This article outlines a framework for the assessment of risk in child abuse work and describes its use in an interagency training programme in Nottinghamshire over the last five years. Two key concepts are introduced: critical pathways and risk analysis. The authors go on to describe the way they have used these as the basis for interdisciplinary learning alongside a number of other useful ways of looking at risk and child abuse.

Central to child abuse work is the need for skills in assessing risk and in making decisions about action to be taken. This work is not made any easier by the fact that such skills and judgements are often needed just at the time when the worker is under great pressure and in danger of being overwhelmed by other people's perceptions. The worker may be aware of the views of other agencies, their own managers, the family, and even the media, yet might find it hard to formulate a clear view of their own. Responding to one handed-on view after another they might really feel that the process has got control of them, rather than them operating as a professional. Such a situation offers no protection to the child, the family, or indeed for the worker. What is needed is a framework within which to make a clear assessment of risk and to provide a basis for sharing decision-making with others.

In a string of enquiries about cases of child abuse it has become clear that each incident relates not to a single cause but to the coming together of a number of factors. Separately these factors might have been manageable, but taken in conjunction they have had fatal consequences. In 1982 one of us was struck by a parallel here with the enquiry report of an aeroplane disaster. A sequence of individually surmountable errors and failures had led to final catastrophe. This investigation had used the concept of a critical pathway: the idea that at each stage in a sequence of events there are a number of alternative pathways, each of which in turn has a number of subsequent alternatives ahead of it. The sheared-off engine fan blade may or may not fracture a fuel line and cause a fire; even if the blade is thrown clear the engine may then overheat and cause a different sort of fire; the fire extinguisher system may or may not successfully put out either type of fire. Theoretically one could plot all these possible points on this critical pathway, and analyse not only how an accident thing useful to learn from other disciplines.

To our surprise one of those disciplines turned out to be nuclear engineering. If it is possible to plot such a critical pathway after an event, it may be possible to plot it in advance, and prevent the accident. Indeed, in nuclear engineering this is essential. The consequences of an accident are so enormous, and the reaction time so short when a fault does occur, that planners have to examine all the possible combinations in advance and plot both the operators' reactions and the consequences. If the gauges on the control panel indicate a particular configuration, what is the complete range of possibilities that this could indicate? And what might be the consequences of a range of possible operator responses to them? Such a form of critical pathway is known as a 'fault tree' and enables...
planning and preventative action, including redesign of the total system.

Now we are not suggesting that such fault trees could be constructed for the families of all children at risk, although this has been demonstrated by one writer as a way of learning from an incident (Lynch, 1978). What we do argue is that something can be learnt from these concepts: highlighting both a general approach and some critical factors. In our training courses we demonstrate this by examining a particular critical pathway: that of the Zeebrugge ferry disaster.

This is presented in a much simplified form, but is sufficient to highlight some concepts of risk. For our purposes we assume that at each point on the critical pathway there are just two possibilities. For instance, a ferry can leave port with its doors open or shut. The consequences thereafter will be affected by other alternatives. The captain may or may not know whether his doors are shut. The ship may be loaded level or bow down. The car deck may be divided or undivided, whilst the sea may be calm or choppy. A critical pathway for this can be drawn as in the attached diagram (Figure 1 omitted) and even if we assume the ‘worst scenario’ we can reach the point (a) in the process without major consequences. So long as the ship is on a straight course all is well; but if it turns, the bow wave will rise and with all the factors we have identified it becomes inevitable the ship will turn over in seconds. However, the consequences of that are influenced by other factors. If the ship turns over in the harbour mouth rather than far out to sea, and if it does so at a time when there is plenty of shipping about, the outcome is altered. Similarly, if this happens at a time when a military exercise is taking place nearby and not long after local rescue services have practised emergency plans, then some of the worst consequences can be averted.

This is no doubt a primitive form of critical pathway and far from exhaustive of the lessons to be learnt from Zeebrugge, but it serves to highlight some features of risk. First of all, it identifies the existence of different types of risk. Some of the risks (such as the weather) were not under human control. Some of the risks were straightforward human error, including a particular type of communication problem based on over optimism. Some of the faults were procedural and some were straightforward design faults. Secondly, we can identify the possibility of reducing the consequences through some of the factors which intervened once sinking became inevitable. Where it happened and who was around were significant features. The existence of a prepared and recently rehearsed rescue plan proved important. The analysis serves to remind social workers that causal factors are not all of the same type. Interventions of a variety of kinds may be influential in reducing risk as well as minimising harmful consequences. This helps to prepare us for the idea of a more disciplined approach to the identification of risk factors.

We found this idea of a structured approach to risk was well set out in the writings of Paul Brearley (1979; 1982) who also believes that social workers have much to learn from other disciplines when thinking about risk. His particular framework of risk analysis has served as a major inputting the training process we shall describe. His definitions are drawn from an extensive study of the concept of risk in insurance, engineering, gambling and safety technology. He challenges us to be much clearer about what we mean when we talk
about risk in social work. One principle that is derived from insurance is that we should consider not merely the likelihood of an event but also its consequences. An event may be likely, but its consequences not disastrous, or it may be unlikely and yet disastrous. Distinguishing these two aspects helps to explain why we choose to do something about one possible eventuality and not about another.

Risk for Brearley is the relative variation in possible outcomes and contains two elements: probability and uncertainty. What is crucial is separating out hard information, subjective uncertainty, and those value elements that identify one outcome as more feared than another. As with the critical pathway there are a number of features which make a feared outcome more likely: these are referred to as 'hazards'. The feared outcome is referred to as the 'danger'. These dangers are identified by someone. Sometimes what is identified as a danger by one person may not be so perceived by someone else. A social worker may identify failure to pay the rent for several months as a hazard, leading to the danger of eviction, but the client may regard that outcome as desirable if they see it as a way of getting off that estate and being rehoused.

Brearley develops the idea that if some factors (hazards) increase the likelihood of a dangerous outcome, then others reduce the likelihood. These positive factors are referred to as 'strengths'. For instance, arranging to pay the rent direct would be a strength against the hazard of rent default and reduce the danger of eviction. He further distinguishes between two types of hazard: some are of a more general nature and are called 'predisposing hazards', whilst others are particular to the circumstances and known as 'specific hazards'. Being one year old would be a predisposing hazard to the danger of abuse: it marks a general vulnerability. Having problems teething is a more specific hazard to this particular child at this time. The different types of hazard would call for different types of response.

Brearley (1982, pp.84-90) sets out a framework for analysing risk in any particular case. A grid is formed with four columns across the top headed: predisposing hazards, situational hazards, strengths and dangers (Figure 2 omitted). Down the left hand side of the grid are listed the individuals involved in the case, including the workers themselves. In completing the grid one asks: 'What are the dangers or feared outcomes for each of the parties?', and lists those in that column. The second task is to identify what factors would make that outcome more likely and list these as hazards, deciding if they are predisposing or situational. Thirdly, one identifies what factors counter those hazards and make the dangers less likely, listing those factors as strengths.

In the training programme we have run, after detailed demonstration of the risk analysis framework, the matrix is used by staff to work on their own cases. We shall describe this process in a moment, but here would like to highlight the value of the framework as experienced by staff attending the workshops. It serves to identify and organise what one knows about a case, as well as what one doesn't know. These gaps in information might be usefully followed up. It can be a tool to check out progress over time and make some sense of what may have been a very confusing involvement in a case. It can be used as a tool to try out hypotheses. What might happen if the breadwinner is made redundant? What could be the impact of a further pregnancy?
Risk analysis allows one to look at the inter-relationship between factors in the situation. The danger to one family member may need to figure as a hazard to another. For instance, a mother facing the hazard of a depressive illness may be in danger of suicide, and that danger could pose a hazard to the child at risk of the danger of assault from the already under pressure father. Intervening to develop strengths which combat the hazard of depressive illness may make sense in reducing the risk of assault. The framework can be used as an aid to planning work on the case. What are the priorities for the next six weeks or next six months? Can the strengths in the situation be increased or can particular hazards be guarded against? What might be the implications of one intervention rather than another? Certainly staff have found it a useful tool for sorting information in discussion with their line supervisor and in developing a strategy for the case. It might also provide a medium for dialogue with other workers or other agencies in preparing a co-ordinated approach. Principally the framework serves to distinguish between values and knowledge, to identify gaps in knowledge, and to highlight the basis for different perceptions of the same situation.

Others have argued for such systematic frameworks for child abuse assessment and even provided other matrices for doing so (e.g. Department of Health, 1988). What we have found significant in the Brearley framework is the inclusion of the worker as a factor in the case. This makes it particularly helpful in staff supervision where questions can be shared about the worker's contribution to the case. Is the worker's relationship with anyone in the matrix a hazard or a strength in the case? What anxieties is the worker carrying about feared outcomes for themselves? e.g. stress, making a wrong decision, being blamed, even getting the sack. Where can the worker find strength to reduce these dangers? - e.g. in regular supervision, in training, in sharing with colleagues, in undertaking relaxation exercises, even in following procedures.

This restatement of ways of understanding risk, and the outline of both critical pathways and risk analysis, serve as the basis for a particular approach to interdisciplinary training on child abuse that we have developed in Nottinghamshire. They have formed the basis of two training courses: 'Working with Risk' for practitioners and 'Managing Risk' for supervisors and advisors, which will be described in this article. Child abuse inquiries and reports repeatedly reiterate the need for post-qualifying training to enable workers to develop their strengths and reduce the extent to which they themselves may be a hazard to the client.

Multidisciplinary working is one obvious source of strength in child abuse interventions, but the consequences for children, families and staff of the failure to work effectively together can be disastrous, as witnessed most recently in Cleveland. It seems self-evident then that interdisciplinary training can contribute to a climate of understanding and mutual respect which will lead to more effective working relationships.

'Working with Risk' is run as a multidisciplinary three day course for experienced probation officers, health visitors, education welfare officers and social workers. It is planned and tutored by staff from four different agencies through joint training. The course seeks to take account of the multi-cultural nature of the communities served. We have found the optimum number of participants to be 16.
This enables small groupwork to take place in groups of four. The size of the large group does not seem too daunting to participants and it is possible to foster a safe enough environment for individuals to express and explore differing views and experiences.

The course moves between theory and practice, with large group presentations by tutors and small multidisciplinary group working. This facilitates the sharing of experiences and knowledge and the applications of theory and practice. Prior to the course, all participants are asked to provide a written outline of a case involving risk which causes them concern. This case is used at different stages of the course and is an essential component. Participants have the chance to reflect in depth, with others from different agencies, on a case which worries them and to do this in relation to ideas and approaches presented on the course.

The first day focuses on participants’ case material, on developing a shared understanding of the concept of risk, on the relevance of a multicultural perspective and on the risk analysis models described above.

We have found it important to ask the group to consider the relevance of race to risk early on the first day. Once this is recognised and understood by the groups, it is possible to integrate consideration of a race dimension throughout. In the past we left this until later in the course with the effect of marginalising the issue.

On the first morning, participants discuss case material brought by others in small multidisciplinary groups and look at the concerns felt by the worker and the nature of risk involved in the case. This provides an opportunity to understand the concerns and issues of staff in other agencies and to develop a clearer understanding of risk, prior to the presentation of the framework of critical pathways and risk analysis. Once these concepts have been described by the tutors, participants return to their small groups to test out their applicability to their own cases.

On day two, participants examine risk indicators and their evaluation in relation to physical abuse, neglect and sexual abuse, and look at two particular practice issues which can cause problems when working with risk - denial and violence.

On day three, the idea that professionals themselves can be dangerous as individuals and through their interagency practice is developed. This links with the Brearley risk analysis framework in which he includes the worker in the assessment of strengths and hazards. We have taken this a step further and considered how white workers may be an increased hazard to black families in cases of child abuse, and acknowledge the assistance of Salim Khan, a black consultant, in developing this element of the course. We then consider stress and its impact on workers. Time is given to considering how to take back and apply what has been learnt on the course and there is the opportunity to apply some of the ideas of the last two days to participants’ own case material.

It is impossible to do justice within this article to the range of materials and items that have proved useful on the course. One of the features of the course is that it keeps evolving as tutors try to respond to the different concerns of participants and the developing state of knowledge in this field, by borrowing and adapting the work
of others. Peter Dale's (1986) work on dangerous professionals, in which he explores a range of ways in which professionals can practise which are in themselves hazardous to clients, has been drawn on and developed. We have linked this with consideration of the 'rule of optimism' and work on the 'Stockholm Bank Syndrome'. This is described by Chris Goddard and Bob Carew who demonstrate how, when violence is implicitly or explicitly threatened, social workers can act as hostages (Goddard and Carew, 1988). Sustained periods of anxiety and a sense of powerlessness can lead a worker to believe only the best of those caring for a child, to discount evidence to the contrary and to seek perversely to protect those who are felt to constitute a threat.

We have used material by Juliet Cheetham and Sharma Ahmed on stereotyping and cultural relativism in assessing risk of child abuse in black families (Cheetham 19,017. Ahmed et al., 1986). Black children can be exposed to risk because workers either over react or under react. They may, for example, remove children inappropriately, or in contrast, fail to protect children who are being abused because of stereotyped assumptions about black families, or from a paralysing fear of being racist.

The work of Gardener and Lancaster (1987) has proved valuable in helping to consider the sources and effects of stress on workers and what they might do about it. Finkelhor's (1986) framework for considering the preconditions which can lead to sexual abuse has been used to help analyse risk factors and plan strategies for intervention. Local probation officers in Nottinghamshire have developed the 'ABC' approach to working with denial with sex offenders in which they examine the Behaviour, its Antecedents and its Consequences, not only for the victim but for themselves. This has proved useful as a way of overcoming denial and finding 'options out' of offending behaviour. This is demonstrated in a video Nothing Much Happened (Notts Probation Service, 1988).

Ensuring the appropriate mix of agency, gender, practice experience and training skills in each tutor team can prove problematic, especially as two tutors seem the optimum number for this course. Priority has been given to ensuring a mix of gender and agency represented. We have recently been able to involve a black tutor in the planning group from which the tutors are drawn; previously the absence of a black tutor had limited our ability to integrate a black perspective and to provide an equal service to black course participants.

One of the recent developments arising out of this course has been a related two day course for interdisciplinary training of middle managers. This course offers the same core material but looks at the particular value of the framework for risk assessment in the supervision of staff. It also seeks to develop the supervisor's understanding of how risk and a high level of stress can trap workers in unhelpful dynamics, and what the supervisor might constructively do about it. The particular value of this course is that it focuses on the centrality of risk assessment in child abuse work. It does so in a multidisciplinary course which provides workers with a framework and space for reflection. It allows them to examine theories in relation to their own case material and encourages them to develop strategies for case management and to find appropriate sources of support. It has spin-offs for work in other risky situations, e.g. care of the
elderly, mental health cases and work with violent offenders. No doubt the training programme will continue to evolve and it is offered here not as a definitive product but as a useful indicator for future developments.

References


Brearley, P. (1979) 'Gambling with their lives', Community Care, 8,15,29 November.


Audio CD is also known as Compact Disc (CD). Initially this optical disc data storage format was developed for audio recordings only. First introduced in the 1970s, it was launched for commercial use in 1982. Somewhat later, in 1985, first data CDs (CD-ROM) appeared. The Audio CD standard can be referred to as "Red Book", which is its official name. Thus a CD player capable of reading CD Text can display title and artist information for each song, reading it directly from the CD. This is especially helpful for car radio but also used on computers and some other devices that work with Audio CD. Windows Media Player can read CD Text, if a special plugin is installed. Most third-party software players support CD Text out of the box. Congress Child Abuse Hearings - Free ebook download as PDF File (.pdf), Text File (.txt) or read book online for free. 2006 Hearings before House Energy and Commerce Committee. Thinking about the number of children that were abused in order to create all of those images is sickening and intolerable. We must do everything possible to stop it. I want to particularly thank all of our witnesses today for appearing before the subcommittee.