

Personal view

Case conferences for child abuse

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Case conferences have been an integral part of child abuse procedures since 1974 when the recommendations of the inquiry into the death of Maria Colwell were published. The case conference is a multidisciplinary forum for the sharing of information, for discussion, and for making recommendations to social services departments, which are ultimately responsible for the welfare of the child under discussion. In principle, therefore, case conferences are advisory rather than executive. In practice, considerable weight is usually attached to their recommendations. In some areas children leave hospital on the day of the case conference as a result of its decisions. In effect, the director of social services has delegated responsibility in advance to the local office managing the case. In other areas the director insists on vetting personally all case conference recommendations. Even so it is relatively rare for such recommendations to be over-ruled.

Few people love case conferences, and many hate them. Certainly their procedures are open to criticism on many fronts.

WASTAGE OF TIME AND RESOURCES

Case conferences can take two to three hours and involve 20 or more people. They can therefore cost between £500 and £1000 per conference in terms of working hours lost.

RAMBLING UNFOCUSED DISCUSSION

This contributes to the waste of time and resources, and if it is allowed to occur is largely the fault of the chairman. If members do their homework and the conference has all the necessary information to hand most decisions are so easy as to be foregone conclusions. One paediatrician known to the author used to forecast each case conference decision in writing and place it in a sealed envelope on the table before the conference. Having been proved right, he would then open the envelope at the end of the conference and reveal to members how much time they had wasted.

DOMINANCE OF HIERARCHIES

Too often the more junior social workers or health

visitors dealing directly with the family refrain from expressing their opinions because they are inhibited in front of their seniors. A good chairman should detect this and encourage them to speak up.

BUREAUCRATIC DECISION MAKING

Child care is a dynamic discipline requiring judgment and skill. Case conferences share the defects common to all committees in that they tend to discourage these attributes in searching for a consensus. This can lead to a 'safety first' mentality when most of the children are taken into care, rather than trusting the judgment of one key professional who feels that rehabilitation is the preferred option. Alternatively, the security derived from being part of a collective decision making process can lead to professionals colluding with each other to return children to situations of high risk, secure in the knowledge that there is safety in numbers and that the social services will have to shoulder most of the blame anyway.

This area of criticism seems to constitute quite a weighty attack on the whole structure of case conferences. On closer inspection, however, these criticisms are directed at human frailty itself. Again, the leadership of a chairman who forces the members to answer crucial questions will go a long way to prevent this failure.

IMPORTANT ABSENTEES

Busy consultant paediatricians occasionally resort to sending their juniors to case conferences in their place. This is to be deprecated as it is difficult for a senior house officer or registrar to speak with sufficient authority, either at the case conference or subsequently in court. Another common important absentee is the legal adviser to the social services. Again this is regrettable as it blocks decision making and wastes the time of those present.

The least defensible reason for important absentees is the deliberate failure to invite key professionals. The invitation list for the case conference that decided to 'rehabilitate' Jasmine Beckford is a noteworthy example.¹

SITTING ON THE FENCE BY PROFESSIONALS

The diagnosis of non-accidental injury is clearly the responsibility of the paediatrician, who, if he sits on the fence, does a disservice to the child, the parents, and the members of the case conference. Similarly, responsibility for the diagnosis of growth failure and developmental retardation due to neglect clearly lies with the paediatrician, who is also best placed to inform other conference members (and eventually the magistrates) of the seriousness of this condition. In older children who are subject to emotional abuse or deprivation an increasing responsibility rests with child psychiatrists who are themselves capable of sitting on the fence.

One possible reason for sitting on the fence by doctors is that they find it natural to remain non-committal unless they can make a diagnosis 'beyond all reasonable doubt'. They should be reminded that this degree of proof is required only in obtaining a criminal conviction and that the standard of proof required in the magistrates' court to obtain a care order is 'on the balance of probabilities'.

PHILOSOPHICAL DIFFERENCES BETWEEN PROFESSIONALS

An undercurrent of ideological disagreement is at the root of many 'stalled' case conferences where discussion goes round in circles. The commonest controversy is between those who favour 'rehabilitation wherever remotely possible' and those who favour the 'care option' in one form or another. This same controversy often simmers beneath the surface at many academic meetings on child abuse.

Because opponents seldom bring their ideological differences out into the open, it appears that their disagreement is simply about the particular case under discussion. The same professionals can have the same argument at 20 consecutive case conferences. Ideally, the chairman should recognise what is happening and invite the conference to acknowledge the gulf of reasoning that lies between some of the participants. Perhaps he can gently suggest that the opponents settle their differences in private.

PRESENCE OF PARENTS AS FULL MEMBERS OF CONFERENCE

Apparently, this practice is quite common in some areas. It is difficult to think of a better recipe for a collusive relationship with abusive parents against the interests of the child. A recent circular from the DHSS strongly condemns parental participation in this manner.²

LAST MINUTE DOWNGRADING OF A CASE CONFERENCE TO A CASE DISCUSSION

This is an infuriating device occasionally used by social services as a form of passive resistance. In

essence it is a very simple manoeuvre, which involves failing to invite key professionals, turning up without a chairman or legal adviser, and not taking any minutes. From bitter experience I have found that the only effective counter is to refuse to participate and to renew requests for a full case conference.

UNDUE RELIANCE ON LEGAL ADVICE

Some legal advisers like to maintain a 100% batting average in the courts and accordingly err on the side of caution regarding care proceedings. Such pessimistic advice should not be accepted uncritically when members feel strongly that statutory control is needed. Legal advisers are the servants of social services not the masters, and can be instructed accordingly.

None of these extensive criticisms is aimed directly at the institution of the case conference itself; they are aimed at areas of practice not of principle, and all the areas criticised are amenable to correction.

The ideal case conference

The conference should have a time limit of one hour and should start promptly. The chairman should be from social services but with no direct role in the management of the case. He should attempt to combine the bluntness of Churchill with the wisdom of Solomon. The social worker (and where appropriate the health visitor and paediatrician) should have prepared duplicated reports which are handed round and studied for five to 10 minutes. No one should be allowed to read out their reports. The contents of the reports are then open to discussion, and other contributions should be invited. The chairman then asks the conference to address itself to the following questions:

- (i) have significant episodes of abuse or neglect occurred?
- (ii) why have they occurred?
- (iii) how likely are they to recur?
- (iv) what action is required?

If the answers to these questions are clear cut discussion should be brief and to the point. If strong disagreement exists the chairman should allow the opposing views to be put clearly (by specially appointed devil's advocates?) and then invite the conference as a whole to commit itself to one or other view rather than strive for too long to reach an unsatisfactory compromise. Whether decisions should actually be put to the vote (and whether everyone who attends is equally entitled to vote) is a matter for debate. Certainly clear opportunity should be given for individual members to record

their opposition to decisions, and as a last resort to dissociate themselves from the management of the case.

Despite the many criticisms of practice outlined above, most paediatricians would not dream of questioning the place of the case conference in child care work. Surprisingly, the Society of Clinical Psychiatrists holds a different view. In a paper, from which extracts were published in this journal recently,³ the authors argue that case conferences are 'pernicious . . . dangerously irresponsible . . . inherently ineffective,' and 'should be abolished'. The authors protest at the gross breaches of confidence that case conferences lead to for 'their clients'—that is, the parents.

Paediatricians have children as their clients and will surely find this stance astonishingly negative. A

detailed rebuttal of this view has already been made in this journal.⁴ For better or worse, case conferences remain a vital part of the procedure for dealing with child abuse, and it is difficult to imagine any satisfactory alternative.

References

- ¹ Report of the panel of inquiry into the circumstances surrounding the death of Jasmine Beckford. *A child in trust*. 1985:100.
- ² Department of Health and Social Security. *Child abuse—working together*. London: DHSS, 1986:19.
- ³ Society of Clinical Psychiatrists. Case conferences for child abuse. *Arch Dis Child* 1986;**61**:1141.
- ⁴ Bentovim A. Case conferences—for child abuse. *Arch Dis Child* 1987;**62**:316–7.

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