Performing 'Initial Assessment': Identifying the Latent Conditions for Error at the Front-Door of Local Authority Children's Services

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Summary

This article draws attention to the faulty design elements at the front-door of children's local authority services, arguing that current attempts to increase safety, through the formalization of organizational procedures and their enactment by IT systems, may have had the contrary effect. We argue that the analysis of errors in organizational settings should focus on immanent *systemic* weaknesses, particularly the 'latent conditions' for error that generally increase the risk of failure. Reporting the findings from a two-year ESRC-funded ethnographic study, and examining the local adaptations of practice arising in the performance context of the 'modernized' front-door of children's services, we draw attention to the short-cuts that the current configuration of the initial assessment system appears to necessitate, given the immutable timescales and excessive audit requirements. New modes of governance can clearly play a central role in error management, but the design of an effective system needs to be based on the needs of users and on a thorough understanding of their working practices.

Keywords: Initial assessment, child welfare, error, latent conditions, performance management

Introduction

> . . . you do not have to be a design guru to spot that this is down to a piece of bad human machine interface design—a design that fails to understand the end user, how they intend to use their product and one which, instead of providing the desired service, provides only an infuriating barrier (Lowe, 2006, p. 1).

Although the quotation refers to 'faulty goods' returned to shops by customers, but found to be in full working order, Lowe proceeds to apply his analysis to the design of health care systems that increase the likelihood of errors and compromise patient safety. In this paper, we present a similar argument, drawing attention to what we claim are faulty design elements at the 'front-door' of local authority children's services. Whilst unintentional errors of judgement and action are inevitable in any socio-technical system, we claim that current attempts to increase safety, through the formalization of organizational procedures and their enactment by IT systems, may have had the contrary effect. Given that child welfare practices are increasingly governed through electronic technologies that standardize procedures and micro-manage decisions and actions according to nationally defined standards, it is important to understand the local adaptations of practice arising from the user/technology[1] interaction that can heighten systemic risk. Although assessment practices in children's services have been the subject of recent research (c.f. Nyborn, 2005; Platt, 2006; Forrester, 2008), such work has not explicitly focused on the interplay of technology and practice as we do here.

The work presented derives from a broader two-year ESRC-funded ethnographic study of child welfare practices in five local authority areas in England and Wales. The study was focused on the impact of performance management on organizational decision making and specifically on attributions of blame. During our fieldwork, we observed that workers at the front-door faced acute challenges to safe practice. Imperatives to safeguard children and support families appeared at odds with, rather than enhanced by, new modes of e-governance and associated performance targets. In particular, the immutable timescales set for the completion of the initial assessment inevitably pushed workers to make quick categorizations based on, at best, one home visit. Equally, the standardized and complex assessment forms appeared to engender a range of problematic recording practices. The general aim of this paper is to draw attention to the short-cuts that the 'initial assessment system' (IAS)[2] appeared to necessitate in its demand for rapid case disposals, and the latent error conditions that this ineluctably creates.

Modernizing initial assessment

In recent years, practices at the front-door of statutory children's services have been subject to significant 'modernization' efforts, aimed at improving

their safety and efficiency as well as reflecting a general trend towards early intervention. In 2000, *The Framework for the Assessment of Children in Need and their Families* clearly defined the initial statutory response as a distinct stage in the assessment process (Department of Health 2000; Horwath, 2002). Reflecting a shift away from narrow pre-occupations with child abuse, much criticized in *Messages from Research 1995*, the new framework depicted child welfare as the triangular function of developmental, parenting and environmental influences (Cleaver and Walker, 2004). Since its advent, the importance of initial assessment practices has been further reinforced by the public inquiry into the death of Victoria Climbié (Laming, 2003), which heavily criticized Ealing and Brent for failings in their referral and assessment processes.

Formalizing initial assessment (IA) is about recognizing the importance of the initial professional response, especially that it be 'timely' (emphasizing the need to see the child at the earliest point). In response to the *Assessment Framework*, many local authorities now have very clear and procedurally policed boundaries between initial response and longer-term teams. IT systems, now generically known as the Integrated Children's System (ICS), have been universally implemented, constraining workers to follow the various steps specified in a formally defined 'model' of the assessment process, hence creating an indelible, auditable trace of day-to-day practices. A standardized IA form prompts workers to collect information in a systematic way, with the expectation that the data so-garnered will contribute usefully to further assessment. Consistent with the universal application of Performance Management throughout the public sector, a range of targets and timescales have been stipulated, which are justified by invoking the importance of a 'timely' professional response to the needs of children. Within one day of a referral being received, agencies are mandated to make and log a decision about the requisite response. When an initial assessment is deemed necessary, this must be completed within seven days, including the requirement to see the child.

Despite these changes, errors continue to occurr, not just concerning the risk of serious harm to children (Brandon *et al.*, 2008; Fish *et al.*, 2008), but indications have also been found that 'children in need' and their families are not receiving appropriate help (The Cabinet Office, 2008). Our impoverished understanding of these continuing difficulties arises from a key limitation in the evidence base. There has been a general tendency to bracket off the technological from the human elements of practice and *visa versa*. For example, performance data are routinely collected concerning compliance with timescales (*www.ofsted.gov.uk*). Whilst these data are used by inspecting agencies to make judgements about 'good practice', without examining actual local practices, such judgements are of limited value and questionable validity. The few research studies that have specifically examined assessment practices offer useful general information about referral details and responses (Cleaver and Walker, 2004; Platt,

2005, 2006; Forrester, 2008), but, in abstracting patterns of reasoning and action from their situated context (including its technological dimension), they suffer from similar limitations. Literature that is most relevant to our discussion derives from Munro (1996), and Reder and Duncan (*inter alia* 2003) and, more recently, Fish *et al.* (2008). This body of work has begun to establish the relevance of a systems perspective for child welfare and our work aims to build on this literature. In order to develop a more effective approach to error management, it is important to conceptualize the initial assessment response as comprising a socio-technical system of interrelated human and technological components. We develop this argument in the next section.

The systems approach to error management

There is a substantive body of work that argues for a systems approach to error management (Reason, 1997; Munro, 2005a; Fish *et al.*, 2008). James Reason (*inter alia* 1997, 2000), perhaps the most well known exponent of this standpoint, argues that errors in human systems have their origins 'not so much in the perversity of human nature as in "upstream" systemic factors' (Reason, 2000, p. 768). Coining the notion of 'latent conditions for error', he argues that the analysis of errors in organizational settings should focus on general *systemic* weaknesses, rather than mistakes made by particular individuals on particular occassions. Such latent conditions refer to generalized, immanent characteristics of a designed system (typically non-obvious and unintended) that increase the risk of errors occurring in the operational situation. In aviation, for instance, efforts to automate pilot functions were based on the premise that this would improve safety (Norman, 1990). However, by displacing the pilot from the 'control loop', his/her grasp of what was currently going on in relation to the status of the aeroplane was necessarily eroded. Such reduction of 'situational awareness' provides an example of a latent condition of error, a direct paradoxical consequence of infelicitous design. When the pilot was obliged to take over control in exceptional conditions, the likelihood of mistakes was increased and, indeed, several serious accidents were attributed to such a causal pattern (Norman, 1990).

An extensive quotation from Reason (2000, p. 769) provides a useful summary of the main features of the concept. Designating latent conditions as the inevitable 'resident pathogens' within the system, he goes on:

> They arise from decisions made by designers, builders, procedure writers, and top level management . . .. All such strategic decisions have the potential for introducing pathogens into the system. Latent conditions have two kinds of adverse effect: they can translate into error provoking conditions within the local workplace (for example, time pressure, understaffing, inadequate equipment, fatigue, and inexperience) and they can create long-

> lasting holes or weaknesses in the defences (untrustworthy alarms and indicators, unworkable procedures, design and construction deficiencies, etc). Latent conditions—as the term suggests—may lie dormant within the system for many years before they combine with active failures and local triggers to create an accident opportunity.

From a systems perspective, approaches to error management that focus on individual breaches of procedure or unwanted aberrations of human conduct will inevitably be limited in delivering safer worker practices. Individuals are fallible and will always err; the trick is to design safe systems that minimize the likelihood and the consequentiality of such inevitable failures. A systems perspective requires that more attention is focused on the design elements of the system 'to reduce the number of latent conditions in the system that can contribute to user error' (Lowe, 2006, p. 2):

> ... active failures are like mosquitoes. They can be swatted one by one, but they still keep coming. The best remedies are to create more effective defences and to drain the swamps in which they breed. The swamps, in this case, are the ever present latent conditions (Reason, 2000, p. 769).

In social services, latent conditions for error are all too readily found. The IAS is a system under pressure. It is estimated that, on average, LA social services departments receive 300 referrals every month,[3] although precise measures are difficult, given definitional issues and local practice adaptations. Whilst not all 'contacts' convert to referrals, contacts must still be filtered to identify cases that require an initial assessment. Teams are legally bound to respond to referrals; they receive no extra compensation or flexibility regarding staff sickness levels; rather, targets must be met whatever the particulars of local context. Pressures are further compounded by the widespread problem of recruiting and retaining experienced staff (Audit Commission, 2002). Where referral rates are high and resources are constrained, trade-offs are inevitable between different components of the IAS. Notwithstanding the limitations of crude performance data, national statistics provide clear evidence of such systemic conflicts. Figure 1 shows that, as volume increases, child-protection work is increasingly prioritized within the overall assessment process. This is, of course, a rational adaptation, though it may not be an intended one. The visibility of such trade-offs at the macro level is important in the present context, as it indicates the work pressures and conflicts impinging upon local teams, which could lead to errors, directly through the down-grading of some services, cutting corners, etc., or indirectly through elevated stress levels and fatigue.

The fieldwork

The project has comprised a multi-site ethnographic study, based in five local authorities in England and Wales and drawing data from fifteen social work duty and assessment teams, variously referred to as 'first
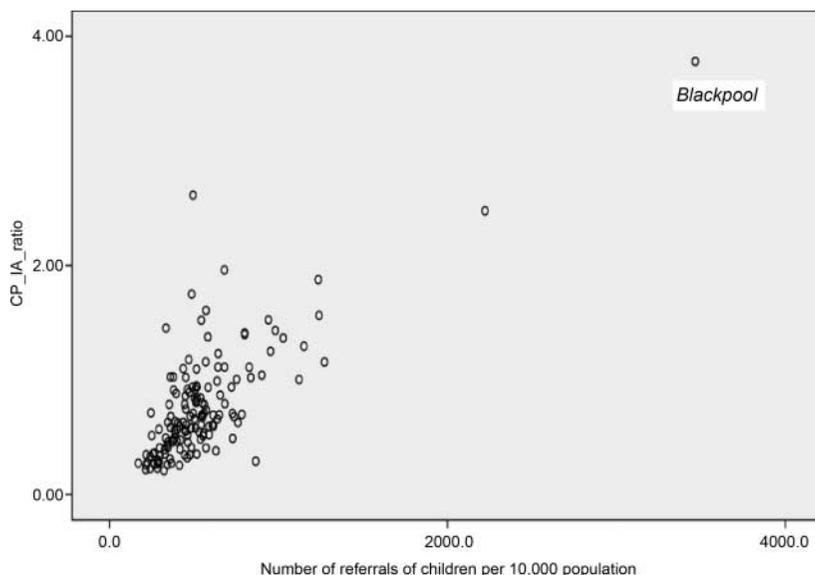
Figure 1 Compiled from Annual Performance Assessment (APA) data for the financial year ending 2007 (England only). Each data-point represents an individual LA social services department. The *y*-axis shows the relative proportion of Initial Child Protection conferences (per 10,000 children) to Initial Assessments (per cent of all referrals). This ratio can be taken as a crude proxy of the local priority given to child protection as opposed to assessments for general family support. The progressive increase of the ratio indicates that, as referral volume rises, child protection work is accorded increasing priority, with the proportion of Initial Assessments steadily falling away. *En passant*, the figure also points up the danger of relying on single performance indicators, rather than modelling and studying the relationships between multiple variables. This is underscored by the example of Blackpool. In terms of the percentage of Initial Assessments carried out, it falls in the bottom ten nationally. However, we can see from the figure that such 'performance' is far from anomalous when its very high referral rate is taken into account

response', 'initial assessment' and so forth. The study has sought to examine the impact of the changes introduced in the context of New Labour's programme of modernization on professional decision making, focusing particularly on patterns of error and the attribution of blame. We have paid particular attention to 'front-door' practices, as such work is particularly subject to exacting performance targets and issues of 'error management' are intrinsically acute.

The five local authority areas have been given the following pseudonyms: a London borough (Metroville); a county council (Shire); a metropolitan borough in the North of England (Westford); a unitary authority (Seaton); a Welsh rural authority (Valleytown). The fieldwork began in 2007 and is still underway. Each authority provided the necessary local permissions and the project was approved by ethics committees in the relevant universities. The ethnographies have involved various levels of engagement across the sites during a twenty-month period. In total, we estimate this has amounted to around 240 days of observation and analysis of everyday

practice, including worker interactions and meetings together with the inspection of key documents and case files. In addition, a total of ten focus groups and sixty formal interviews have also been conducted. Transcripts and field notes were uploaded to a dedicated project website to allow the research team to share and discuss the data. Regular meetings were held to examine and validate emergent themes, supported by group e-mail exchange and discussion.

Unless otherwise stated, the extracts have been chosen for their typicality and this has been cross-checked amongst the research team. We observed remarkable consistency across the sites in the practical struggles that workers experienced in managing the competing demands of IAS. We have maintained an open mind throughout and, with the data presented here, we do not intend to argue that workers *always* do this or that; rather, our goal has been to identify and catalogue representative improvisations and expediencies that are necessitated by the system, which we have repeatedly seen.

Findings

In presenting the findings, we have removed all detail relating to individual sites. Our rationale for this is ethical. Individual sites may be able to recognize themselves from the pseudonyms we have given: obviously, the authorities know who they are (but not the others) and, thus, presentation of workers' practices as specific, for example, to 'Valleytown' may expose those teams to blame, despite the fact that we are describing systemic problems.

In each site, the 'duty and assessment' teams are tasked to respond to initial contacts and referrals that come by way of telephone calls, faxes, e-mails, multi-agency assessment forms (MAARFs) and Common Assessment Forms (CAFs). These various external contacts cover the range from reports of serious injuries to children, more uncertain concerns about children's welfare, right through to straightforward requests for information and advice. In all sites, there is increasingly little opportunity for a 'customer' to walk in and directly request help; rather, all approaches are mediated through some form of 'front of house' customer service interface, with unqualified workers often acting as initial gate-keepers, with varying degrees of oversight. To enter the assessment system, a contact or referral must meet *local* eligibility criteria that are based not just on the nature and relevance of the concern, but also on team-specific factors reflecting available staffing and resources. Thus, thresholds are not static, but rather shift and flex to fit local conditions.

Whilst practices varied across our sites, we found a number of distinct commonalities reflecting the influence of the performance management elements of IAS and the concomitant preoccupation of staff with

maintaining 'workflow'. Workers consistently claimed that it was easy to lose sight of the primary activities of supporting families and safeguarding children, to the second-order activities of performance and audit. In the rest of this section, we will focus on the latent conditions for error created by this administrative regime. Our analysis of the five sites found that in well staffed teams, nested in a local context of adequate third sector or universal services, the 'latent conditions' for error might lie dormant or be mitigated. But, in situations of high referral rates and/or worker inexperience, turnover or sickness, the short-cuts that the system necessitated inevitably triggered the latent conditions for error. We illustrate these risky adaptations in the sub-sections that follow, limiting our report to three discrete aspects of the initial assessment process: (i) accepting a contact/referral, (ii) making further enquiries and seeing the child, and (iii) the completion of the IA record. Skilled workers will attempt to work around the limitations of IAS to minimize the possibilities for error, but IAS increasingly limits the scope for constructive professional discretion.

Accepting a contact/referral

Our sites reported variable 'referral' rates, ranging from eighty to figures significantly higher than 300 per month. In all but one site, far more contacts/referrals were received than could be managed. The recent requirement placed on the police to provide notification of all logged domestic violence incidents, irrespective of severity, contributed much to this increase. Such notifications, together with requests for information (and other seemingly trivial contacts) threatened to overwhelm teams that, at the same time, had to deal with requests for urgent help for children and families.

The requirement for an initial decision within twenty-four hours necessitates a rapid but not necessarily reliable response, and, where workloads are high, the potential for error is clear:

> Admin. worker: The phone will be ringing continuously, you put the phone down and it rings straight away ... one comes and another one comes ... and your mind just gets frazzled, I might have written 5 or 6 pages of A4 paper ... and when I come back to reading them, it's all looking a bit messy ... I can't quite make out what I've got down.

Such pressures created significant anxieties for experienced staff workers, who understood that the pace of work created less than ideal conditions for practice, but there was also evidence of 'speed-practices' becoming habituated and normalized, especially in newer staff, such as the following:

> Social worker: We are busy, exceptionally busy, you are never on top of things, but I am more able to accept that now, to start with I hated it, because I'm not like that and I like to get things done and to get them finished, but I've realized that I'm never going to be like that now.

For staff higher up the hierarchy, it was critical that only a manageable number of contacts or referrals were actually allocated for initial assessment. In the extract below, taken from one of our busiest teams, the team leader makes clear her reasons for clearing contacts by the end of the day, in anticipation of tomorrow's influx. The practical mandate for her actions is directly related to the exigencies of managing work-flow dictated by performance timescales:

> Team leader: There are 50 contacts in your inbox . . . you are under pressure because you have to clear them by the end of the day . . . and the question of whether you are more likely to close them in these circumstances? Well yeah . . . so, really we are looking to <u>close</u> cases not open them . . . that's why we work to the highest thresholds.

The IT systems maintained the pace of work, typically by providing digital reminders of deadlines and timescales. In one site, we found an e-tracking device in the form of traffic lights, which informed workers about how much time was left before the specific episode was deemed out of timescale. In another site, 'higher management' were planning to print out weekly graphs of levels of attainment in meeting targets, alongside tables exposing individual failures. Whilst local contingencies of practice shaped the actual conditions of pace, across our sites, we found much reference to key points in the working day; the start of the day was significant, bringing new work, whereas, by 3 p.m., anxieties were mounting as the close of business drew nearer and the day's tasks were not yet complete.

In order to manage the volume of referrals, we consistently observed that the teams had well established 'general deflection strategies' that included: *strategic deferment*, namely sending the referral back to the referrer to ask for more information; and *signposting*, deflecting the case to a more 'appropriate' agency. Whilst such adaptations are sensible if proportionate, the inherent risks are also clear. Where insufficient time precluded the pursuit of more detailed information from a referrer, other decision-making heuristics came into play. These included the routine categorization of anonymous referrals as malicious (indeed, referrals from neighbours and family members were also often treated as suspect). We were told that children aged thirteen, fourteen and fifteen were routinely 'NFA-ed' (i.e. 'No Further Action' was recorded) on the basis that these children and young people 'must have lived with these concerns for a long time and be quite resilient'. Similarly, we found questionable methods for dealing with the volume of domestic violence notifications often on the basis of scant information. For example, in one site, first and second notifications were always responded to automatically by a standardized letter to parents. We found that well intentioned, but very busy, workers became habituated to these methods of rationing, with little time to reflect on, or question, such rationales and the risks they entailed.

In the following extract, the worker indicates how the imperative to prioritize a case already categorized as child protection (section 47 of the 1989 Children Act) required that she give less priority to an incoming referral, which also sounded malicious. Although she acknowledges her lack of knowledge, she justified her decision as follows:

> Social worker: I've got this s.47 and actually this family are in crisis and I want to put support in for them, before I worry about this other family that don't even know I'm coming, because it's an anonymous referral from a neighbour … and you think, well OK, I don't know if there's a real risk or not, but from reading it it sounds a bit malicious, well this family, actually are about to fall apart if you don't put something in.

We also found that formulae used to compute staff workloads often compounded these decision-making biases. In one site, at the point of allocation for initial assessment, a workload weighting was attached based on an expectation of the work that the IA would entail. Whilst the assessment had barely commenced at that point, shared norms about the likely trajectory of the case enabled the formula to make sense.

In order to manage workflow, we also observed 'safer' locally improvised methods for meeting timescales that generally amounted to holding a case open for 'review', but logging the IA as complete on the system so as to meet the target. In cases in which the seven days has not provided sufficient time to establish confidence about the child's welfare, this 'review space' enabled further information to be gathered. In addition, and of equal importance, this space also protected the local authority from coming up against problems at annual review, when too many IAs were seen to convert to core assessments—another performance indicator that proved itself tricky to manage. However, such workarounds, even when they are constructive, by their very nature, can only survive while they remain undetected by inspecting agencies and their technological proxies.

Making further enquiries and seeing the child

A number of cases will get through the first layer of filtering and be allocated to a social worker for initial assessment, which will include making further enquiries and seeing the child. At this second stage, we also found short-cuts in operation. There was a tendency to abort an assessment whenever the 'opportunity' arose. In the case of the referral from a grandmother below, the routine treatment of referrals from family members as potentially suspicious, and that the health visitor had seen the child, together enabled swift disposal of the case:

> Team leader: Being a bit cheeky … we contacted the health visitor and said when did you last see the child and *lucky enough* the health visitor had seen the baby recently and it wasn't as bad as the grandmother had alleged … so we didn't take it any further, no further action.

Workers widely reported that the timescales created undue pressure. One senior practitioner observed: 'I personally worry about sometimes the time scales that you've, you've got to do it in . . . I've been sort of worrying about work for, for a while really.' The tempo and volume of work, together with the seven-day target for IA completion, were widely reported as making cases at this second stage equally susceptible to partial analysis and rapid disposal:

> Social worker: If it's not looking that serious . . . sometimes you don't get all the information and the temptation is then to take a short-cut and maybe not contact the school, or because the school are on holidays you say I think I've got sufficient information to make a decision- NFA.

Needless to say, school holidays are not factored into the seven-day time-scale! Neither are parents and children who are not at home, nor health visitors who are on sick leave and so forth. These factors necessarily interrupt the expeditiousness of the assessment process, but the system offers no accommodation for the individual tasked with the work. Thus, timescales can create perverse incentives to dispose early on the basis of incomplete information. Whilst, in many cases, an 'NFA' decision may be quite appropriate, our file analysis of open cases did find a common pattern of repeated initial assessments of escalating severity, before the case eventually found its way through the front-door.

Front line team managers played a key role in the operation of IAS. In some teams, they worked closely alongside new recruits to defuse their inevitable frustrations and induct them into 'local methods'. Managers could play a key role in mitigating the potential for errors, as the following extract indicates:

> Team Manager: I *always* look at what the referrals were saying what the concerns were at that particular time and then I look at the initial assessment to see if they have covered the history and whether they have identified repeated patterns of concern.

However, we also found some tension between workers and their managers regarding the primacy of meeting targets. For example, in a particularly pressurized team, managers described their frustrations with workers spending too much time 'social chatting' or needing lessons in 'diary management'; such critical attitudes would seem likely only to exacerbate work that was already stressful enough. Invoking 'safeguarding' could buy a worker more time, but only in cases in which there was a clear moral mandate to set aside the all-important target. The degree of assertiveness required to challenge the performance system could also lead to overt conflict:

> Social worker: My manager said to me 'why haven't you finished that yet?' . . . and I said 'well the health visitor hasn't called me back' . . . and they said, 'well no, if you've decided that it's family support, then the outcome won't change, whatever they say'. I said 'I disagree' and of course that information informs my assessment, I'm not putting my name to that.

Where workers were juggling the completion of IAs with cases needing to progress to case conference, 'NFA' was described as a welcome relief. Again, we see the latent potential for errors in this expediency; in the busiest of teams and in spite of the good intentions of workers, time precludes, for example, getting back to the referrer to inform him/her of a decision, which closes down any immediate challenge to the categorization.

Seeing 'the child' is a central and critical part of initial assessment. However, even in relation to this imperative, we found worrying short-cuts, as the following extract illustrates:

> Social worker: My new manager . . . she comes back and says, it [the IA] doesn't say have *you* seen the child, it says 'has the child been seen?', you can put 'yes' and then make it clear that the teacher has seen the child. I thought hmm, I bet the teacher saw Victoria Climbié as well, you know, what's the point me even doing an assessment if I haven't seen the children.

Children are not easy to 'see' under the conditions of initial assessment, for a variety of reasons. First, there is a requirement to see all children, irrespective of ages, but older children can be difficult to track down. Second, 'seeing' should involve talking to the child alone to make an assessment of the child's development and needs, but this is hard to achieve within seven days in a single visit.

With initial response to telephone calls increasingly mediated by administrative staff and home visits curtailed, the space between help-seeker and help-provider is steadily widening. Skilled workers might attempt to reduce this, but, for many, in the absence of knowledge derived from face-to-face work, they fall back on readily auditable justifications, often offered by fellow professionals, which invoke missed health appointments, school attendance problems and the like.

Completing the record

A standardized assessment record invites workers to comment on a range of factors relating to the child, his/her parents or carers and the presenting concerns. A general observation across our sites was the paucity of information recorded on the actual initial assessment document. In one site, we examined sixty-five records of individual children; the scantness of the information, compounded by the difficulties of piecing together fragments of narrative scattered across multiple boxes,[4] made it very difficult for the reader to glean a holistic picture of the child and his/her family. The IA record requires copious information that is difficult to garner from one home visit and from other professionals; it thus invites workers to discard the majority of its sections as irrelevant. With remarkable consistency, we found an expedient method of 'front and back-ing' (or 'back-to-back-ing') had spontaneously sprung up across all our sites, wherein middle sections of the document were omitted altogether:

> Researcher: So what about the middle of the document, because everyone seems to miss this out?
>
> Social worker: What middle document?
>
> Researcher: You know, practitioners are concerned with the referral and the outcome on the back, but what about all those pages in between about the child?
>
> Social worker: (laughing) To me well ... yes, there <u>is</u> a page about the child, I would always put in something, depending on what the child is like ... I would always put something in, but in IA you wouldn't ... this is *initial* assessment.

It was clear that workers were trying to make the form fit their work, as illustrated in the statement that 'this is *initial* assessment'. The assessment record was not only overly long, but the standardized questions and sub-headings were not easily adapted for this or that case (c.f. White *et al.*, 2008), so workers went straight to 'analysis' of 'that dreadful form', putting 'nothing-in-between'. Scrolling through the pages of the record ourselves, we found it difficult to distinguish between the material typed by workers and material already on the form, namely the numerous sub-headings and explanatory notes provided. Workers have become experts with the copy-and-paste function, as material is regularly repeated. In addition, the principle that, for every family, a record of each child was required tended to encourage practitioners to produce a general homogenizing account that 'fitted' all children:

> Social worker: If I know that the IA is more than likely going to turn into no further action, and I know that after I've had my conversation with the family, then I will massage the information on each of the children and talk in plural 'the children presented'.

Whilst workers were clearly attempting to work around the excessive audit demands of IAS, to salvage some time to spend with families, even the most perfunctory response left too little time for the real work of face-to-face comunication with families (Peckover *et al.*, 2008; White *et al.*, 2008). The speed with which workers attempted to complete the IA record also meant that errors of recording were common. Whilst workers were aware of these errors, it was difficult to make corrections, as material was often 'locked down' in the system after twenty-four hours, and special permission would be required to make changes. Very obvious errors, such as putting a case note in the wrong file, might prompt such requests, but not improve the wording of key records.

We have particularly highlighted aspects of risky practice in teams that were under pressure to demonstrate the latent conditions for error. It was clear that teams with lower referral rates and better resources could manage the tensions better, without the same recourse to risky short-cuts. However, even here, the demands of timescales and performance

management appeared to dominate and were not always seen as conducive to good practice with families:

> Social worker:... we're told by supervisors to work towards the timescales cos' it's their indicators isn't it,... they go off to the Department of Health, ... you're trying to think of the best outcomes for the family and for the child but...you're trying to get things done in timescales and get cases moved on, they don't want to hold cases in a duty and assessment team so it's moving them on, which is not, it's not always in their best interests.

Discussion

> A pilot that reveals a policy to be flawed or ineffective should be viewed as a success rather than a failure, having potentially helped to avert a potentially larger political and/or financial embarrassment .... Appropriate mechanisms should always be in place to adapt (or abandon) a policy or its delivery mechanisms in the light of a pilot's findings (Jowell, 2003, p. 3).

From our analysis, it is clear that the design of the modernized initial assessment system of children's statutory services is not only flawed, but that its dysfunctions provide the 'latent conditions' for error. To summarize, active errors are inevitable in the context of the short-cuts that workers, as end-users, operate to maintain workflow. Meeting performance targets, especially when the volume of incoming work threatens to exceed capacity, workers must make quick categorizations based on limited information; this will inevitably mean that some cases are filtered out that may require intervention. New referrals are considered in relation to cases already in the system and thresholds may thus be driven to unacceptably high levels in busy teams. Patterns of tacit reasoning can become entrenched as workers become habituated to methods of finding quick disposals. Pressures are compounded because practitioners must deal with incoming work whilst simultaneously progressing cases to initial child protection conferences. The ubiquitous 'front and backing' of the IA form indicates the lack of fit between tool and trade, leading to practitioners omitting whole sections. Even in the context of these short-cuts, data input demands seriously eroded valuable face-to-face time with children and their parents/carers.

Lipsky's concept of the 'street level bureaucrat' (Lipsky, 1980) emphasizes the importance of professional discretion in effective front line practice in the public services. Any system only functions when configured to suit local implementation contingencies; however, when faced with excessive rigidity, such workarounds may become defensive rather than innovative. Whether these short-cuts take the form of early categorizations based on incomplete information, or the fudging of details of a 'home-visit', all are attempts to cope with a system that is replete with design faults. As illustrated from our ethnography, it is preferable to dispose of a seemingly nebulous referral in the face of the more immediate performance demands

of the IAS. But it is often just those kinds of referrals that appear to be irrelevant, or somebody else's business, that can provide the warning signs of a more serious malaise.[5] Scarcity of resources will inevitably mean that giving priority to one part of the system, the most immediate, will result in cuts in another (Rustin, 2004).

The prevailing performance culture is also not conducive to honest and reflective feedback. Workers are too busy responding to the relentless targets, and, in a culture in which individuals are held accountable for error, and 'heads roll' in response to unfavourable audits, everyday errors will inevitably be kept quiet (Reason, 2000; Munro, 2005a; Fish *et al.*, 2008). Unfortunately, despite the huge volume of resources poured into these audits, the inspection process can seem to amount to little more than an elaborate game of cat and mouse, rather than a useful exercise of organizational learning in which pertinent 'systems-focused' questions are posed. When errors do surface in the context of a serious case review, public inquiry or inspection, a connection is not always drawn between one incident and the *routine dysfunctional practices* that created the conditions of its possibility. As Reason (2003) argues, public services are plagued with the problem of attempting to manage the last error, rather than examining the latent conditions that made the error more likely to occur. As we write, the case of Baby P is breaking in the UK press. The case illustrates the paradoxes of the inspection regime and many of the consequences of administration and audit.

Since the Laming report (2003), there has been a very significant reconfiguration of children's statutory services. However, the 'latent conditions' for error have not decreased; indeed, we would argue that the increased audit demands of ICS, together with on-going resource constraints, have served to further burden front line workers (Bell *et al.*, 2007; Peckover *et al.*, 2008). It is no surprise to have found that workers continue to pursue opportunities to deflect incoming work, and dispose of cases on the basis of superficial analysis, or to fall back on fallible heuristics such as 'it's probably malicious'. Although Clarke (2007) argues that decision making in public services takes place in less than theoretically optimum conditions, with workers responding to the immediate 'exigencies of the here and now' (p. 68), he argues that we should nonetheless aim to 'identify the ideal mode of decision-making' (p. 69). In social services, priority needs to be given to reduce the distance between workers, family and community that many studies have cited (by both service users and front line workers) as central to good practice (Pithouse and Holland, 1999; Gray, 2002; Ruch, 2005). We have seen that the IT-enabled, performance-driven IAS has created further distance between worker and service user, offering instead a scientistic veneer of codes, risk scores and metrics.

The findings we present are controversial and are presented in a designedly polemical tone. We draw attention to the multiple opportunities for errors on the part of front line professionals that are exacerbated

given the current configuration of IAS and its technological embodiment in the ICS. Our observations should sound a chord with assessment teams throughout England and Wales, if not further afield in cognate jurisdictions in the UK, North America and Australia. Performance management is designed to enhance rather than inhibit quality performance, yet our study has found this regime actually worsens the latent conditions for errors. Whilst it is tempting to berate the maverick professional who subverts correct procedure, it is important to remember that there are 'good' organizational reasons for such behaviours, namely reconciling the competing elements of the IAS with imperatives to safeguard children and to support families. The latter role, however prominent in current policy, is particularly vulnerable. Perhaps the real tragedy of IAS is that, in busy teams, inevitably, demands to *support* families will be routinely subordinated to pressures to maintain 'workflow'. We have seen such trade-offs in operation at both the macro (Figure 1) and the micro levels in our ethnographic despatches.

Although this paper challenges the huge investment in systems of performance management and IT, we are not arguing for a wholesale abandonment of new modes of governance and new technology. The remedy, we believe, lies elsewhere, in a radically different approach to design, to ensure that the tools we provide for our workers are fit for purpose (Munro, 2005b). The reader is referred to the paper's epigraph that underscores the need to found the design of systems on the needs of users and a thorough understanding of their working practices. This insight applies to the design of any artefact, be it a form, a simple process or a complex sociotechnical system such as the IAS, with integral technological and organizational subdomains. The case for user-centred design (UCD) has been cogently made in many design disciplines, including software engineering and human–computer interaction (Norman, 1998). The arguments are both ethical and technical. Technically, UCD is essential in order to gain reliable knowledge for designing new tools and processes. We believe that new systems and technologies can be developed that both assist the users in their daily work and achieve desired organizational goals, but without an ethnographically informed understanding of human practice (such as this paper provides);[6] this virtuous circle will not be achieved.

Failure to involve users in the development of new systems inevitably engenders alienation, and there were unmistakable signs of practitioner disquiet (concerns variously relating to additional workload, 'bureaucratization', form usability, etc.) in pilot studies of the assessment framework (Cleaver and Walker, 2004); further troubles have also been found in more recent 'evaluations' of the ICS (Bell *et al.*, 2007; Cleaver *et al.*, 2008). It is regrettable that such early warning signals apparently went unheeded, written off as 'implementation issues' rather than more fundamental problems of design dogma. In the context of the

present findings, the cautionary remarks of Horwath (2002) seem especially prescient:

> . . . there is a danger that the Assessment Framework will become form-led and interpreted merely as another procedure to follow . . . making sense of the information . . . becomes secondary and the focus on both identifying and meeting the needs of the child is lost [pp. 203–4] . . . the assessment triangle becomes a Bermuda triangle [p. 209].

Acknowledgement

1. We use 'technology' in its widest sense to encompass formally defined procedures and methods (administrative technology) as well as physical machinery, such as the ubiquitous personal computer.

2. The descriptor 'initial assessment system' (IAS) is used throughout the paper to convey a sense of the duty and assessment elements of practice as comprising a system of interrelated human and technological components, worker, machine, form, procedure and so forth.

3. National performance statistics for England show an average monthly referral rate of 306 for 2006/07. This figure is an estimated average referral rate for the local authority, rather than specific teams, and will be subject to significant variation.

4. The initial assessment form is typically ten pages in length. Apart from the usual administrative fields, there are well over twenty free text fields addressing the developmental status of the child and relevant environmental factors, including the child's 'social presentation' or 'self-care skills', the 'family's social integration', etc.

5. The Laming report (2003) identified that everyday biases contributing to errors of judgement in Ealing and Brent social services included the treatment of anonymous calls as *a priori* malicious. Victoria was referred twice by Ms Ackah, a family friend who asked to remain anonymous.

6. Ethnographic studies have shown time and again that even work that seems highly routine is a skilled accomplishment (Gasser, 1986); its orderliness is a product of the artful worker, not determined by the imposition of a formal rule-base. It is noteworthy that some design methods explicitly call for ethnographic engagement in order to develop a valid evidence base for design, such as the SPRINT methodology, which has been specifically developed for the public sector (Wastell *et al.*, 2007).

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