



# Review of Safeguarding Procedures in Bradford Metropolitan District

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## **EXECUTIVE SUMMARY**

This review has identified the following, highly encouraging, aspects of safeguarding arrangements in Bradford:

- User-friendly and thorough safeguarding procedures provided by knowledgeable and responsive providers;
- A stable workforce in children's social care;
- Considerable experience at the front line and in first tier management;
- A well-respected and well-organised safeguarding board;
- A well-organised training programme in relation to safeguarding;
- Evidence of strong relationships between senior staff in key agencies.

The review has also identified some areas where further attention is needed in order to strengthen safeguarding systems:

- Thresholds need attention in a context of inter-agency discussions. Staff working in family centres and children's centres are central to such discussions and developing understandings and practices in relation to the Common Assessment Framework could provide a focus for this work;
- The notion of a learning culture should be actively embraced and should involve staff across agencies and in the wider research community. It is particularly important that the benefits of on-going learning are recognised by experienced practitioners and managers and that they are actively supported to take advantage of learning opportunities;
- Technological and performance management systems are having an adverse impact upon the amount of contact time with families. All systems developed should be assessed in relation to how far they encourage good quality human contact with families and reflective supervision.

## **Introduction**

The death of Baby P has prompted National and local reviews of safeguarding arrangements. Alongside these, there are ongoing debates in the media and professional and academic journals about the safety of the reforms, many of which were put in place in the wake of the Laming Report (2003) into the death of Victoria Climbié. This report outlines the findings from the review in Bradford and locates these in the context of National debates and developments.

## **The review of procedures in Bradford**

Overall aim of review: To assess the procedures for safeguarding children in the area covered by Bradford Metropolitan District Council in relation to the following:

- Are they clearly written? Are they user-friendly?
- Are there gaps that could be considered problematic?
- How do they inform practice including supervision and training?
- Do the procedures equip practitioners to challenge families?
- Do they help with 'thinking the unthinkable'?
- Do they help with resolving disputes within the professional network?

## **Methods used in the review**

The Bradford Safeguarding Children Board (BSCB) procedures are available on the BSCB website and are also incorporated into the Bradford Department of Services to Children and Young People Manual (latest version dated 4<sup>th</sup> November, 2008). While all the procedures were read, it was the safeguarding procedures that were concentrated on. They were assessed in the context of the Joint Area Review carried out into the death of Baby P in Haringey<sup>1</sup>. A discussion was also held with the providers of the procedures. Interviews were held with social work practitioners and managers in children's social care, training personnel, reviewing officers and members of the safeguarding board and staff in agencies such as Education Bradford, the police and the primary care trust. In all, fifteen individuals were interviewed formally. However, it is important to note that individual interviewees had consulted with members of their teams so these findings do reflect the views of a larger number than those interviewed formally. The discussion at the practitioners' forum on 19<sup>th</sup> January, 2009 has informed the analysis. Academic

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<sup>1</sup> Whilst this aspect of the review was carried out, it is not reported upon here as the JAR was considered to be less relevant in the light of subsequent events.

research and political debates about safeguarding policies and practices have also been drawn on.

It is important to acknowledge that this review is limited in a number of ways:

- The data is derived from the accounts given by a number of interviewees working in the area of safeguarding. Files were not read and working practices were not observed. It is understood, however, that this review is part of a wider piece of work being undertaken which includes the inspection of case files. Moreover, there is an ongoing piece of research seeking the views of service users on their experience of safeguarding processes.
- The author did not formally interview staff working in a range of preventive services such as children's centres or family centres. However, it would appear that a great deal of safeguarding work is being carried out in such services and, whilst some of the issues are reflected upon in this review, they would benefit from further exploration.

## **Findings from interviews**

### **Are the procedures clearly written? Are they user friendly?**

There was consensus across agencies that the procedures in relation to safeguarding were clearly written. In general, it was considered that they were easy to locate, although some felt that an index would be helpful. Feedback is encouraged by the company providing the procedures and their monitoring would suggest that this facility is used by staff in Bradford. There are six-monthly meetings between the providers and the safeguarding manager and the chairperson of the relevant sub-committee of the board (the Professional Practice sub-group).

A minority of respondents wanted a paper-based system. This was suggested in the context of concerns about IT capacity within children's social care. A common complaint from interviewees was the lack of storage capacity on CareStore and the frequency of system breakdown. Indeed, this was experienced on a number of occasions by the reviewer. The existing difficulties with IT capacity have been exacerbated by the introduction of the Integrated Children's System (ICS).

### **Are there gaps that could be considered problematic?**

No gaps were identified by respondents. However, there were concerns raised about aspects of implementation in terms of whether there was sufficient independence and scrutiny built into practice and management.

For example, there was a consensus that the chairperson of the local safeguarding board should be independent of the provider agencies. It is extremely important to note that there was a widespread perception that the current chairperson was doing an excellent job and the distinction between person and role was made. For some respondents, an independent chairperson was considered important as it would help perceptions within the wider community. Others felt that an independent chairperson would provide an important degree of outside scrutiny. The Adoption Panel, which has an independent chairperson, was used as a positive example of the benefits independence could bring. It was considered that agency relationships on the safeguarding board would benefit also as there would be a 'level playing field'.

Reflecting on National discussions about authorship of serious case review reports, there was agreement that independence was important, though there were serious concerns expressed about expertise and capacity and the level of resources that might be expected to be attached to serious case reviews in the future.

It was also felt that a further degree of independence and outside challenge could be introduced if reviewing officers for looked-after children were independent of the local authority. Currently there is a view from some that reviewing officers are 'toothless tigers'. There is recognition of the dangers of pursuing independence at the expense of expertise and a fear that independence is being viewed as a panacea by National figures.

### **Do the procedures inform supervision?**

Those involved in supervision felt that there was ongoing informal discussion of procedures in the context of decision making about individual cases. Child protection co-ordinators offer a duty service which is perceived as very valuable by some respondents outside children's social care. It was, perhaps, surprising that some of the practitioners in social care did not seem aware of this system. This may be linked to an impression, gained by the reviewer, that some offices were quite inward-looking.

Supervision and Policy Guidance Notes (dated April, 2008) provide a framework for one-to-one supervision of all staff working for Bradford Metropolitan District Council in children's social care. This includes staff working in settings such as social work teams, family centres and residential units (and includes all staff including agency staff). These notes were read by the review author. They contain a useful framework and specify, for example, the need for supervision contracts. However, because of their generic orientation, they do not acknowledge the complexities of the kinds of work that practitioners may be engaged in and the emotional impact that work could have on them and other workers.

Overall, there was a view that collective approaches to supervision would offer opportunities, particularly to newly-qualified workers, to be exposed to a range of approaches and philosophies. It was felt that the system of individual supervision may result in workers developing particular practices without enough engagement with alternatives. Moreover, an individual senior care manager may be 'too powerful' in some situations.

It did appear from the interviews in this review that, in children's social care, forums for critical reflection and peer supervision were not widespread. By contrast, there was considerable emphasis placed on a range of different types of supervision, including group and clinical supervision, in other agencies involved in safeguarding, such as the Primary Care Trust.

### **Do the procedures inform training?**

The training organised by the BSCB is offered on an inter-agency basis and is informed by the safeguarding procedures. This training is routinely evaluated. The majority of respondents were well aware of, and had participated in, training events (although there was a minority who seemed unaware of this training). Overall, the training was considered to be very comprehensive and well organised. It is generally well attended. However, a worrying tendency in recent months has been identified by the organisers. There has been an increase in the numbers who fail to attend pre-booked events. This was attributed to increased work pressures and, very specifically, to the pressures arising from the introduction of ICS.

A number of respondents suggested the need for further work on engaging practitioners and senior care managers in children's social care with multi-agency training around the issues involved in safeguarding. This needs to be understood as part of on-going learning and reflection as well as a vital contribution to multi-agency working.

Each agency has its own training as well as contributing to inter-agency training. The police are expected to do extensive training before taking on specialist safeguarding duties.

### **Do the procedures equip practitioners to challenge families?**

Those interviewees engaged in direct work with families felt confident about asking to speak to children alone and checking sleeping arrangements. They cautioned against assuming that certainty could always be reached about specific living arrangements.

One respondent felt, on re-reading the procedures in preparation for the review, that the introduction read as too parent-centred. Overall, however, those interviewed were experienced and confident and used the procedures flexibly.

Whilst procedures can play an important role in equipping practitioners to do tasks such as those identified above, there was a feeling that to rely on procedures to inform practice was very problematic. In order to challenge families it was important that practitioners had the time and space to understand what was going on within them. This could involve a range of activities which obliged the use of professional judgement and the expertise of others. Being able to weigh up conflicting versions of events and 'mull over' complex situations, often in the context of a great deal of anxiety and distress, requires emotional and intellectual resources and the space and support to deploy such resources.

Practitioners, however, spoke of the pressure to complete initial assessments based upon one visit and of their frustration with then spending days in front of a computer trying to input the data obtained.

They linked this to the problems with ICS and to the emphasis on completing tasks within set timescales in order to meet targets. It was also acknowledged that cultures could develop in some offices where the approach seemed akin to that of a production line.

ICS, in the context of IT problems more generally, was considered to be impeding safe practice and a number of examples were offered of this. A key theme was that it consumes valuable resources such as worker time and takes time away from engaging with families and other professionals. Moreover, the format is repetitive and descriptive and does not facilitate the telling of a story about the difficulties and strengths in particular families.

A further issue identified is that the assessment tools which are mandatory to use (such as the Framework for the Assessment of Children in Need and their Families) do not provide sufficient support for engaging in risk analysis. The difficulties of hearing and assessing all aspects of a child's situation, including risk issues, can be sharply posed in when an interpreter is used and adequate time is not deployed to ensure a thorough assessment.

Those who read reports regularly expressed concern at their low quality. Moreover, particularly since the introduction of ICS, they were considered not to be user-friendly as they were repetitive and lengthy. They often lacked a clear analysis and, crucially, a risk analysis.

There appears to be a considerable amount of re-assessing. This may be a consequence of the superficiality of previous assessments. A rather surprising point was made by one practitioner that, although based in the same building, practitioners from initial assessment and long-term teams did not meet to discuss cases. This may also help explain some of the re-assessments that are occurring.

### **Do the procedures equip practitioners to 'think the unthinkable'?**

This question was prompted by an article by Andrew Cooper, Professor of Social Work, at the Tavistock Clinic in *The Guardian* on December 2<sup>nd</sup>, 2008. Professor Cooper argues there are a minority of cases involving people whose minds, actions, motives and ways of relating to others is incomprehensible. These people create closed worlds governed by lies, terror and distortion and are skilled at evading the attentions of child protection services. He argues that a key task is to work out how to improve the capacity of practitioners to tolerate 'thinking the unthinkable' and therefore have a better chance of interrupting the unthinkable actions to which some children are subjected.

There was a consensus from respondents that procedures could not equip practitioners to 'think the unthinkable'. This view was shared by those involved with the safeguarding board and reviewing officers and the author of this report.

What is needed is time and space to be able to think carefully about what information is being presented and to weigh up the merits of differing types of evidence. Critical reflective supervision is needed to challenge the distortions in reasoning that can occur. This is explored in a further section but refers to the research by Munro (2005) that indicates how difficult it is for all of us to see and understand our own biases and our tendency to cling to a train of thought and screen out evidence that may contradict it. Moreover, there has to be space to engage with the emotional complexity of what may be happening in families and the effects this can have on workers and on teams and organisations.

A number of staff mentioned the need to develop more expertise in working with men, including those who are dangerous as well as those who may be overlooked sources of support for children. For some this was prompted by the Baby P case, but also by wider evidence that indicates men are often ignored by social care and health staff partly because of the fear of violence but also because of a lack of expertise in working with them (Featherstone et al, 2007).

A number of respondents mentioned a reduction in the possibilities for exercising professional judgement and discretion when working with families. For example, the emphasis on completing tasks within set timescales could mean both too much but also too little work was done. In relation to the former, reviews cannot be 'even one day late' and, for example, may need to be held in the summer holidays when crucial school personnel are not available. Duplication of meetings can occur also with core group meetings and child protection reviews. Interviewees also noted that for looked-after children there can be a tendency to 'do the minimum' in terms of visits and so on. Thus the inspection framework is satisfied but children, particularly those placed in other authorities, may have very limited contact with their social worker. A further issue concerns children who may come in and out of the care system within twenty-eight days. Because a review is not required within those timescales, they can drift without a proper assessment or plan to safeguard their welfare.

Examples were also given of how legal and policy changes have reduced individual discretion and impeded the exercising of professional judgement. For example, the public law outline requires that a letter be sent by the principal care manager to a family who is not co-operating outlining the possible repercussions. There can be practical difficulties here. The unavailability of the principal care manager, for example, can create unhelpful delays. However, it also exemplifies a growing tendency to rely on impersonal or technological means of communication. As one practitioner asked 'would it not be better if we communicated directly in such circumstances?' Highly-experienced, as well as newly-qualified, workers are all subject to the same requirement which reinforces a sense that practice wisdom is not valued. This can both reflect and contribute to a low trust climate, a point returned to in the discussion below.

### **Do the procedures help with resolving disputes within the professional network?**

There is a clear set of procedures for resolving such disputes and these were understood and used. The Local Safeguarding Children Board (LSCB) is considered to be an important and well-respected arena for the development and encouragement of strong relationships across agencies.

A range of respondents gave examples of disputes, the most common of which involved disagreement about whether the case met the threshold for action by children's social care. A number of very experienced respondents felt that these thresholds were much higher than in the past and indeed expressed considerable anxiety about how high the thresholds were. Whilst it was beyond the remit of the review to explore this empirically, it is important to note that the issue of very high thresholds has been noted in recent research which is discussed further below (Broadhurst et al, 2009). There was also a feeling from those trying to refer into social care that the thresholds document is not helpful in aiding discussion as it is confusingly written. Indeed this document has, subsequently, been read by the reviewer and it does not appear to be clearly written.

A further anxiety expressed by a range of respondents concerned **neglect** cases. Such cases could drift without any agency taking ownership and working out a clear plan. They were also subject to re-referral and re-assessment in the absence of a clear grip being taken in the first instance. Moreover, partly because of the publicity that is often attached to the mistreatment of babies, the risks for older children can be neglected by agencies.

There was also some concern about the levels of risk in cases being held by workers in family centres. Whilst, as indicated above, this section of the service was not explored as part of the review, a number of issues did emerge from respondents in relation to thresholds. Unqualified workers may be carrying complex cases for a number of years with no social work involvement. Moreover, in training sessions workers recounted their concerns about feeling 'dumped' with such cases and their anxieties about working with dangerous parents and situations.

A number of respondents noted that the Common Assessment Framework (CAF) is not being used widely and there is considerable inconsistency between agencies and children's social care offices about when it should be used. A number of reasons were advanced to explain this. The implementation was not resourced adequately. There is widespread confusion and anxiety about the lead professional role. This may be linked to the issues about thresholds as workers fear if they take on a lead professional role they will be left 'to carry the can' alone. The difficulties around CAF are recognised by those involved in its implementation and there has been extensive

consultation on the issues. There is a very clear plan of work developed to deal with these difficulties. However, there is a view that senior managers need to engage with and commit to ensuring that implementation is resourced adequately. Furthermore, it was pointed out that there are plans for CAF to become an electronic system in the future and this is a matter of considerable concern in the context of existing IT problems.

There was a view from those referring into children's social care that customer advice workers may not help with ensuring the necessary dialogue (a form of 'mulling over') is held about what are professional judgements in relation to risk or need. Examples were given of rote-like responses – have you done a CAF? Examples of poor communication and recording practice by customer advice officers were offered also. It was felt that professionals such as teachers should be able to talk to qualified social workers about concerns.

Respondents also gave many examples of how disputes were resolved and recognised that there were a variety of mechanisms for this to happen. There was evidence of strong relationships between individuals at senior operational levels and, as indicated above, the LSCB is considered to work very well, although there are issues about the participation of some agencies as explored further below. Police and social care managers meet regularly and have developed an audit mechanism for exploring problematic cases. However, this does not always translate into co-operative relationships on the ground. Senior people gave examples of having to intervene in disputes around referrals to get action. Children's social care staff would like more joint visits with police and on occasion there are concerns about police co-operation in relation to information sharing. But the police, in turn, report increased demands upon their capacity (such as increasing evidence of sexual abuse on the internet) and the impact this has upon their ability to respond to the many demands upon their resources.

National developments could be seen to have created new tensions. For example, education and social care are now integrated in one government department as well as at local levels. Health personnel can experience this as exclusionary, however.

There are dedicated and highly motivated individuals from Education Bradford involved in safeguarding. However, there appear to be difficulties with the development of a consistent and coherent input by Education Bradford at a strategic level.

There appear to be difficulties in developing integrated understandings and responses around children, disability and safeguarding and such difficulties impact disproportionately upon Asian families.

## **Assessing the procedures**

As indicated above, the remit included the requirement that the author read the procedures and assess them in the context of the special Joint Area Review (JAR) of Haringey Children's Services Authority Area. This was a *Review of services for children and young people, with particular reference to safeguarding* (Ofsted, Healthcare Commission and HM Inspectorate of Constabulary, 2008). It was commissioned following the death of Baby P and the subsequent findings of the serious case review. As indicated, whilst this assessment was carried out, it is not reported upon here as it was considered by the commissioners of the review to have been superseded by subsequent events.

The procedures were read by the author and the providers were spoken to. As an outsider reading them they did appear well-written and easy to follow. They were then considered by the author in the context of the qualitative interviews carried out as outlined above. These activities were also located in the context of wider debates.

### **Situating the findings from Bradford in the context of National developments and debates**

The review commissioned by the Minister for Children, Schools and Families from Lord Laming had the following remit:

1. What good practice has been achieved in safeguarding children since the publication of the report into the death of Victoria Climbié in relation to the following areas?
  - The effective implementation of safeguarding systems and procedures;
  - Inter-agency working;
  - The development and deployment of professional workforce capacity;
  - Effective systems of public accountability.
2. What are the key barriers (including in the legal process)?
3. What specific actions should be taken by Government and National and local agencies to overcome these barriers and accelerate systematic improvements in safeguarding practice across the country?

Lord Laming has now reported and whilst assessment of his review is beyond the remit of this piece of work, it is important to note that his initial response was to indicate that the key challenge is to ensure the

current system is fully implemented and to caution against seeking 'root and branch' changes.

However, there are those who question whether the right direction has been taken over the last period and, indeed, since the inquiry into the death of Victoria Climbié. The death of Baby P has offered the opportunity for such views to be heard and, in some instances, taken up more widely. It is beyond the scope of this review to outline the critiques in any depth but a number are explored as they have proved very important in understanding and locating some of the findings outlined in this report into systems in Bradford. These concern the introduction of ICS and the emphasis on performance management and inspection. According to well-respected researchers such as Eileen Munro, these two issues are symptoms of a profound misunderstanding on the part of the Government about the nature of child protection work (Munro, 2008, 2005). She argues that we can only understand what is happening in families and detect abuse by spending time with parents and children. This carries its own dangers as we can become over-involved with such families. Psychological research has shown that people are very bad at policing their biases. Regular critical supervision is needed to ensure that such biases do not distort assessment.

Organisations need to be centred on supporting human contact with families and providing good quality supervision. 'Instead, what we have now are organisations centred on feeding the Government's ever-growing appetite for hard data at the expense of the complex and subtle information social workers actually need to form a realistic assessment of child welfare' (Munro, 2008).

The focus on audit and inspection places too strong an emphasis on what can be measured. It is easy to measure whether forms are completed within specific timescales. But that tells us little about the quality of the form. It is easy to measure whether a meeting has been held and whether the child was present but harder to measure the quality of the child's participation.

The introduction of ICS has reinforced existing pressures to spend less time with families as the research in Bradford demonstrated. From research conducted in five local authorities, there is evidence that ICS is overly complex and audit-driven (Broadhurst et al, 2009). Data must be recorded on complex forms for each individual child. This poses obvious problems where families have multiple children. While it does provide a mechanism for the generation of a chronology, this is not placed within a narrative and practitioners routinely record difficulty in compiling a good social history. The researchers, who had many years experience of reading case records, found it very difficult to understand the cases. This was a common complaint from independent reviewing officers and workers and managers new to cases. The sites included teams with high staffing levels so the

issues were not just confined to those experiencing resource constraints.

ICS was introduced with no increase in administrative resources and it was argued that it would reduce the amount of time spent on administration. However, practitioners reported much more of their time was spent in front of the computer trying to fill in forms.

A key theme from many of the researchers is that the priority of systems and arrangements must be to ensure that there is good quality practice involving engagement between workers, children and families and that space is available to liaise with a range of professionals and reach considered judgements about need and risk. However, the picture on the ground, in their view, is that the priorities are feeding the technological and inspection regimes. It would appear that some of their criticisms have been taken note of by the Government and the Opposition. For example, Ed Balls has asked the taskforce that has been established to review the roles and responsibilities of social workers, to review ICS as a priority and stated a strong commitment to ensuring that front-line practice is not hampered by bureaucracy. Oliver Letwin, the Conservative Party's policy chief, has argued for a move away from rule-based regulation to judgement-based regulation and in its submission to the Laming review the Conservative Party have called for the abolition of ICS (Hencke and Mulholland, 2009).

It is important to repeat that whilst a range of interviewees in Bradford made it clear that National developments, such as the emphasis on timescales and technological changes, were impacting adversely on their work, there was a concern not to 'hide behind' ICS and to confront a range of other issues that may be impacting adversely upon practice. It was recognised, for example, that office cultures can become stuck in patterns that are not conducive to reflection and the active exploration of good practice.

Many of the staff in children's social care teams are experienced and have worked in Bradford for many years. There is a good degree of stability. This is a major strength, but it obliges constant attention to ensure on-going learning and renewal. It would also appear from this review that a blaming culture is not perceived to operate in Bradford. This is also a major strength particularly in the current climate.

However, in the opinion of the author, more could be done to build a learning culture. There are pockets of excellent practice. For example, the LSCB can call upon an impressive array of expertise and is committed to developing learning through a programme of on-going work. Police and social care managers have been working on an audit process to evaluate 'near misses' and problematic cases. However, there are examples of missed opportunities. Although numbers of staff are sent each year on post-qualifying training, more opportunities could be offered to cascade their learning and also to support them to do pieces of research of value to the service.

Differing models of supervision should be explored and the important

work carried out by training officers could be expanded further to embed reflective practice across children's social care. This needs to include staff working with children and families in a range of settings.

A learning culture starts from the assumption that individuals are fallible and likely to err. Of particular relevance to safeguarding practice is the understanding that individuals struggle with information processing and reasoning. As Munro (2005) notes, these are some of the questions that then need to be asked: Why are humans in these circumstances performing badly? What demands do the tasks make on their knowledge and skills? Does the person have the necessary capabilities and are the demands realistic given what is known about humans' reasoning skills? How do these tasks interact with those of others? Crucially also we need to explore the systemic weaknesses which make errors more common or increase the likelihood of them being more serious.

However, the current approach, fuelled by the media and encouraged by inquiries into child deaths, is to set about identifying error and those responsible. The review in Bradford found examples of supervisors who addressed the importance of building the kinds of relationships where mistakes could be acknowledged openly and learned from. Moreover, as indicated above, there are examples of inter-agency processes, such as those being developed between the police and children's social care, where problematic situations or cases are being evaluated in terms of their learning.

A crucial word, used sparingly in the interviews for this review, and only by those who encouraged the admission of mistakes, was the word 'trust'. Many researchers have located the emphasis on performance management as evidence that successive governments do not trust the public sector (Smith, 2001). In such a climate it is very hard for trust to flourish, but it is crucial in work that is concerned with uncertain outcomes and with risk, anxiety and vulnerability. It has been argued that many of the systems developed to measure performance are applicable if seeking to ensure that a worker such as a plumber delivers a reliable service. However, such measures are of limited value in work as complex as safeguarding. Such measures are not only unsuitable but they can have dangerous implications and can promote cursory and cynical practices. Many commentators are doubtful about the possibilities of trust flourishing in contemporary contexts where there is such vilification of those involved in trying to protect children. However, there was evidence that in some agencies in Bradford it was considered important to encourage trust. This needs to be built upon as a crucial aspect of a learning culture.

## **Conclusion**

This review offers a snapshot of safeguarding arrangements in Bradford at a particular point in time. It is based upon an assessment by the reviewer of data provided by respondents in a range of agencies, analysis of the procedures and of the debates at a range of National and local levels in the wake of the death of Baby P. It is hoped that the review will contribute towards building upon the strengths which are apparent and support the ongoing development of safer systems.

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