contexts within which it takes place and which is accomplished by situated social actors. The word "actors" is used to denote participants in social interaction who make decisions themselves to some degree rather than simply behaving in response to

wider social influences so their actions have local variations – what Sibeon (1991, p.23) calls "site-specific idiosyncrasy".

In his discussion of knowledge production processes Atkinson concludes that "clinical decision making is not the outcome of individual minds, operating in a social vacuum. It is not disinterested...and is as susceptible to shaping by social influences as any other knowledge" (Atkinson, 1995, p.54).

10.9 Conclusion: the nature of social work practices

The purpose of this study was to examine how social workers made decisions in situations of uncertainty, complexity and stress. In this chapter I have tried to develop a number of concepts for substantive theorising that could provide hypotheses or conceptual frameworks for further research. This study has lent support to previous work suggesting that social workers – like many others working in complex and fluid situations – reason and make decisions based largely on intuitive, experiential forms of cognition. Naturalistic forms of decision making involving the use of experiential frames or lenses were evident. The social workers appeared to see cases through a moral lens based on certain professional beliefs, values and assumptions

Intuitive thinking often works well, and is suited to the dynamic situations of daily practice, but it is prone to certain errors and biases. More analytical modes of reasoning can be introduced in a number of ways – through the expertise of other professionals, through the use of structured decision aids and through the use of theory and research-based knowledge but as we have seen all of these processes can be problematic and their impact is limited. Another way is through supervision. The evidence of the participants in this study is that supervision could be an extremely valuable and skilfully managed process that provided both cognitive and emotional support. However, it also emerged that supervision is a complex social process with unofficial, local functions as well as more official ones. It is deeply embedded in the localised context and those participating in it engage in a range of artful practices that are not necessarily congruent with its espoused aims although they may be socially important.

Child abuse is a complex and contested problem which cannot be resolved through linear solutions. The organisations social workers and other professionals work within are systems which reflect this complexity so where linear solutions are attempted they tend to cause unexpected problems elsewhere.

The production and reproduction of knowledge in the settings studied here reflected the complexities of both the social problem and the systems set up to manage it. Knowledge was drawn from a range of fallible sources and reproduced or reconstructed in the workplace and this production and reproduction took place through complex social processes and routines that were intimately enmeshed in the local context. This made it easier for the social workers to adapt it to the needs of specific families. But it does raise questions about the quality and completeness of this knowledge given the variable robustness of the standards by which these diverse knowledge sources are judged (Pawson et al., 2003). As noted previously it can be argued that the knowledge practitioners found easiest to use and apply in practice had the most contested quality standards while the knowledge with the most robust standards, academic and research-based knowledge, was that which they found least relevant to their practice and where it was used it was largely used to retrospectively justify decisions made using more intuitive forms of reasoning.

Social work decision making and social workers' knowledge are so embedded in the contexts, routines and processes of practice that they can only be understood by a close examination of those local factors. This study has attempted to do this on a small scale. Further research would need to look at the factors operating in a range of local contexts and through the activities of a greater range of stakeholders including policy-makers, senior managers and the families themselves. Munro (2005) argues that inquiries and reviews when children die should focus much more on the systems the professionals work within: instead of focusing on individual error such reviews should look for evidence of the manifestation of systemic errors that may have existed in latent form for some time (Broadhurst, 2010a; Gambrill, 2005, Reason, 2000) rather than focusing on the perceived mistakes of individuals who may be at the end of a chain of system problems. Errors will never be eliminated when dealing with such a complex problem as child abuse. But close study of how professionals make decisions within their local practice contexts could help researchers understand better where and why errors arise and what sets of social processes make those errors more or less likely to occur.

This concluding section has been titled "the nature of social work practices". It has been suggested that the close study of local contexts is invaluable in identifying how knowledge production and decision making arise from the complex processes making up social work practices and why errors might occur. In developing his concept of family practices Morgan (1996) argues for a focus on the everyday activities through which people create meaning and significance in their families rather than on "the family" as a static form. This idea of a focus on

“practices” could well be applied to social work, offering a theoretical framework for examining the diversity of ways in which social workers, as skilled and situated actors, perform their daily practice rather than examining static institutional forms such as procedures or supervision. This would help to address Ferguson’s (2011) and Hardiker & Barker’s (2007) calls for theories of intimate social work practice and the significant lack of research into these complex and intimate everyday activities which has been noted. In using the term “practices” Morgan emphasises the actor’s ordinary everyday activities: activities that are shaped by wider social and cultural forces but which are carried out with a degree of flexibility and fluidity. It is through these everyday activities that people create meaning in the sets of circumstances and relationships they inhabit (Morgan, 1999; Finch, 2007). Morgan’s work has been found very useful in a range of research studies that have consolidated and further developed his ideas (Morgan, 2013 chapter 4). Studying the ways in which social workers “do” home visits, “do” supervision, “do” case recording and being a team, the ways in which managers “do” management – as this research has tried to do in a limited way - could lead us to the development of substantive theories of “social work practices” that may reveal the complexity and diversity of social workers’ activities and decisions in day to day situations. Just as Morgan’s family practices seek to encompass both structural forces and individual agency so social work practices might reveal the varied ways in which situated social workers struggle with the daily practicalities of managing the complexities of child abuse.

CHAPTER 11: CONCLUSION

11.1 What this study has achieved

"A fairly standard and not unreasonable response to a detailed sociological description of some small segment of the world is 'so what?'" (Strong, 2001, p.183). What was the point of the study and did it achieve what it set out to do?

This study set out to answer the research question: how do social workers form judgements and make decisions about child protection cases within everyday working contexts where those contexts may be marked by significant degrees of stress, complexity and uncertainty?

Decision making was researched through a detailed examination of some day to day routines and activities and the accounts social workers gave of them. As I have suggested in the previous chapter an emphasis on "practices" – borrowing from Morgan's concept of family practices – helps to focus attention on what social workers do in carrying out their day to day tasks as skilful situated actors creating localised versions of social work. The study has constructed detailed descriptions of some routine and taken-for-granted activities such as the taking of new referrals, the doing of supervision and home visiting and the daily tasks of working with families with complex and enduring problems. By exploring these processes in detail as practices their contingency and complexity have been highlighted and simplifications avoided. This study may be able to make a contribution to understanding how these activities work in real-world settings and how they contribute to and shape decision making. A possible model for the ways in which social workers draw on information from a range of fallible sources and then construct knowledge for practical decision making through a series of complex social processes has been suggested. This model draws on an ecological model of knowledge (Atkinson, 1995) which suggests that knowledge is not neutral or objective but is negotiated within complex organisational systems.

The strength of this study, I suggest, is in the detailed exploration of some of the complex and uncertain processes that dominate almost all aspects of social work in child protection and the part those processes play in producing and reproducing knowledge and shaping decision making.

A question with which a number of writers on decision making have wrestled is whether or not it is possible to "see" decision making. Atkinson (1995) argues that professional decisions are

not single events but take place across time and space and are embedded in complex negotiations between a range of actors. Hackett & Taylor (forthcoming) argue that trying to identify decisions as single events fails to capture the complex contexts that shape them and produces an unrealistic, overly orderly, account, though they also argue that looking at decisions as embedded in daily contexts can produce too "noisy" an account. Both conclude that decisions cannot be seen as straightforwardly observable events. This study lends support to this argument. Decisions here are constructed from fallible knowledge produced in complex and uncertain situations and further reconstructed through the complex social and professional processes of the work. They are dynamic processes shaped by a host of local contextual factors.

This study may also help to address a gap in social work research which, it has been argued from the beginning of this thesis, has not provided a body of detailed research into the daily processes and activities of practice: with some exceptions social work research has not examined social work as a "mundane, everyday activity....a job carried out in meetings, phone calls, case files and home visits" (Hall et al., 2006, p.164) that takes place in offices, cars and on doorsteps (Ferguson, 2004; 2011). Yet it is argued that such detailed studies can open up often tacit practices to analysis and provide invaluable insight into the processes of the work (White & Stancombe, 2003).

11.2 The limitations of the study

An obvious limitation of this study is that it was restricted to a very small number of contexts. Given that the study was carried out by a lone researcher a larger study would have been impractical. The teams which made up the sample were purposively chosen but while they may have had features representative of other social work teams they were also shaped by a host of local, unofficial, tacit factors. Case study methods always strike a balance between seeing a case as representative of others and seeing it for its own intrinsic qualities (Stake, 2003). There are bound to be local variations and looking at just two small cases means that any theoretical generalisations will be limited.

Again, the small scale nature of the study meant that potentially important aspects of the cases were not studied. For example, while there is some discussion in this study of case recording no systematic analysis of case files (paper and computerised) was attempted. The suggestion made in this study is that case files are fallible sources of knowledge, artfully produced by actors with particular audiences in mind and reference has been made to other

studies which have examined their status as sources of knowledge. While they may be of contested status their importance as evidence of how cases are conceived of and managed is considerable. Another area that the thesis alludes to but which is central to social work practice and could be covered much more systematically is the use of IT systems. Another gap is that while an analysis of home visiting has been central to this study home visits were not directly observed and the only data gathered came from social workers' accounts given in interviews and in observed talk. Similarly an analysis of supervision is important to this study but again most of the data gathered came from interviews: attempts to directly observe supervision were abandoned as my presence was grossly disturbing the setting.

The two teams chosen were to be seen as contrasting case studies: one a local authority team with statutory powers and the other a voluntary-sector team, part of a nation-wide charity, who took on specific work at the local authority's request. Unfortunately the latter team fell victim to cuts in service funding and ceased to operate during the period when the field work was being carried out. This limited the data I was able to collect from this case.

As I have suggested above, studying decision making in its day-to-day context could be excessively "noisy". The teams were complex organisations and, as argued above, choices had to be made about which aspects of the teams were most relevant to the research question. One of the chosen data-collection methods, that of qualitative observation, poses major challenges to the researcher regarding which aspects of the situation under observation to focus on (Spradley, 1980) and this may have exacerbated this potential problem. Decisions were also made about which topics to discuss (and therefore which topics to omit) in the interviews. While the semi-structured nature of the interviews meant that participants could, and did, introduce topics they felt were important it could be argued that the topic guide missed out key areas such as the use, or non-use, of structured decision aids. These points suggest that because this was a small scale study carried out by a lone researcher, choices had to be made about what to study and possibly vital areas were overlooked.

Every effort has been made to ensure that this study, and the account of it, is as rigorous and as transparent as possible, following Yin's (2009) concept of construct validity (see chapter 5). A limited number of cases were studied, only certain aspects of those cases were examined, and so choices were made which may not always have been the best ones. How these shortcomings could be addressed will be discussed when considering directions for future research.

11.3 Reflections on methods

The initial intention for this study was to examine the nature of social workers' decision making and to do so by exploring the perspectives of the social workers themselves by observing them going about their daily work, observing their activities and interviewing them in detail about their daily experiences of their work. A precise and answerable research question, with a set of sub-questions was formulated and data collection methods chosen to answer it.

Undertaking observations of day-to-day and often taken-for-granted activities seemed to be the best way of getting close to what the social workers were actually *doing* (Lofland et al., 2006). While observations will inevitably disturb the setting being observed, professionals doing a job will continue to do it even when observed (Strong, 2001). They may do it somewhat differently but this should minimise the degree of disturbance or distortion. A key issue for me was whether I could have got the data I collected through observation by any other means. Observing social workers acting as duty workers, dealing with the stress of processing new referrals, making phone calls, discussing cases with team members and with the available duty manager – this latter seeming a crucial determinant of where thresholds for intervention were set – provided invaluable data about the day-to-day experiences of the social workers. I was able to write down in my field notes a good deal of the talk between social workers and between social workers and clients over the phone, providing me with examples of the ways social workers spoke and the language that they used. Talk is a form of action and is a crucially important encoder of the culture (Spradley, 1980) and to hear and note down naturally occurring talk was invaluable data. Two telephone conversations stood out for me: one where a social worker questioned a parent over a reported bruise to her son and the other where a social worker talked to a member of the public who was communicating a concern. The latter added to the sense of a rich variety of unofficial and unaudited strategies and skills being used. I was able to follow up the former conversation with some short interviews with the social workers involved in the referral and subsequent investigation. These bore some resemblance to what Spradley (1979) calls ethnographic interviewing – where participants are interviewed in a range of settings arising out of the researcher's observations – and this leads into a discussion of the synergy between observing and interviewing.

Observing enabled me to gather data I would not otherwise have been able to but it also had an effect on the data I gathered through interviews. A key element of successful interviewing for research purposes (where success is measured by the degree to which participants talk in

detail about the subjects in the interview topic guide) is rapport (Rubin & Rubin, 2012). Before undertaking any of the interviews I had already spent some time in the team observing and talking to team members. They were aware that I had some "insider" status as a former social worker. Insider status is not necessarily advantageous to the researcher (Miller & Glassner, 2004), and some slightly awkward moments occurred when I asked participants to explain expressions and phrases which they thought I must already understand, but the participants had had some time to get to know me and ask about my experience and in the majority of cases this created a sense of rapport before the interviews actually began. I believe that this was an important reason why the participants' accounts were so full and rich in detail.

I have discussed in chapter 5 how I changed some aspects of the topic guide as the interviews progressed and how I learned to let the interviews unfold and not to get anxious that they were going on too long or straying off topic. Being told by the participant in one of the early interviews that I had interrupted her and spoiled her flow of thought was a salutary lesson. When I came to code and analyse the data I began to feel that some areas I should have discussed had been omitted – notably the question of which (if any) decision aids were used to augment the social workers' decision making. I realised that when I undertook the interviews I had not done enough research into the use of decision aids which can be an important way of introducing more analytic thinking into decision making but which social workers in the UK and other countries are often reluctant to use (see chapter 3).

Any research can be a messy and unruly business, particularly perhaps when it takes place in real-life settings where a host of multiply-interacting factors are at play. There are bound to be errors and omissions in any research and the intention here has been to present as "thick" a description as possible so that the research process is fully and transparently described, giving the reader ample opportunity to identify the shortcomings of this study.

What I hope is that my research process has accorded with certain principles drawn from research texts that have influenced me. My model is that

- Analysis must always be grounded in local data (Coffey & Atkinson, 1996) and in concrete, specific details and localised actions and processes (Charmaz, 2006; Miles & Huberman, 1994).

- There must be a clear audit trail so that the researcher can demonstrate in an explicit and transparent way how analysis has been drawn from this data (Mason, 2002; Yin, 2009).

• Data never speaks for itself (Silverman, 2006, 2010, 2011): interpreting data is a complex process in which the researcher plays an active part (Mason, 2002) and must therefore be seen as part of the process.

• Analysis is an abductive process (Blaikie, 2009), a mix of deductive and inductive thinking in which the researcher moves back and forth between data and theory thus remaining grounded in the data while at the same time developing theories that may go beyond the local nature of the data (Coffey & Atkinson, 1996): what Mason (2002, p. 182) calls "making ideas" and Silverman "thinking through" (2010, p.356) the data

• Finally there is no linear process of collecting data, coding data, analysing data but an iterative process in which analytic memos play a crucial part

11.4 Future research

It is hoped that this study can provide help in providing hypotheses and concepts for future research. Recognising complexity has been one of the key themes throughout this thesis. Realist research, centrally concerned with the contingent and context-bound nature of change and causation, focuses firmly on complexity and could be a fruitful way forward (Pawson & Tilley, 1997; Hood, 2012; Pawson, 2013) to unlock the "black box problem" (Pawson & Tilley, 1997, p.30) of why social workers make the decisions that they do.

Realist research seeks to uncover underlying causal mechanisms which may not be apparent or "explicitly manifest in the empirical patterns themselves" (Mason, 2002, p.178) and which have complex and context-bound interactions with each other (Miles & Huberman, 1994). The "basic realist formula" (Pawson & Tilley, 1997, p.xv) of mechanism + context = outcome, suggests that causation will always be complex and contingent upon a range of contextual factors. It is suggested that people do not act passively because certain external forces impinge upon them: they think, scheme and negotiate – causation is *internal* as well as external (Pawson & Tilley, 1997) – and the ways in which people think will be affected by a range of local factors: wider social forces shape peoples' choices and motivations but it is what local actors do in local situations that make things actually happen (Miles & Huberman, 1994). Realist research argues that complex social situations cannot be understood by searching for linear, universal causal factors but by revealing the tendency for some factors to work in particular ways in particular contexts. In the language of realist research this means looking for "context-mechanism-outcome pattern configurations" or "CMO configurations" (Pawson & Tilley, 1997, p.217)

What has become clear in the course of this study has been the ways in which constellations of local factors have shaped the actions of situated actors in producing local versions of social work practice. While social workers anywhere in the UK will know what “supervision” is, or what a “home visit” is these things do not exist in some detached and ideal form, this study suggests, but as locally constituted practices, complex social interactions which are related to official policies and procedures but not in straightforward or linear ways. Much more attention needs to be paid, it has been suggested, to the intimate and localised nature of practice. Realist research emphasises the local and complex ways in which interventions or programmes “work”.

Realist research is an approach to social inquiry, not a set of methods, and a larger scale realist study of child protection work could employ a range of methods across a much wider range of contexts and stakeholders than was possible in this study:

- more work could be done looking at social workers’ daily practices and the ways in which knowledge is used and decisions made in specific contexts.
- A detailed focus on such apparently routine practices as home visiting and supervision could be undertaken with a view to understanding how these practices are carried out in different contexts.
- The often skilful strategies social workers use in their day-to-day work to manage complexity and uncertainty could be studied in greater detail in real-world settings. For example, in this study I have explored how duty social workers and managers negotiated thresholds for intervention, how social workers sought to form alliances with family members during telephone conversations, how social workers gathered, synthesised and made sense of information to complete poorly made referrals. These skills were seen by participants as common-sense, taken for granted and left un-recorded
- Areas which this study has neglected such as the impact of IT systems and an analysis of social work case-files could be explored.
- A wider range of stakeholders including senior managers, policy makers and clients could be included.

What might emerge are new ways of thinking about localised versions of the complex systems that operate in child protection work. Munro (2005; 2011) has highlighted the complexity of these systems and argued that we can best understand how errors occur through a systemic

study of what social workers were doing *at the time* rather than in hindsight. The words "at the time" are critical because this requires a detailed examination of social workers' practices: what they were *doing* on a day-to-day basis. A larger scale study could do more to examine how these practices are embedded in and shaped by the complex systems in which they exist.

A recent example is a study by Forrester et al. (2013), an evaluation of the systemic model of social work developed in Hackney in London and now adopted by a number of authorities. This study was explicitly influenced by a realist methodology: the researchers seeking to examine the ways in which contexts and mechanisms produced outcomes. They looked at the contexts of service delivery across three local authorities, how the contexts shaped practice, with social work practices defined as the mechanisms, and what patterns of outcomes could be identified. The researchers used a range of methods, including observations, shadowing workers on visits, simulations, interviews and surveys of practitioners and families. What emerged was a detailed exploration of what social workers did, how they spent their time and how they worked with particular cases. The research analysed, for example, how workers and managers did office duty, how social workers managed interviews with hostile families and how they undertook report writing. The research took an ecological view of practice, seeing practice as embedded within interlinked organisational systems and produced findings that echoed Morgan's emphasis on practices: findings which paid close attention to workers' day-to-day activities but also took account of how those actors were sited within wider social structures.

11.5 Implications for policy and practice

A number of suggestions for future policy and practice arising from the findings of this study might be made:

- Social workers and their supervisors would benefit from a clearer understanding of models of decision making and their strengths and weaknesses.
- They would benefit from an understanding of the possible consequences of social workers' heavy reliance on more naturalistic or heuristic decision making processes. These are, in many ways, well-suited to the nature of their practice but they are prone to error and bias. How more analytical decision processes might be introduced more widely is important but account needs to be taken of the ways in which practitioners resist such processes or find them problematic.

- Supervisors, especially those new to the task, need comprehensive training in how to be a supervisor and manage the many social, affective and cognitive demands that supervising entails. Schemes where more experienced supervisors mentor the less experienced could be useful.
- More research needs to be done – and disseminated to social workers – about the ways in which decision making operates in specific contexts such as home visits and inter professional meetings. Practitioners' perspectives are often absent from research into knowledge production and decision making and so the complexities of how decision making occurs in actual practice can be neglected and overly linear, simplistic models of decision making produced which make little sense to practitioners coping with uncertainty and ambiguity.
- More research needs to be done on the skills social workers use in practice. Social workers employ many skills and strategies in their day-to-day work to enable them to cope with uncertainty and these are often taken for granted and not audited. At the same time research suggests that in some areas social workers' skills may be lacking (Forrester et al., 2008) and it would be worthwhile identifying these skills deficits so that they can be addressed.

Some of these suggestions could be addressed by improved training. Others could be addressed by research into practice, involving practitioners and focusing on the intimacies and complexities of daily practice. These intimate complexities do not, of course, exist in isolation – they occur within complex, bureaucratic and hierarchical organisations which play a crucial role in how practice takes place so research into social work must be both intimately concerned with the routines and practices people engage in and the wider systems within which those practices are embedded.

It has been suggested that social work is an "invisible" trade (Pithouse, 1998), carried out in private and intimate spaces which are not easily seen and which are made visible and rendered meaningful through social workers' artfully produced accounts. Much of the work the social workers did and accounted for in this study was done in private and invisible places – in people's homes, in supervision, in team talks, in confidential meetings – and much of the work they did in constructing narratives about it revolved around managing and making sense of great uncertainty and complexity Opening that private and uncertain world up to examination and understanding the ways in which social workers and their managers make

crucial decisions about children and families must be a high priority for researchers, policy makers, practitioners and users of social work services.

APPENDIX A: Participant Information and Consent Forms

Participant Information Sheet

Title of Study: A Study of Decision Making in Child Protection Social Work

I would like you to take part in the above named study but before you decide, please read the following information.

What is the purpose of this study?
Making decisions about child protection cases is central to the work you do and to the work of many social workers and other professionals. It requires great skill and my study hopes to find out more about how professionals such as you make those decisions.

Who is doing the study?
My name is David Saltiel. I am a lecturer in Social Work at the University of Leeds. I am conducting this study for my PhD. I will be the only researcher though I have a supervisor, a very experienced researcher, who will oversee my work. My supervisor is Professor Dawn Dowding who can be contacted at the School of Healthcare, University of Leeds. Email D.Dowding@leeds.ac.uk

Who is being asked to participate?
I am asking all the qualified social workers in the team to participate. I am also asking qualified workers in another team to take part in order to provide more breadth and depth to my study.

What will be involved if I take part in this study?
You will be asked to participate in two one-to-one interviews with me. Each should take about an hour and will take place on your office premises. We will book these in advance so as to minimise any disturbance to your daily work. In one of these I would like you to look at a fictionalised scenario of a child protection situation and in the other to discuss a critical incident from your practice where you made a significant decision about a case. I will give you a definition of this critical incident to help you choose a situation for the interview.
I also want to observe a number of events in the team: team meetings, "duty" work with new referrals and supervision sessions with your manager. You will be asked if you are prepared to be observed in these situations. I appreciate that this could feel intrusive and you will be able to opt out of any situation you do not feel comfortable with. If any participant involved in a situation I want to observe does not want me to observe it then I will not do so.

What are the advantages and disadvantages of taking part?
The potential benefit is that you will be contributing to a study which may help to improve decision making in your profession and thus increase protection to vulnerable children.
The potential risks are that you may feel the research is intruding into areas of your work in ways that may feel upsetting or disturbing. You will be able to withdraw from any part of the study you do not wish to participate in.

Can I withdraw from the study at any time?

You can withdraw from the study at any time without needing to give a reason. If you do so I will destroy any information obtained from you if you ask me to do so. I may want to use any information obtained from you before your withdrawal but I will only do so if you give me written permission. There is a section of the Participant Consent Form asking for your permission in this eventuality. Should you wish to terminate a particular interview or observation you may do so at any time.

Will the information obtained in the study be confidential?
All the information I obtain will be kept securely by me. All computer files will be kept on the University's computer servers in encrypted files and any hand written notes will be kept in a locked cabinet until they are transferred to a computer. All information will be anonymised so that you, your team and any third party referred to cannot be identified. I will retain information for 3 years after the study or 2 years after publication whichever is the longer. After this it will be destroyed or deleted.

Data handling procedures are in accordance with the Data Protection Act 1998.

What will happen to the results of the study?

The study will be written up in my doctoral thesis and I may seek to publish some of the material in books or journals so that the findings can be seen by a wider audience. I may also seek to use it for training and teaching purposes. All material used in this way will be anonymised.

Who has reviewed this study?
Ethical approval has been obtained for this study from the School of Healthcare Research Ethics Committee at the University of Leeds.

If you agree to take part, would like more information or have any questions or concerns about the study please contact me as below:

David Saltiel
School of Healthcare
University of Leeds
Leeds LS2 9JT
Tel: 0113 343 9428
Email: d.saltiel@leeds.ac.uk

Thank you for taking the time to read this information sheet.

Participant Consent Form

Participant Consent Form

Title of Study: A Study of Decision Making in Child Protection Social Work

	Please confirm the statements by putting your initials in the box below
I have read and understood the participant information sheet	
I have had the opportunity to ask questions and discuss this study	
I have received satisfactory answers to all of my questions	
I have received enough information about the study	
I consent to participating in one-to-one interviews with the researcher	
I consent to interviews being audio recorded so that the recordings can be transcribed for data analysis	
I consent to taking part in situations that are observed by the researcher. Unless all participants in the situation to be observed agree to be observed the observation will not take place.	
I understand that I am free to withdraw from the study:- At any time Without having to give a reason for withdrawing	
If I withdraw from all or part of the study I will be asked to consent to one of the following statements:	

All information gathered from me will be destroyed. Information gathered from me before my withdrawal can be used by the researcher.	
I understand that any information I provide, including personal details, will be confidential, stored securely and only accessed by those carrying out the study.	
I understand that any information I give may be included in published documents but my identity will be protected by the use of pseudonyms	
I agree to take part in this study	
Participant Signature …………………………… Date	
Name of Participant	
Researcher Signature ………………………………… Date	
Name of Researcher David Saltiel	

Thank you for agreeing to take part in this study.

APPENDIX B: Interview schedule

Interview topic guide

I would like you to bring to the interview a critical incident drawn from your own practice which I will ask you a number of questions about. The incident should be about a child protection situation and should be one where you feel you made, or were involved in making, a significant decision. You might, for example, choose a decision that you feel was an example of good practice on your part, or a decision that you learned something important from or even a decision that you feel in retrospect was not the right one and which now you would make differently. My purpose in asking you to do this is not to judge whether or not you made a "good" decision but to discuss the process that you went through in order to make it.

The Critical Incident:

Please tell me about the critical incident you have selected:
Prompts to use during this phase of the interview:
Can you tell me what happened?
What decision did you take?
Was this decision supported by your manager? By your colleagues?
What emotions/feelings did you have at the time?
What were the key factors influencing your decision? – what were the key risk factors and strengths and how did you rate them in importance (e.g. high risk/low risk/positive strength)?
Did any new information cause you to re-evaluate your assessment of risks and strengths? (if not, what new information *might* have caused you to re-evaluate?)
Discuss whether or not the case involved assessing “significant” harm – how easy is it to decide whether or not harm is “significant” ? Do other colleagues agree on this or is there a range of views? Can you give an example of this?
What did you think were the key risk factors?
In retrospect was the decision the best one or would you now make a different decision?

Other issues:

How are decisions made in your team?
Do you find you have to make decisions rapidly?
What if you do not have all the information you need at the time?

How do you review or revisit the decisions you have made?
Who do you talk to about your case decisions?

In what ways are decisions affected by team dynamics and relationships?
Follow up questions about team culture and communication: seating arrangements, desk space. What are the key words you would use to describe the team?
What about people outside the team? Other professionals?

What do you find useful/not useful about the supervision you get?

To what degree are your decisions influenced by your training? Academic research? Practice wisdom and experience? The views of your manager? The views of your colleagues?

Probes about stress: issues of stress in the work. How does this affect you? One team member has had a client accused of murder: this seems to highlight issues of safety and security in the work. How has this affected you? Can you give an example?

Questions about IT and computerisation.
How does it affect your work?
Do you find it easy/useful to use?

APPENDIX C: Extracts from fieldwork diary

Extract 1 (see section 5.6): An example from my fieldwork diary during an early stage of the fieldwork shows how informal observations gave valuable insight into the day-to-day "feel" of the team: the gallows humour, the importance of maintaining team identity, the sense of this being dirty work dealing with dirty cases which I discuss in more detail in Chapter 6.

> *(SSW1) is inundated with pink Police Forms. She jokes about filing them in her naughty men's file. (SW4) and (SW6) joke that it should be the naughty person-with-no-specific-gender file. When I arrive (SSW2),(SW4) and (SW6) are talking about a case. (SW4) complains about senior managers' attitudes: "do they forget they were social workers? They don't know they (ie the clients) are real people. They're just writing on a screen to them". At the same time (SW2) is on the phone (to the police?) re. a young man who coerced 2 children to simulate sex together. It's a horrid, nasty little tale. She tells it v. matter-of-factly in her normal voice. Everyone can hear but no-one reacts. It's just business....*

Extract 2 (see section 5.15) was written while stuck on a train the day after one of my early visits to Moorhouse:

> *I worry constantly that my precious hard-won access will be withdrawn...These anxieties peak during the time I spend downstairs at the ------- Centre having phoned through and spoken to some admin worker who invariably has no idea who I am and then waiting – sometimes for 10-15 minutes – for someone to come down and get me. In fact last time I was there the person I'd come to interview simply waited for me to come up. How did she think I was going to get there? (as I had no swipe card to let me in).........I have come to see this as a "liminal" period wherein I await passage to my researcher identity from my ordinary, everyday identity and like any rite of passage or transition it is loaded with anxiety. One day the lift will open and some manager will emerge to escort me off the premises.*
>
> *This anxiety fades as soon as I get up to the office but is then replaced by a host of minor anxieties arising from social intercourse with the team. Did I say the wrong thing? Was that slightly joky remark misunderstood? Was someone offended?...*

But here in Extract 3 I reflect on the perils of becoming accepted after an observed team meeting in which several team members – in the absence of the manager – shared some of their dissatisfactions. The reference is to Wolcott (2001):

> *Am I becoming an insider? No, but there is some acceptance here of me here as someone they feel some trust and familiarity towards. I keep thinking of that comment (in Wolcott, p.147) that you end up betraying them when you write it all up – that all fieldwork is fundamentally an act of betrayal.*

Extract 4 (see section 5.15) was written about one month later and was jotted down whilst in the Moorhouse office waiting to do an interview.

> *What don't I see? I don't see what happens outside the office though I see people depart and return and, often, talk about what's happened – often to (SSW1). (SW1) was talking with some passion about a visit to a young boy who was upset and she did a vivid cameo of his lower lip trembling – quite a forceful communication about him but also about it as an experience she'd had. This as Pithouse (1998) says, is how workers make this invisible out-of-office experience visible. I can't see it but then neither can the others in the team. I should look out for these stories told as workers return from "out there" to the security of the base. Several people have talked about looking forward to coming back to the base to off-load, to share, get support in the team. Pithouse argues that it is the routine resolution of the many dilemmas and unpalatable issues of practice that is absent from the literature and I am trying to get detailed descriptive data on this: what do they do? How do they do it? What is the mix of knowledge and skill they use?*

APPENDIX D: examples of analytic memos

Extract 1: In this extract I make links between what I saw as the moral performance of a participant and some of the literature on the ceremonial or liturgical aspects of professional talk and to Dingwall et al.'s (1983) concept of the Rule of Optimism. I also make a link to an interview with another participant and note a theme about the tension between investigatory and more traditionally person-centred approaches. I refer to White (1997b), Atkinson (1995), Emerson et al. (1995) and Strong (2001).

> *Her interview started very "official" and full of social work jargon.... but I felt by use of specific questions I got us into more concrete examples of her work. She said at the end I had to really think about some of those questions....*
>
> *The jargon is, as Sue White says in her PhD thesis the liturgy through which "social workers routinely display and reproduce a professional identity through their talk"(p179). She defines liturgy as "the consecrated and ritualised correctness of certain utterances" (p179). The dictionary definition refers to codes and formularies for public ceremonies of worship. Atkinson subtitles his book Medical Talk and Medical Work "The liturgy of the clinic" and Strong's famous study is called The Ceremonial Order of the Clinic. So such professional talk and the identity work and cultural stories it encapsulates is an area for analysis in itself and use of language as an encoder of culture is one of the themes of my Construct Validity table. Also, this is members' language and should be seen as an important way of describing their perceptions rather than having an external set of criteria imposed upon it (eg see Emerson, Fretz & Shaw p109).*
>
> *However, it increasingly seems to me as I listen to and transcribe interviews that this use of jargon and moral language is the Rule of Optimism in action – and there is a tension between this "moral vision" of the work and its increasingly forensic, investigatory nature – see also (SW9) memo sheet*

Extract 2: In this extract I reflect on the meaning of co-operation between families and social workers and draw comparisons between this interview and another. I reflect on links between the interview data and some key literature both on the Rule of Optimism (Dingwall et al., 1983) and on analyses of child abuse inquiries (Reder & Duncan, 1993). I also note the participant's awareness of the lack of optimal outcomes in social work. Thus a number of the themes in the study begin to emerge from my thinking as encapsulated in this memo.

> *I ask her to rank the risk factors and she puts mum's mental condition first – home conditions and X's disclosures come next. Is this because her mental state means she cannot be seen as cooperative and her capacity to change is doubted? (SW6) agrees that if mum were saner and more cooperative this would make a big difference to how the case is seen.*

So, this is the key risk: her mental state precludes cooperation, change, “engagement” with services and without these things the moral accounting/Rule of Optimism doesn’t apply. As in (SW5)’s case the action seems to be authoritative and unambiguous (though that’s also a response to how the case has been handled previously) – is that authoritativeness made possible by the fact that mum can’t be seen as someone they can work with? If so, what is the source of the authoritativeness in SW5’s case?

SW6’s reason as to why parental cooperativeness is so important is in lines 165-179 (of transcript):if mum made an effort and X could go home this would be a better prospect for him than what SW6 sees as the alternative – a long-drawn-out court case lasting up to 18 months by which time he’ll be 8, going on 9, and thus less adoptable so he may well spend the rest of his childhood in long term foster care which she clearly doesn’t think much of. She says “will that provide better care for him than his mum will?” (lines 171-2): a fairly astonishing thing to say given what SW6 knows about mum. Does this relate to “natural love” – one of the “institutionalised devices” Dingwall describes as defining the Rule of Optimism?

So for a variety of reasons he’d be better off at home if mum made some changes even though SW6 knows how flaky she is, how much support she needs and how quickly she “deteriorates” without it (line 173).

I ask why do you think the poor home conditions, mum’s state, the poor care of X weren’t picked up on. SW6 says – line 187 on – hindsight is a wonderful thing but a reading of the case suggests serious errors – she cites workers failing to take problems seriously when the Placement-with-Parent Regs were in place – there were all sorts of things going on which perhaps should have prompted a rethink (fixed views as Reder & Duncan suggest?). also SW6 says a series of inexperienced student social workers were involved, the family didn’t get much support during the Supervision Order, the case was closed prematurely.

Extracts 3 and 4: here I compare extracts from two memos arising from interviews with managers about supervision. What is emerging is the dilemma both (relatively inexperienced) managers have about the status to give to practitioner accounts and how to manage a situation where those accounts do not seem to be adequate. This thinking helped develop a key theme about the complex and artfully negotiated social nature of supervision and its importance in maintaining team harmony – an importance which may get in the way of challenging practitioner accounts.

Extract 3:

(SSW1) discussed a case where she had been the supervisor rather than the manager – a case where a pre birth assessment was done on a couple with learning difficulties. The assessment concluded things were ok but once the baby was born it was clear they weren’t. The case had to be reopened and the child made subject to a CPP(Child Protection Order).

This error was upsetting for (SSW1) who had originally agreed the assessment conclusion and a decision to close the case – she said this was a big learning experience for her: she says the social worker clearly missed some key points and she didn't question him/her enough. There were some themes here arising from (SSW1)'s position as a manager which could be explored further in upcoming interviews with (SM1) and (SSW2):

- good practice as a supervisor, focusing on "significant" factors in a case, addressing practitioners' errors without blaming or making them feel bad, managing team communication, worries about taking responsibility for practitioners' errors, looking after people Also look at my interview with (TM3) at (Family Project) – what did I get from this in terms of the manager perspective?

Extract 4:

***Supervision:** the theme that as a supervisor you are dependent on the accuracy and quality of material people bring to supervision. She gives an example (p8 of transcript) where the worker's view was completely contradicted by other professionals and the family at a meeting. (SSW2) presents this as "extra" rather than contradictory information when she talks to the social worker so as to preserve their relationship.*

(SSW2) says that this is also about not having a fixed view, being prepared to change and be flexible in the light of new information.

*On p9 (of the transcript) she talks about **common sense and using theory**. What is common sense? She also talks about the term **"good enough"**: what does that mean? Means different things to different people and such differing standards are often an issue in neglect cases where "home conditions" are an issue. I noticed in this section she differentiates between knowledge and information.*

APPENDIX E: team seating arrangements

Two photographs of seating arrangements for the duty and assessment team in the Moorhouse office.

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