In the Shadow of Baby P – What Has Changed?

Now is a good time to reflect on what has changed since the death of Baby P, whether and how services for vulnerable children have improved and developed since then. The publication of the following contribute to the thought process:

- “The Story of baby P setting the record straight” by Ray Jones, Professor of Social Work at Kingston university and St. George’s, University of London;
- The independent enquiry into Child Sexual Exploitation in Rotherham by Alexis Jay;
- The first annual report of the national panel of independent experts on serious case review;
- The first thirty two inspections of local authority services for children in need etc. by Ofsted.

Key themes central to all of these publications and inspections is that of responsibility and accountability. What these themes mean for practitioners, managers, leaders and politicians in children’s services when there are service failures, whether about individual children; groups of children or when Ofsted says a whole service or Local Authority (LA) is not meeting children’s needs and leaving children at risk of harm.

“The Story of baby P setting the record straight” reminds us of the awful circumstances of Peter Connelly’s death and how this became a focus of major media and political attention. The book describes the background to Peter's death, including the service response to his needs, and those of his family. It unfolds how the media developed the story and the way this fed into the political argument about Peter and his death, the role of public agencies and the role of individuals in those agencies. In particular how the media and political attention focused in on the Director of Children’s Services in Haringey, Sharon Shoesmith, and other senior and frontline staff in the children’s service in Haringey. The book describes the disproportionate focus on Haringey and its staff as opposed to the roles of other agencies i.e. Police and NHS. The way the first and second Serious Case Reviews (SCRs) were dealt with is described in some detail. The first, which identified issues for all the key agencies with forty five paragraphs of recommendations, was deemed inadequate. The second SCR focused more on the role of the LA with more limited attention to the roles of other agencies and consequently its recommendations reflected this. The recommendations were only for Haringey LA and the Local Safeguarding Children Board (LSCB).

The book lays out how a climate of fear and blame was generated which remains part of the background for practitioners, managers and leaders in children’s services today.

If we are looking for a more positive legacy from Baby P then it may lie in the recognition by more thoughtful commentators and politicians that the climate of blame the case generated, and the scapegoating of social workers and other staff, was harming the ability of local authorities and their partners to develop more effective services to safeguard and protect children.
There was recognition that the climate of fear and blame encouraged defensive and risk averse practice which was characterised by a “tick box” approach.

The incoming conservative government in 2010 commissioned Professor Eileen Munro’s review of safeguarding. This review, liberated from the need to focus on a particular case, was able to look at the system as a whole and put forward a powerful case to focus safeguarding practice on relationships, professional competence, understanding and assessment of risk, good organisational systems, the importance of early help and a recognition that the work carries risk, which can be mitigated but not eliminated. Professor Munro’s review’s focus on the critical factors to improve safeguarding for children and were reflected in the report’s small number of key recommendations.

Professor Munro’s review led to developments to simplify processes i.e. single assessment, the development of early help services and a reclaiming of the centrality of good professional social work practice to safeguarding children. Central to the changes sought were the importance of exercising judgment based on sound assessment in decision making rather than a process and procedurally driven approach.

Running in parallel were the social work task force and its recommendations for the improvement and development of social work as a profession. These have seen social work education and training get more positive attention from government than it had for many years. The development of The College of Social Work sought to give social work a voice and status it has not had before. The requirement for an assessed and supported year in employment for new social workers gave recognition to the need for employers to nurture and develop their new social workers. Newly qualified social workers were no longer to be seen as ready for whatever was thrown at them.

There were efforts to bring wider understanding of what social workers do in children’s services through a number of television series filmed in Coventry, Bristol and Stockport. These programmes were generally well received and attracted good audiences.

These were all positive developments.

When we reflect on where we are now these changes remain significant and important. What seems less secure is that the changes can resist forces which recent publications and events suggest are pulling us back towards a culture of blame, compliance focused accountability and a lack of recognition and understanding of the complexity and risks involved in safeguarding vulnerable children. The positive changes that remain have not had time to develop strong roots. Early help services are still in development and many under pressure from the severe budget reductions LAs are having to make. The development of models of social work practice, which promote the exercise of judgment and the management of risk, remain fragile. There are regular calls for more regulation and process, some of which are implemented e.g. new processes for out of area placements.

While the social work reform programme continues, there remain major difficulties for many LAs and others who employ social workers in recruiting and retaining sufficient experienced and competent social workers. This is especially acute for those LAs with negative inspections or otherwise seen as difficult places to work. The social work profession is not united as the College of Social Work and BASW are both speaking for social workers. It is unhelpful that social work does not have a clear and united voice to speak for the profession.

Professor Jay’s report on Child Sexual Exploitation (CSE) in Rotherham, commissioned by the Council, is shocking on a number of levels: the extent of the abuse in numbers, the seriousness of the harm to many children and young people, the collective failure to respond to the children and their families’ needs over time and the suspicions of cover up or at least wanting to look the other way and not recognise the scale of the problem or the community implications of the problem.
The public and political response has been considerable with calls for resignations and sackings. The questioning of some of the senior political and officer figures by the House of Commons select committees looking at the issue has at times been very hostile. While the questioning needs to be probing, the hostile tone and style of some questioning provides no information or illumination as to what has happened, why and what might have been done about it. The focus is on a rather crude version of accountability. As the Rotherham LA commissioned Professor Jay’s report the focus has been disproportionately on the LA. This may change when the Police enquiry that has now been initiated is published. There has been almost no focus on the role of NHS bodies.

What is occurring provides little opportunity to reflect on what has happened and why. There is little reflection on what senior managers and leaders can reasonably be held to account for. The Jay report describes well the serious difficulties in Rotherham’s children’s services in 2008/09 prior to their being judged inadequate by Ofsted. The report recognises the progress that has been made in improving services since 2010 with substantial investment from the Council. The social work staffing position has been turned round. There is a focus on quality of practice. Over time the response to CSE has been steadily improved. The search for people to blame has not allowed much space to explore this improvement, to understand how long such changes take and to ask the reasonable question of whether and how much more could have been done sooner.

One of the wider issues these events raise is how do LAs and other agencies recruit and retain staff where the challenges are greatest, the risks high and where reputation is already low or damaged. There seems little consideration in the commentary on these events that faced with such hostility and the risk of being scapegoated a natural response is, rather than seek to take responsibility, to avoid responsibility as to do so is personally too costly.

There is some way to go before what has happened in Rotherham is fully developed. There are inspections and reviews to come from Ofsted and Louise Casey. There will also be impact from other reports on CSE. The serious case review of what happened in Oxfordshire is still to come. This may well support the contention that the nature and scale of abuse in Rotherham was not unique and that as the Deputy Children’s Commissioner’s report evidences this is a national problem.

In reflecting on the tone of the comment on Rotherham it is interesting to note the approach of the first annual report of the national panel of independent experts on serious case reviews. The report provides some useful factual information on the cases it considered. However there are two areas where the report makes criticisms which in the context of trying to promote more open discussion of what goes wrong and understanding current pressures on LAs and partners are not helpful.

The report is critical of the reluctance of some LSCBs to undertake SCRs. Describing their logic “…tortuous and considerable intellectual effort expended on finding reasons why an SCR is not required.” While the panel says it appreciates the financial and workload implications of undertaking an SCR it may not fully appreciate the financial and resource pressures on LAs and partners. There is no one on the panel with relevant experience working in the key operational safeguarding agencies to whom the work of an SCR falls.

The panel considers different types of review and it is unhelpful that the panel expresses this as “The panel is not confident that other types of review necessarily investigate failings with sufficient independent, thoroughness and openness...”. The concern is the tone that arises from using language “failings” and later on “mistakes” and “what went wrong” as if all cases where there is an SCR will have “mistakes” and things will have gone wrong amongst those working with the child and family. This tone does not help give confidence that SCRs are about reflection and learning and not about blame.
Finally it is worth considering how these developments may impact on LAs as they experience the new inspection framework for services for children in need etc. To date 32 inspection reports have been published. Of these nine are judged good, seventeen require improvement and six inadequate. Of those judged good only one is an urban area, all the rest are counties with below average child poverty. Those areas that have improved since their SLAC inspection are overwhelmingly Counties while those declining from good to require improvement are overwhelmingly urban areas with above average levels of child poverty. Figure 1 shows a grid comparing SLAC and Single Inspection judgments to mid September.

**Comparison of SLAC and Single Inspection Framework Outcomes**

Figure 1: Comparison of SLAC Outcomes and Single Inspection overall outcome. SLAC outcome based on lower of LAC and Safeguarding Judgment i.e. to be judged ‘Good’ on SLAC requires both Safeguarding and LAC judgments to be ‘Good’.

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<tr>
<th>SLAC Judgement</th>
<th>Inadequate</th>
<th>Require Improvement</th>
<th>Good</th>
<th>Outstanding</th>
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<tr>
<td>Inadequate</td>
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<tr>
<td>Adequate</td>
<td>Coventry M Manchester M</td>
<td>Barking &amp; Dagenham ULB Bolton M Haringey OLB Herefordshire C Sheffield M Newham OLB Portsmouth U Blackpool U</td>
<td>N. Yorkshire C Staffordshire C Cambridgeshire C</td>
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<tr>
<td>Outstanding</td>
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How is the accountability of directors and lead members being seen in the light of these mixed inspection outcomes? Ofsted has previously commented on the high turnover of DCSs. Their evidence is that stability of senior leadership is generally associated with better inspection outcomes. In this current round of inspections it will take time to see whether LAs and government have the patience to allow DCSs working in difficult circumstances the time to make a difference or the time to put things right when there are serious problems.

The inspection outcomes suggest that the task for urban areas with higher levels of need is getting harder and that the scale of budget reductions in these areas is having an impact on their ability to meet need. This is especially relevant given the expectations in the inspection of the depth, reach and quality of early intervention services where funding cuts have often been deepest in urban areas.

The link with Rotherham is that Rotherham has invested in its children’s services and responded to the need to tackle CSE in its area. Will other areas be able to meet the need now recognised nationally for a better response to CSE?
Can LSCBS, LAs and partners meet the increased expectations for SCRs? Can LSCBS meet the expectations placed on them to lead improvement and to be accountable if services are not effectively working together?

Much progress has been made in recognising the role of social workers. There is a better appreciation of the importance of relationship based social work and understanding of the complexity of work with vulnerable children and their families. However when things go wrong and children are harmed the culture of blame is still prominent. The capacity to have a thoughtful discussion of why mistakes are made, the systems issues that may drive error and how individuals and organisations are held to account for their work seems very limited.

The evidence is that the response of staff to serious cases, adverse publicity and to poor inspection outcomes is that they leave. Thus adverse events and inspection far from helping through learning and driving improvement may make things worse, at least in the short term, for vulnerable children.

There remains a need for a better balanced debate about accountability and responsibility at all levels in the difficult work of safeguarding children. Criticism without reflection is of little value and we badly need a more reflective approach to these difficult issues.

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