The paralysis of practice in child safeguarding

understanding and responding to deceptive practices

by parents and carers in the child safeguarding context

This thesis is submitted in partial fulfilment of the requirements for the award of the degree of Doctor of Philosophy of the University of Portsmouth

Leah Fox, MA, MBA
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Abstract

The research reported in this thesis aims to evaluate the current child safeguarding practices adhered to by practitioners to identify and respond to deception in parents and carers. The thesis also aims to establish whether any developments in professional practice could contribute to the reduction of child homicide and serious abuse.

This study employs a qualitative approach drawing on secondary data from Serious Case Review (SCR) overview reports, and on primary data through interviews with key participants and frontline child safeguarding professionals in England and the United States, as well as ethnographical observational fieldwork. Although this thesis primarily focuses on the work of practitioners in police, social and health care services in England within the scope of their roles in child safeguarding, the experiences of child safeguarding professionals in the United States are drawn upon to provide an insight into any alternative strategies to deal with potentially deceptive parents.

This current research reveals that amidst the widespread occurrence of deceit, child safeguarding professionals are well attuned to it on the whole and are largely aware when they are being lied to by parents. Although no specific deception detection training is offered to professionals to assist them to detect parental deceit, a combination of approaches, including intuition, verbal and non-verbal signs of deception, as well as practice wisdom, are employed by these professionals to help them recognise the signs.

It is the professionals’ subsequent response to the deceit that determines the effectiveness of their decision-making, and the extent of interventions in relation to the child. The research has revealed serious and concerning deficiencies in the response to parental deceit.

The differentiated response by professionals to suspected or confirmed parental deception is underpinned by organisational values and ethos, but is largely actioned through the paradigm of relationship-based practice and the ‘working with families’ culture.

The study concludes that professionals need to accept that parents will lie in order to cover their abuse, and they should view parental deception dispassionately and objectively. The culture of any child safeguarding organisations needs to reflect this reality.

341 words
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**Appendix B:** Interview schedule 1a: Key participants (initial)

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Declaration

Whilst registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award.

Word count: 75,064 words
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Acknowledgment

To Professor Nash and Dr Fox for being truthful
Dissemination

Two presentations, both titled "Trapped in a 'relationship'" and both addressing the emerging findings which formed Chapter Six of this thesis, were delivered at the following events:

- BASPCAN Child abuse review national conference 'Evidence-Informed Practice, Practice-Informed Research' on 18th November, 2016, Birmingham;

- The international and intercultural week 'Human Rights', VIVES University during 27-31 March, 2017, Kortrijk, Belgium.
One  Introduction and structure of thesis

1.1  The aims, the origins, the value, and the potential impact of this research

The crime of child abuse claims many victims. The most obvious sufferers, the children, are deeply affected by it (Radford et al., 2011). The abusive parents themselves are often victims of abuse in their own childhoods, but perhaps, less often considered, the professionals who confront these distressing circumstances can become victims of practice they subscribe to when responding to and dealing with the allegations of child abuse.

This research aims to examine whether the culture, current practice and organisational support for child safeguarding professionals enables and equips them to assess the veracity of parents and carers during the assessment process and professional contact, and enables them to make appropriate decisions.

This study explores the following key questions:

1. Do child safeguarding professionals feel able to detect deception in parents and carers?

2. What is the response of child safeguarding professionals to suspected or identified deception in parents and carers?

3. Does current training properly equip child safeguarding professionals to identify deception and disguised compliance, and challenge and rebut lies told by parents?
4. Are there strategies already established within the criminal justice investigative arena in relation to deception detection which might be useful, and if so, are they transferrable to child safeguarding work?

5. Is there, within child safeguarding, a dogmatic culture of "working with families at all costs", and if so, what effect, if any, does it have on child safeguarding professionals’ ability to challenge non-compliant parents and carers?

6. What role, if any, does the family-centred practice play in the way child safeguarding professionals deal with potentially deceptive parents and carers to ensure that the best interests of the child are met?

As will be more fully explained in subsequent chapters, the inspiration for the current study emerged through the experiences of the researcher as an established professional who has worked in the child safeguarding arena in the UK and United States for approximately seven years.

In particular, a poignant professional anecdote provided by one of the researcher’s former colleagues is a useful scene-setter for what the next 366 pages are all about.

The former colleague (who shall be referred to as 'the worker') was 22-year-old Natasha’s social worker for two and half years. Natasha became known to social services due to allegations of neglect and the physical abuse of her only child: the 3-year-old boy came to the attention of authorities with numerous burns on the lower parts of his body, a scabies infestation, and a severe speech impairment as he was unable
to talk or respond to most basic verbal instructions. Although initially denying any wrongdoing, the mother soon accepted her responsibility for the abuse and agreed to “change” so that she could “get her son back”. The worker strived tirelessly with service providers to address, among other issues, the mother’s history of abuse as a child, as well as ongoing mental health issues, drug misuse, and having multiple violent partners. The worker empathised with these circumstances, felt for what the “poor girl” had been through in her life, and saw her as a victim. The worker argued she “went out of her way” to enrol Natasha in an in-patient drug clinic and facilitated long visits between the mother and child. As the time went on, she started to become confident that the mother was making the necessary changes because after all, she was a “good parent” and wanted the best for her son. The drug tests were coming back all clear, the providers commented on how “engaging” Natasha appeared in parenting classes, and Natasha herself said repeatedly that she wanted to focus on her child only and did not want any men in her life. She claimed that she “hated” her prior life and what it was doing to her boy. Coupled with the feedback from service providers working with Natasha, the genuineness of such an attitude and behaviour was never disputed- the worker believed Natasha had become “a new mum”. She was supported in her judgement by her supervisor. It was not until Natasha was released from the clinic, whilst continuing testing negative for drugs, that the worker found out through Natasha’s grandfather (largely by chance), that Natasha had been cheating her tests all the time, continued seeing her abusive partners, and in fact, persisted in maintaining the lifestyle she always led. The talks of a change were no more than a charade. Upon learning of these facts, the worker’s reaction was emotionally devastating. The
effect of being deceived manifested itself in several ways. First, she blatantly refused to believe the facts (“I just cannot believe it”; “It just does not make any sense.”). Consequently, the worker became enraged at “being taken for a fool” (“How dare she? After all I have done for her?”) and finally, she felt foolish and embarrassed for not being able “to see the obvious.” The worker took long-term sick leave citing mental health issues. She did eventually return to work, but her confidence was permanently undermined as she felt mistrusted by her supervisor, but more notably, by her own self.

This anecdote highlights some of the inherent complexities of child safeguarding work amidst the public’s expectations of professionals in this field to be able to identify and manage risk for the child in question. Yet it does not depict a set of rare or atypical circumstances, because although every family is unique, every professional tasked with keeping the child safe would be involved in assessing a parent for the veracity of their statements, declarations, behaviour, and notably, any positive changes that parents have allegedly made in their lives. During her career as a social worker and a child abuse investigator, the author often found herself in a situation of making key decisions relating to child safety and wellbeing, and has assessed many parents, sometimes openly resistant and outright hostile, but more often than not seemingly truthful, or possibly showing feigned compliance. The latter phenomenon was perhaps the most worrying because it was very difficult to assess how much of the carer’s communication was genuine and not based on their objective ‘to play the system’, which in turn made the decision about the carers’ readiness to be reunified with their children a difficult and dangerous one to make. Detection of deception, and the organisational response to deceitful parents proved to be one of the most challenging aspects of the job, and it
was often felt that tackling the issue lacked a systematic and rigorous approach. Yet the consequences of a safeguarding professional failing to identify deceit, or failing to challenge the deceit when recognised, can be immensely dangerous and in some cases, as in the highly publicised deaths of Victoria Climbé (Laming, 2003) and Peter Connolly, sometimes known as Baby P (Laming, 2009), catastrophic for the children involved. This can also have a debilitating effect on professionals in child safeguarding as the public are often too quick to blame the child protection system and its ‘inadequate’ workers (Munro, 2011).

Thus for practitioners involved in child safeguarding, whether social workers, teachers, police officers or health workers, assessing a parent or a carer (both definitions will be used interchangeably throughout this thesis) amidst the circumstances of suspected or verified child abuse is fundamental to their roles. Whilst having the responsibility to safeguard the child, the professionals are required to identify and appropriately respond to ‘causes for concern’ that the child is suffering or likely to suffer significant harm when in the care of their parents. Undoubtedly this involves assessing the veracity of parental assertions and positions the detection of deceit at the heart of child safeguarding practice.

Despite evidence that people tell lies on a daily basis (e.g. Vrij, 2008), and acknowledging that detection is embedded in child protection work (Ferguson, 2011; Dale et al., 1986; Reder et al., 1993; Calder 2008), the literature examining the rationale behind professional decision-making when engaging with potentially deceitful parents is scarce.
Some of the evidence examining the practitioners’ response to deception is offered in serious case reviews (SCR), the local authority multiagency reviews of a child death or a serious injury where neglect and abuse was a factor. The reports into many such reviews provide a useful source of information about how local professionals and organisations work individually and together with parents to safeguard children (HM Government, 2010). These reviews are invaluable as they uncover the actions behind the decision-making, particularly where indicators about significant harm were overlooked and opportunities to protect the children were missed by professionals. However, they have two notable limitations. On the one hand they often do not sufficiently delve into the underlying reasoning process behind the professionals’ decisions, thereby leaving the why question largely unanswered. On the other hand, by the nature of such reviews and referring to parents in terms of a continuum (Calder, 2008), the SCRs’ focus is mainly on parents on the right end of the spectrum (Figure 1 below), whose engagement with child safeguarding professionals is often characterised by prevalence of deception, hostility and lack of cooperation. Within the reviews however it is argued that not enough consideration is afforded to the professionals’ interaction and the decision-making involved with parents to the left of the spectrum, who account for the majority of carers in child safeguarding, especially as the latter move through the continuum from the left to the right end of the
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This focus on a relatively small proportion of parents thus creates the impression that the cases in the reviews do not offer a true reflection of typical child protection practice (Brandon et. al., 2012) which does not normally result in such a grave outcome for children, and that professionals are largely successful in managing risk when working with all other parents. In relation to deception, parents on the right side of the spectrum are portrayed as "intentionally deceptive or manipulative" (Laming, 2009, p.51) with all parents being seen as generally decent, although vulnerable, but nevertheless wanting the best for their children. This reinforces the perception that professionals are rarely confronted with deceitful parents. What sometimes is missing from this analysis is the fact the professional decision-making in relation to uncooperative parents, and in particular, their response (or a lack thereof) to the accumulation of risks to the child, influences their actions with potentially deceitful parents to the left of the continuum, who may be motivated to lie for a variety of reasons. Thus the way child safeguarding professionals deal with uncooperative parents, who arguably require quick interventions, clouds their judgement in
dealing with seemingly cooperative parents on the other side of the spectrum, who make up the vast majority of service users.

This research aims to bridge this gap by critically evaluating the orthodoxy of current safeguarding practices used by professionals to detect and respond to deceit in abusive parents and carers.

Research data in the UK indicates that children under 1 year of age are four times more likely to be victims of homicide than people in any other age range (Brookman & Maguire, 2003), and statistics reveal that more generally, children aged under 16 years represent approximately 10% (54 in 2015) of the recorded homicide victims, with approximately 60% of these victims being killed by a parent or a care (Office for National Statistics, 2016). Accepting that one of the reasons that prompts parents to lie to professionals is to hide the abuse and neglect to which they are subjecting their children, this research also aims to establish whether any developments in professional practice could contribute to the reduction of child homicide and the crime of serious child abuse. In a sense, it represents the researcher’s “drive to chase a long-held question” (Petre & Rugg, 2010, p.2).

1.2 The chosen approach

With the bulk of child safeguarding research and inquiries focusing on organisational systems and inter-professional communications, this research draws on the works of Ferguson (2010; 2011; 2014) and Forrester et al. (2008a and 2008b) to examine how practitioners in this line of work interact with parents, and what underlines their decision-making when conducting child safety risk assessments. It explores the effect these decisions have on the practitioners
themselves, both personally and professionally, and how it influences their subsequent decision-making and practice.

This thesis primarily focuses on the practice of key professionals in police, social, and health care services in England, within the scope of their roles in child safeguarding. When brought into contact with children and families, these key professionals have a legal duty to protect children from harm and promote their welfare (HM Government, 2015). Their roles and duties were explained in full in a previous edition of the Working Together to Safeguard Children guidance (HM Government, 2006) as follows:

**Children’s services authorities (social services):** have specific duties in respect of children under the Children Acts 1989 and 2004. They have a general duty to safeguard and promote the welfare of children, provided this is consistent with the child’s safety and welfare-whilst working in partnership with parents. They are “responsible for co-ordinating an assessment of the child’s needs, of the parents’ capacity to keep the child safe and promote his or her welfare, and of the wider family circumstances” (HM Government, 2006, p.43);

**Health services:** are responsible to “make arrangements to safeguard and promote the welfare of children” by “protecting children from maltreatment, preventing impairment of children’s health or development, and ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.” This applies to all health professionals who work with children and families, who “should be able to understand the risk factors and assess the needs of children and the capacity of parents /carers to meet their children’s needs” (HM Government, 2006, pp.46-47);
The police: are responsible for safeguarding and promoting the welfare of children. Their duty is to investigate criminal offences against children, "contribute swiftly to inter-agency requests in addressing any perceived risks." Their role is to understand the risk factors and assess the needs of children and the capacity of parents/carers to meet their children’s needs (HM Government, 2006, pp.60-61).

As set out in the above cited guidance, all these professionals must have "arrangements to ensure that all staff undertake appropriate training to equip them to carry out their responsibilities effectively" (HM Government, 2006, p.41).

The rationale behind targeting these specific groups in this research is to examine any effective methods or strategies utilised by professionals in these organisations to manage risk with potentially deceptive parents that could be transferred across child safeguarding practice.

Given the children’s services authorities’ lead role in child safeguarding imposed by the legal framework (DH, 2003), inevitably in some areas throughout the thesis the focus of discussions is centred around social care practice. However great care is taken by the researcher to provide a balanced examination of child safeguarding practice as a whole in order to represent a “systems approach” (Munro, 2011).

Additionally, this research draws from the experiences of child safeguarding practitioners in the United States. Since historically both the UK and the USA have been characterised as adhering to a child protection approach (Gilbert, 1997; Munro & Manful, 2010), that is not punctuated by a radical departure from the core principles
of child safeguarding practice, an insight, rather than a comparison, into alternative strategies for dealing with potentially deceptive parents is utilised within this thesis to identify strengths and weaknesses in professionals’ practice on both sides of the Atlantic.

With the narrative above dedicated to the detailed description of the approach utilised in this study, it is felt that a brief explanation about what this research is not about may be particularly useful given the nature of the study. The discipline of psychology has studied deception at great length, offering a plethora of academic literature that explores indicators of deception (Vrij, 1993; Vrij & Mann, 2001a and 2001b) as well as the professionals’ ability to detect lies in adults (Ekman & O’Sullivan, 1991; Mann et al., 2004; Reinhard et al., 2011) whilst using a variety of specific lie-detection tools and instruments (Vrij et al., 2006; Bond & DePaulo, 2006, Hartwig et al., 2004). Most of these studies however are carried out in an experimental environment where many aspects of the natural work in a professional context are missing. The fairly recent use in England of polygraphs and eye testing techniques to assist in the risk assessment of sex offenders, as pioneered by Professor Don Grubin, University of Newcastle (Grubin & Madsen, 2006), is still being evaluated, and even so the context of such use is very different from that of child safeguarding and working with families.

Additionally, although some studies provide a useful insight into the nature of deception and how it is understood by professionals, they do not offer a full view of how parental deception is experienced and dealt with by individuals in the child safeguarding context.

Thus it is felt that in order to explore the nuances behind professional decision-making it is important to explore deceit not through the
notion of psychological science, but rather from the practical perspective of professionals involved in work with parents.

Additionally, the current research does not offer a full evaluation of individual organisational cultures or the effectiveness of intra-agency cooperation, despite these issues being referred to extensively throughout this research to provide important context.

1.3 The surrounding context of this research

Before examining the approach to the current research, it is important to explain what is meant by ‘child safeguarding’, how this concept has developed, and the emergence of the abovementioned professionals at the heart of this practice, thus providing the context for the study.

In respect of the modern era of protecting children, the term “safeguarding” was defined by the first Joint Chief Inspectors’ Safeguarding Children Report as “all agencies working with children... and their families to take all reasonable measures to ensure that the risks of harm to children’s welfare are minimised, and where there are concerns about children and young people’s welfare, all agencies to take all appropriate actions to address those concerns, working to agreed local policies and procedures in full partnership with other local agencies” (Chief Inspectors’ report, 2002). Representing a shift from the long-established child protection approach to encompass wider concerns about the welfare of a child, the concept of ‘safeguarding’ was redefined by the Victoria Climbié Inquiry (Laming, 2003), and subsequently, formalised in the Children Act 2004.
Historically however it was not until the late nineteenth century that the interventions of child protection policy in Britain were aimed at injustices within the family (Cleaver & Freeman, 1995). Prior to that the primary objective of the welfare legislation relating to children was to combat issues outside the family and tackle social conditions such as delinquency, poverty, health and education. The domestic affairs of a traditional patriarchal family, including the use of physical punishment on children, were left unchallenged by the State (Parton, 2006; Frost & Stein, 1989).

Nevertheless, social regulation not based on the family and community was no longer sustainable amidst famine and riots of the 1850s and 1860s, and the elevated state of moral panic these triggered over threats to social order by destitute children (Parton, 2006). During this period, the children came to be seen as both impetuous (hence in need of control) and vulnerable (and therefore in need of protection), a notion that resulted in a child becoming the core of the child safeguarding policy (Foley et al., 2003; Parton, 2006). In 1889, upon establishment of the National Society for the Prevention of Cruelty to Children (NSPCC), Parliament passed an act to protect children from abuse and neglect, mandating the State for the first time to intervene in the relations between parents and children and allowing public agents, including police and social workers, to protect children within their homes (Parton, 2006, Cleaver & Freeman, 1995; Ferguson, 1990).

In the United States during this time interventions to protect children were already taking place, albeit sporadically and initially, by the non-governmental child protection societies only (Myers, 2008). By this time both prosecutors and courts already had powers to intervene to ensure the child’s wellbeing, and as early as 1642 Massachusetts had a law that gave magistrates the authority to
remove children from parents who neglected their children (Myers, 2008). In 1874 the New York Society for the Prevention of Cruelty to Children (NYSPCC), the world’s first entity devoted entirely to child protection, was established, which preceded by around 20 years the establishment of the NSPCC in Britain.

Yet despite the focus of such interventions on both sides of the Atlantic being the wellbeing of a child, the role of the authorities in such interventions was seen as to assist the families in need by very much strengthening the family ties (Parton, 2006).

Following a series of child abuse scandals in the 1970s and 1980s however, child welfare services in England became dominated by “a narrow, legalistic, and forensically orientated focus on child protection” (Parton, 2014, p.2043) characterised by the identification of high risk cases attributed to ‘dangerous families’ (Parton & Parton, 1989). This development was taking place in other nations including the United States (Parton, 2014). During this stage, however, the importance of the role of the family was largely left intact, which in turn resulted in the resurfacing of family partnership-driven approaches between child safeguarding professionals and parents in the mid-1990s and extending into the late 2000s (Parton, 2014). In response to the Victoria Climbie public inquiry and consequent findings of the Government Green Paper ‘Every Child Matters’, the Government in 2006 issued revised Working Together statutory guidance with the term ‘safeguarding’ firmly underpinning the practice of professionals working with children and families (HM Government, 2006). In this guidance the protection of children from ‘significant harm’ (Children Act 1989 s.31(2)(a)) was to be accomplished by an integrated approach of joint working between agencies and professionals, whilst promotion of children’s welfare was to take place within the context of their
families’ lives (HM Government, 2006); whereas the local authorities’ preventative and participatory measures of providing parents a range of support services to meet the needs of children (Parton, 2014) were implemented to reduce the likelihood of parents abusing their children. The role of prevention, including tackling negative factors such as inadequate parenting and substance abuse dependency, and enhancing parental protecting capacities by provision of housing, employment and strengthening family ties, was evident in Every Child Matters: Change for Children programme (DfES, 2004).

Thus, criminal justice, social care, health and education agencies’ professionals were to work together in earlier identification of risks as well as provision of opportunities to families in order to prevent child abuse. A standardised process of gathering and recording information about a child at risk, whist identifying their needs and how to meet them, otherwise known as the Common Assessment Framework (CAF), was introduced at this time (DH, 2004).

Similarly, familial support was at the core of the child protection practice in the United States (Keenan, 2006) and it has been favoured by federal legislation since the 1970s. In a majority of States federal funding is allocated to schemes to help families stay together and individual States have to make ‘reasonable efforts’ to prevent the removal of children from their homes. Miller (2012) argues that the importance of family and family centred services is particularly acknowledged in health care settings and should also be advocated in social work. In fact, Briar-Lawson (1998, p.543) considers families "as foundations for welfare state investments” and discusses the prevalence of family-partnered approaches in the USA.
In their evaluation of family preservation prevention programmes and strategies, Huebner et al. (2012, p.221) argue that “more funding and support should be directed toward collaborating between public and private agencies to strengthen families and enhance community and professional systems of care with in-home preservation services and other family-centred interventions”.

Parton (2014, p.11) however argues that the 2007 death of Baby Peter Connelly, who suffered over 50 child abuse injuries, and the consequent public outcry in the UK, resulted in a reinforcement of ‘the importance of child protection in the centre of safeguarding policy and practice with a particular emphasis on early-intervention to prevent children from significant harm; a view supported by research elsewhere. Such interventions were to include the assessment of parents for deception which needed to be factored into the professionals’ decision whether or not to intervene to protect the child (Tuck (2013) in citing Laming (2009)).

Furthermore, commissioned by the Coalition Government, an independent review of child protection in England by Eileen Munro (2010, 2011) acknowledged that some parents were inevitably resistant to interventions and that professionals needed to “develop professional expertise” (Munro, 2011, p.6) in order to promote safety and welfare of children.

Yet despite the numerous reforms in the child safeguarding arena and the increasing number of children on a child protection plan (NSPCC, 2017), it is argued that professionals continue to miss the signs of parental deception, as evident in more recent child deaths (e.g. Ajit Singh, Ayeeshia Jane Smith etc.) and serious abuse (BBC, 2010; Stevenson, 2016) cases.
In the United States several cases where professionals missed signs of deception and manipulation in parents were also subject to public scrutiny. In New York City, when examining 38 deaths involving vulnerable children on the child protection register of the Administration for Children’s Services (ACS), an agency responsible for protecting abused and neglected children in NYC, the *Audit Report on the Administration for Children’s Services*’ found that “without reform [the outcomes] will continue to prove fatal for an unknown number of children who will foreseeably need to rely on ACS for protection from abusive individuals in their own households” (NYSOCFS, 2016).

Arguably the underlying reasons behind the failings of the child safeguarding agencies on both sides of Atlantic are complex and may be attributed to a number of factors, including the increasing number of referrals, “high caseloads, finite resources and not having enough quality time to undertake direct work with the children and families” (Stevenson, 2017).

Although the researcher acknowledges these factors as important, this thesis examines whether these failings can be attributed to how child professionals deal with potentially deceptive parents in their daily practice.

It is with this background and context in mind, the current research will explore the key questions included on pages 7-8 of this chapter. To achieve this, the remainder of this thesis is divided into seven chapters.

Chapter Two provides an overview of the relevant literature into the prevalence of parental deception and resistance in cases of child homicide and serious abuse. Additionally, the chapter examines the
ability of child safeguarding professionals to detect deceit in abusive parents and carers and the array of methods and techniques available to these professionals, both in England and the United States, to detect deceit and evaluate resistance. This chapter is divided into two parts: Part One deals with academic literature whereas Part Two provides an overview of serious case review reports.

Chapter Three outlines the methodology used in relation to this research and explains the rationale behind the chosen approaches. The explanation includes the research design, methods employed as well as relevant ethical considerations.

The subsequent four chapters provide both findings and analysis of empirical research. This is arranged so that the reader is able to follow the arguments by the researcher as well as the corresponding inferences.

Chapter Four explores how deception is rationalised by the professionals working with children. It examines the common tactics utilised by parents to deceive professionals and investigates whether the professionals are able to identify these. This chapter provides findings in response to research question 1.

Chapter Five looks into specific strategies and methods available to practitioners to detect deceit in abusive parents. The role of the assessment and the interviewing process, as well as any training opportunities afforded to child safeguarding professionals, are discussed. This chapter provides findings to research questions 3 and 4.
Chapter Six examines the response of professionals to deceit by parents in the context of their organisational practice and provides answers to research questions 2 and 5. The concept of a ‘professional relationship’ is fully explored.

Chapter Seven explores the context of family-centred practice and the ability of professionals to strike a balance between being caring and sceptical when dealing with potentially deceptive parents. The findings of this chapter provide a response to research question 6.

In concluding this thesis, Chapter Eight offers a summary of conclusions, as well an explanation of some limitations of the current research and suggestions for further work in the area.

Before continuing, it might be useful briefly to mention the tone taken in this thesis, and perhaps to offer a disclaimer. Later on, there will be a discussion which reveals that in everyday life, many people are uncomfortable using, or hearing, strong terms such as ‘lying’, or ‘deceit’ because it jars upon their sensibilities. Such words are used frequently, and without apology, in this thesis, yet they are not used gratuitously, or in a pejorative way. Bearing in mind the context of the study it would be disingenuous were the author to seek to soften the tone of the writing to make things more palatable for the reader, yet it is recognised that some readers may find the tone rather uncomfortable at times and some may recoil from the text. Unfortunately, ‘confronting the uncomfortable’ is the everyday reality that many professionals are faced with in child safeguarding work and this study will not shirk from its mission in fully exploring that reality.
Two Identifying and dealing with deceit in abusive parents: The review of the literature

2.1 Introduction

This chapter offers a review of the key literature concerned with ascertaining the ability of child safeguarding professionals both in the United Kingdom and the United States to identify the signs of deceit and resistance in parents and carers and evaluating their consequent practice response. In Part One, the chapter starts by exploring the prevalence of parental resistance and deception in the child safeguarding practice and establishes a link between the two concepts above. Furthermore, the ability of practitioners to detect deception in adults is examined and the deception detection methods identified in the literature and utilised by child safeguarding professionals in the UK and USA are discussed. The professionals’ response to suspected deceit in parents is explored and the examination of some individual and organisational factors that might affect the child safeguarding professionals’ decision-making is provided. Finally, in Part Two the review of the literature concludes by offering a comprehensive synopsis of the evidence of professional decision making from cases where children died or were seriously harmed and where parents were deceitful with the professionals involved.

Literature search strategy

For Part One of the review of academic literature, a “non-committal” literature review (McCallin, 2003) was undertaken first in order to align the research questions to the existing body of knowledge on
the topic, yet also to allow the researcher to maintain openness of mind in order to stay clear of the predefined concerns and solutions. This was consistent with the principles of the Grounded Theory method utilised for this study (McCallin, 2003; Urquhart, 2013) and it allowed the researcher to assess the contribution of existing literature to the chosen topic and identify any gaps in the research thereby providing a rationale for the current study.

Upon examination of the topic under study by the researcher, the literature search strategy for the “non-committal” review identified *deception in parents and carers, detection of deception, child safeguarding practice, child safeguarding professionals, training, work with families* as some of the key component areas to examine. A list of primary keywords and phrases, including synonyms was created and comprised of words and expressions such as *deception and parents, detecting deception, family practice, professionals who work with families, safeguarding, deceit, lies by parents, challenges in safeguarding, working with parents in child safeguarding*. English only text was used. The researcher alternated between broad and narrow searches using Boolean operators (and, or, not) in order to maximise relevant results.

Using the University of Portsmouth library catalogue and Google Scholar the search utilised multiple bibliographic databases such as *Web of Science, Global ChildNet, Community Care, CINAHL, The Campbell library, Research in practice, ICPR, Lexis, PoliceProfessional.com* for existing studies, both quantitative and qualitative, and other peer-reviewed publications relevant to the research. Additionally, some key journals such as *Child and Family Social Work, Journal of Social Work Practice, Child Abuse Review, Child and Family Law Quarterly, Social Work in Health Care, Journal of Social Work, Applied Cognitive Psychology, Psychology, Public*
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The researcher also consulted relevant academic books, relevant organisational publications including guides and reports and any ‘grey literature’ including government reports, policy statements, working papers and conference proceedings, theses, white papers. Although the search focused on the developments in the last four decades, the search extended to the earlier periods in order to examine the historical context behind some of the key concepts.

To keep up to date with current literature, the researcher had also subscribed to relevant journal, publisher and database alerts.

The literature search strategy concentrated primarily on the US and UK based studies and excluded research carried out elsewhere, as it was deemed most appropriate given the parameters of this current study.

As the current research progressed and evolved as a result of coding and analysis, the researcher undertook the final literature review to apply the generated concepts to the existing literature to focus on more selective concepts. For example, following the analysis of data more selective keywords /phrases such as relationships in child safeguarding, the value of motivational interviewing, organisational culture and practice were used to promote more focused search. This represented the comparative/integrative stage (Martin, 2006) of the literature review. This aim of this stage of the review was to bring out literature that was left largely untouched in the initial “non-
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committal” stage, identify the key authors holding the established viewpoint and confirm the development of the current research as either being challenging to these preconceived positions or strengthened by them.

In relation to the literature search strategy of professional publications examined below in Part Two, these were selected from the NSPCC National Case Repository in the UK using the search keywords (including synonyms) such as deception, non-compliance, resistance, social work practice, police, professional curiosity, health visitors. The search covered the period from June 2010 (with full reports only having been made available to the public since then) up until 2016 (upon the completion of the analytical stage of this current study). The search included cases in England as was set out by the parameters of this study. The examination of similar types of cases in the United States was informed by the search of the NYSOCFS site using similar keywords and time period above.

The following sections provide a detailed summary of the literature review utilising the search strategy mentioned here.

2.2 Part One: What is deception and the relationship between deception and resistance?

It is widely acknowledged in the literature that people lie all the time (Vrij, 2000; Vrij, 2010; DePaulo, et al., 2003; Ekman, 1992) and that "deception is neither unusual nor unconventional...[but] a common, frequent, and often expected way of behaving in our society” (Kagle, 1998, p.235).
Whilst it is accepted that ‘white lies’ told in social situations can be innocuous and indeed at times helpful to “facilitate comfortable social interaction” (Andrewartha, 2008, p.88), understanding deception and being able to detect lies in professional settings is of paramount importance (Humphreys & Peelo, 2013; Shawyer, et al., 2009). Within the child safeguarding context, a failure by professionals within their risk assessment to recognise signs which might indicate that they are being deceived can be catastrophic for the index child.

It is identified that deception is “a significant feature of everyday child protection practice” (Tuck, 2013, p.5) and in their relations with professionals, parents were found to be “intentionally deceptive or manipulative” (Laming, 2009, p. 51) and capable of going to “great lengths to hide their activities from those concerned for the wellbeing of a child...” (Laming, 2003, p.3). Reder et al. (1993) discuss how calculating and convincing parental conduct of doing just enough to keep workers at bay, a behaviour known as disguised compliance (Reder et al., 1993), impairs their professional judgments. Both deceitful behaviour and disguised compliance are evident in “assessment savvy” parents, willing to adapt their behaviour to come across as compliant when needed (Brandon, et al., 2008, p.65).

Yet, there is a significant lack of research that characterises parents in a child safeguarding context as deceitful per se. Instead, in their interactions with practitioners, such parents are usually described in literature as hostile, non-compliant or exhibiting ‘disguised compliance’, uncooperative, reluctant, resistant, highly-resistant, aggressive and manipulative (Fauth et al., 2010; Munro, 2010; Brandon, et al., 2009; Laird, 2014).
Whether this is an oversight of no significant consequences or there is a reluctance to use the word deceit when speaking of parents in the current discourse of child safeguarding practice will be explored in detail in the subsequent chapters. In the literature, an explanation to rationalise such incongruence appears to come from Brandon et al. (2008; 2009; 2010) in their biennial analyses of serious case reviews in England, commissioned by the Government to draw out key findings from the local reviews and identify their implications for policy and practice (DH, 1999). Whilst acknowledging that almost three-quarters of parents represented in these cases were found to be uncooperative, hostile, non-compliant and manipulative toward professionals, (Brandon et al., 2008; 2009), the authors nevertheless discern that it is difficult to assign families to one or more categories of cooperation as their behaviour is often unpredictable and fast changing (Brandon et al., 2009). Nevertheless, in criminal justice and social work literature, these behaviours are often attributed to individuals who do not wish to engage with professionals despite being legally mandated to do so (Andrews & Bonta, 2006; Rooney, 1992; Trotter, 2006; Ivanoff et al., 1994; Calder 2008). Ferguson (2011) identifies these as involuntary or uncooperative service users.

In the absence of a concrete framework to assess parental conduct and in order to bring some clarity into practice, researchers and professionals have proceeded to examine these behaviours in isolation whilst focusing primarily on resistance (Forrester, et al., 2008a and 2008b, 2012; Tuck, 2013; Robb, 2014; Littlechild, 2012), ‘disguised compliance’ (Reeder et. al, 1993; Ferguson, 2010), and aggression or hostility (Laird, 2014; Littlechild, 2005a & 2005b; Newhill, 2003). A number of Local Safeguarding Children Boards (LSCBs) have produced interagency guidance to help professionals to recognise and deal with non-compliant behaviours by parents.
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(e.g. Coventry LSCB, 2010; Warwickshire LSCB, 2007). What is inexplicably missing from the analysis, yet nevertheless candidly referred to in the majority of these publications, is that some parents act in the way they do because it allows them to keep the abuse away from the attention of safeguarding professionals; or in other words, intimidation, avoidance and hostility are often being utilised as effective tools to conceal what is really going on within the family.

The link between resistance and deception, with the former being a manifestation of the latter, is partially explored by Fauth et al. (2010, p. 8) who argue that “highly resistant” parents would include a wide range of individuals from those who are reluctant to seek help despite accepting that they need it, to “highly manipulative parents who are very accomplished at misleading” child safeguarding professionals. This is supported by Wild (2010) who maintains that the resistant to change parents would often use a number of hostile and emotional tactics including threats and evasiveness, with the latter representing a common way of lying (Shepherd, 2007). With the bulk of the literature, however, focusing on resistance as the problem and on deception as one of symptoms present in a parent who is "unwilling or feels coerced into engaging" (Monds-Watson, 2011, p.11), the professionals’ efforts are inevitably geared toward addressing resistance by trying to build an open and honest relationship (Trotter, 2004; Hodges et al., 2003; Majer, et al., 2003) rather than assessing it as a method utilised by a parent to hide the truth.

Research literature suggests that deception involves lying with or without the use of words (Krauss, 1981; Mitchell, 1986; Bond & Robinson, 1988; Ekman, 1992; Vrij, 2000) and can include "limiting disclosure, equivocating, exaggerating, distorting, or presenting irrelevant information" (Kagle, 1998, p.235). Yet, it is Vrij’s (2000,
p.6) definition of deception as “a successful or unsuccessful deliberate attempt, without forewarning, to create in another a belief which the communicator considers to be untrue”, that provides a clearer demarcation between a deliberate attempt to lie and an inaccurate representation of facts. Whereas the liars in the former category would deceive for malicious purposes (Vrij, 2008; Vrij, et al., 2010), the ones in the latter may do so as a result of their distortion of perceptions and/or memory or because of some other situational factors (Kohnken, 2004). Hence when people lie in order to protect themselves, whether to avoid punishment, obtain advantage (Vrij, 2008; Vrij et al., 2010), or to control situations (Turner et al., 1975), they do so strategically and intentionally (Ekman, 2001; Shepherd, 2007), employing vigilant planning over a prolonged period of time (Humphreys & Peelo, 2013) and by using a number of elaborate tactics to cover the truth.

In applying military strategist Whaley’s (1982) terminology and linking it to some of the parental tactics used in the child safeguarding context, when liars try to hide reality they would often mask (avoid discussing the significant facts and evidence and divert the professional’s attention to other issues), repackage (put on disguised compliance) and dazzle (cause the professional to lose a clear picture of the situation by demonstrating aggression, hostility and refusal to engage), leaving the practitioners with “the distortion of perceived reality” (Humphreys & Peelo(2013,p.56) in citing Whaley(1982)).

In cases of Fabricated or Induced Illness (FII), a type of child abuse sometimes known as Munchausen Syndrome by Proxy, a parent (usually the mother) may go to great lengths to deceive the practitioners by covering the harm she is inflicting on her child. As described by Lim et al. (1991), in FII cases a common feature is that
an apparently caring, concerned and sociable parent would quickly become aggressive and hostile to professionals when confronted or thwarted by them. In one such case of FII the mother "deliberately lied to ...general practitioners so as to obtain prescriptions of drugs that [the child] did not need in ever increasing amounts, ...reinforced those lies with further exaggeration and lies to other health professionals, school staff, ... used dishonesty and subterfuge to obtain large extra quantities of these drugs with which ...[the mother] overdosed him further"; all of which resulted in a child with “some easily manageable health problems” (SCR M, 2004, pp.4-5) to be confined to a hospital where he later died. During this time, the mother continuously switched physicians who challenged the child’s condition, avoided doing extensive tests, caused malfunction of life-saving equipment and fabricated evidence to cover her deceit (SCR M, 2004).

The serious case review into the death of Khyra Ishaq identifies that the mother’s aggressive and hostile behaviour toward practitioners was a ploy used “to deter professionals, steering them away from efforts to protect her children” (Wild, 2010, p.1).

The main implication of these findings for child safeguarding practice is that it is not unusual for parents to resort to any or all of the tactics such as disguised compliance, evasiveness, aggression, hostility or other forms of resistance to deceive professionals and cover the circumstances of abuse. However, it is not being proposed here that every resistant parent is deceitful; arguably, it is anticipated that all parents display some form of resistance in their interactions with practitioners due to their feelings of anxiety, shame, mistrust of services or any negative past experiences (Collins, et al., 2010; Marshall, 2010; 2011). Yet every deceitful parent is indisputably a resistant one, a liar who is not accepting responsibility for abuse or
unwilling to make a change. Thus it is reasonable to suggest that resistance by parents, whether aggression, hostility or non-compliance, should be recognised by a professional as a potential deception tactic to hide abuse and be followed by the appropriate intervention response.

### 2.3 Ability of professionals to detect deceit and common issues with detecting deception

Amidst the plethora of deception detection research offered by the field of psychology, there is a significant gap in literature in relation to the ability of child safeguarding professionals to detect deception in abusive parents.

It is acknowledged elsewhere that certain clusters of verbal and non-verbal behaviours exhibited by those who deceive can aid professionals in their ability to detect deception (Akehurst et al., 2004; Vrij et al., 2011). Yet lie detection research, the majority of which involves low-stake stimuli (Shaw et al., 2013), demonstrates that similar to lay-people, legal professionals such as police officers, customs officers and judges who are involved in accessing the veracity of truthful and deceptive statements on a regular basis typically perform at or below average (Bond & DePaulo, 2006; Vrij et al., 2011, Shaw et al., 2013, Ekman & O’Sullivan, 1991; Hartwig et al., 2006; Vrij, 2004; Vrij & Mann, 2001a and 2001b). In the absence of physical evidence, the accuracy to detect deception by professionals stands at 40-65% (Vrij, et al, 2008).

Yatchmenoff’s (2008) study looking into practitioners’ and families’ overall perceptions of engagement finds that professionals are not able to differentiate between parental compliance and engagement.
The only two studies that investigated social workers’ deception detection accuracy (Vrij et al., 2006; Reinhard et al., 2014) find that social workers have limited skills in discriminating between lies and truths, as demonstrated by their total accuracy level of fifty-one percent. And when comparing groups of professionals, Vrij et al. (2006) also find that social workers do not differ from police officers or teachers in their ability to detect deception, achieving fifty-four percent accuracy. This raises a question about the availability and/or efficacy of training opportunities provided to child safeguarding professionals to help them identify parental deceit, a point which will be discussed later in this chapter.

Given society’s expectation of the competence of these groups to ascertain the veracity of child abuse allegations, these findings are disconcerting.

Professionals’ disappointing lack of ability to distinguish liars from truth tellers has been attributed to their overreliance on non-verbal cues to deception (Mann et al., 2004) as well as their faulty assumptions about cues that were established in the scientific community to be unreliable (eg. Shaw et al., 2013, DePaulo et al., 2003; Vrij et al., 2011, Porter & ten Brinke, 2010; Stomwall & Granhag, 2003; Granhag & Hartwig, 2008).

A survey of US law enforcement officers examining their beliefs regarding deception behaviours supports the view that there is a reliance on stereotypical non-verbal behaviours when detecting deceit (Colwell et al., 2006).

Researching non-verbal behaviour (or body language) associated with deception, Ekman and Friesen (1969) suggest that it is difficult
to conceal lies because deceiving requires a great deal of mental effort, it causes a liar stress and anxiety and it is accompanied by enhanced emotional response. Consequently, a liar who is unable to sustain the pressure ‘leaks’ out through various forms of non-verbal behaviour such as fidgeting, gaze aversion, blinking, sweating and others, all of which might represent the signs of “normal” stress. This assumption has been disputed by a substantive number of studies that find only increased blinking and increased pausing to be the most reliable non-verbal indicators of deception (Vrij, 2000; Mann et al., 2002; DePaulo et al., 2003). However, when professionals rely on inaccurate behaviours such as gaze aversion, grooming gestures and fidgeting (which they often do (Mann et al., 2004)) they naturally perform worse at detecting deceit (Tyler & Feldman, 2004).

A more optimistic picture, however, emerges with regard to verbal cues to deception, which are found to be more reliable. Schafer (2010) argues that when writing or speaking, people tend to choose certain words, analysis of which could indicate deceptive behaviour. Vrij (2010) states that detection accuracy rate based on contents of a statement is at a significantly high sixty-five to ninety percent. Vrij et al., (2010) find a correlation between deceptive detection accuracy and vocal cues such as speech fillers and pauses and voice tone, which are of particular relevance when conducting interviews. The implications of these findings are of particular importance to child safeguarding professionals who interview parents routinely, when making their determinations about the level of risks to the child.

Certain verbal behaviours are found to be associated with the type of lie that is being communicated (DePaulo et al., 2003; Gustafson & Orne, 1965; Shaw, et al., 2013). For example, in contrast to low-stakes lies, high-stakes lies that involve significant consequences to
a deceiver (negative - of being caught and positive - of getting away with the lie), and which are most likely to be attributed to parents in the child safeguarding context, are thought to be more difficult to tell (O’Sullivan et al., 2009; Mann et al., 2004). Hence in trying to keep their account consistent and appear credible to the observer, a liar would ‘leak out’ signs (“the motivational impairment effect”) only distinguishable to the informed observer (Shaw et al., 2013). With this in mind, the value of deception-detecting training to child safeguarding professionals is particularly significant.

The ability accurately to tell truths from lies is also linked to the type of involvement by a professional. Studies find that familiarity in interviewing provides better deception-detection results (Mann, et al., 2004). Yet length of service on its own and occupational experience per se do not increase such accuracy (Mann, et al., 2004; Reinhard et al., 2011a and 2011b; Bond & DePaulo, 2006; Ekman & Sullivan, 1991). These findings are confirmed by Reinhard et al. (2014b) in relation to social workers. Furthermore, Reinhard et al. (2014a and 2014b) and Mann et al. (2004) state that high familiarity with the situation results in a greater detection ability. Similarly, having a full picture about the family and the circumstances surrounding the allegations of abuse can help professionals greatly in their assessment of risk.

Performance in deception detection is also thought to be largely influenced by human biases. Research by Vrij (2008) provides that police officers are better at detecting deceit based on verbal cues partly due to the officers’ lie bias. Laypersons, on the other hand, as well as teachers and social workers, tend to show truth bias (Vrij, 2008; Reinhard et al., 2014a and 2014b)
Reinhard et al. (2014a) suggest that social workers “do not see their clients as possible cheaters or liars” (p.343) and tend to believe them because trust is an essential component in their empathic relationship with clients. As social conversation rules would dictate that disbelieving a client would invite a confrontational response and irritation, this is a consequence that social workers tend to avoid. Police officers however, who are more often confronted with deceit, tend to employ a suspicious relationship (Reinhard, et al., 2014a). These points will be developed in subsequent Chapters Four and Six when the child safeguarding professionals’ ability to detect and deal with deceit in abusive parents will be discussed.

It is also noted that disbelieving a client would require additional cognitive effort by expenditure of time and effort in proving or disproving information-a resource that is not readily available and often distributed with great caution. Hence a busy social worker would choose to judge an account as a truth rather than a lie (Reinhard, et al. 2014a).

Relational truth bias heuristics (Vrij et al., 2008; Reinhard, et al., 2014a) also offer an explanation as to social workers’ inclination to believe their clients; when social workers are confident that they ‘know’ the parents well enough to detect their lies, they tend to believe that the parents would not lie to them.

Despite a number of factors affecting deception-detection and amidst findings that there is not a single non-verbal or verbal behaviour solely related to lying (Vrij, 2004a and 2004b), certain professional groups or “wizards” (O’Sullivan & Ekman, 2004) are found to be considerably better at detecting lies (Ekman & O’Sullivan, 1991; Mann et. al., 2002). These individuals are able to
observe and interpret the possible verbal and non-verbal cues and distinguish between truth tellers and liars effectively.

It is acknowledged in the deception detection literature that "being suspicious is a necessary prerequisite to catch liars", and for professionals, being suspicious is advantageous as it “typically leads to a more fine-grained level of analysis of nonverbal and verbal behaviour” (Vrij, 2010, p. 398). However, it is also noted that although it is essential for professionals to stay suspicious with potential liars, it is vital not to show their suspicions in order to avoid inducing nervousness in respondents and consequently risk misinterpreting it for deceit (Atkinson and Allen, 1983; Schul et al., 2007), and in order not to provide liars with “escape routes” (Vrij, 2010). In light of these findings it not surprising to discover that certain professionals, whether social workers or teachers who exhibit truth bias (Reinhard et al., 2014a and 2014b), or police officers who may come across as being overtly suspicious, are deficient when it comes to detecting deception.

In relation to observational methods, research suggests that high-stake liars (of whom abusive parents are part) would normally display high emotions and attempt behavioural control when trying to appear credible, in order to avoid being caught (Vrij, 2010). Hence professionals should be on the lookout for these when trying to ascertain the veracity of parental statements. However they also need to ensure that their approach is not too forceful and overzealous so as to not to evoke nervousness in truth tellers. Additionally it is important for professionals to pay attention to deviations from an honest person’s reactions in similar situations (Vrij & Mann, 2001a), thus establishing baseline and "comparable truth" responses, whilst noting verbal and nonverbal cues simultaneously (Caso et al., 2006).
However, it is often primarily through communication, and specifically through interviews with parents, that safeguarding professionals need to be able to determine what imminent and impending danger there may be to the children, and in particular whether they already are, or are likely to become, victims of abuse.

2.4 Interviewing to detect deception

Despite the fact that social workers, health professionals and police officers are required regularly to interact with deceitful and resistant parents as evidenced in serious cases reviews (Brandon, et. al., 2008; etc) and elsewhere in literature, there is a significant gap in research about the specific methods and techniques available to these professionals to assist them in interviewing to detect deception.

For social workers in particular, interviewing is a very important activity because “most of what they are responsible for doing depends on interviewing” (Kadushin, 1990, p.xi). Furthermore, Vrij (2000, p.407) argues that "lie detection is perhaps easier during the first interview than during subsequent interviews”.

The interview has been characterised as a conversation with a purpose (Milne & Bull, 1999) that is "mutually accepted by the participants" (Kadushin, 1990, p.3). In the child safeguarding context, for social workers such purpose is to gather selective information (Kadushin, 1990) necessary for a child safety appraisal decision.
In social work a diagnostic (Kadushin, 1990) or formal (Trevithick, 2005) type of interview which is geared toward the appraisal of risk in parents and carers is routinely used by practitioners in child safeguarding. Trevithick (2005, p.141) notes that one of the main purposes of the initial screening interview, otherwise known as assessment, is to "find out as much as possible in ways that open up the possibility for an honest and respectful dialogue and 'partnership' to be created".

However, in citing the review of key social work textbooks (Forrester & Harwin, 2011), Forrester, et al. (2012) provide that no practical advice is offered to practitioners on how to interview resistant and deceitful parents.

It is noted by Diggins (2004) that social work training in relation to interviewing is focused predominantly on therapeutic and counselling types of interventions, despite the findings that "it is not acceptable to borrow approaches from therapeutic settings and suggest their use in child protection social work" if there is no consideration of how one might tackle resistance related both to deliberate lies and manipulation and the more general tendency to minimize the extent of problems (Forrester, et al., 2012, p.158). Yet social work literature puts great emphasis on the necessity of supporting (Fauth, et al., 2010; Beck, 2005; Bogo, 2006) and trust-building (Shemmings, et al. 2012) relationship, respect (Yatchmenoff, 2008), compassion and genuineness (Forrester, et al., 2007, Shemmings, et al., 2012) in interactions between social workers and families, including resistant families; practices associated with counselling and therapeutic approaches. Shemmings et al. (2012, p.134) claim that attachment-based interventions including interviews with resistant families are particularly successful as they “avoid criticism... and instead privilege empathy and
strength-building”. In fact, Nijnatten (2010) argues that a conversational approach in interactions with parents would encourage them to reflect on their issues and that it is important to “keep the communication with parents open; for only with their help and agreement the conditions for the children’s upbringing are likely to be improved…” (Nijnatten, 2005, p.74).

In the USA, the pre-service interviewing training aimed at prospective social workers in the State of Florida also emphasises the importance for social workers of developing interviewing techniques that would facilitate trusting relationships with parents, with methods including exploration (asking parents to tell their story), focusing by encouraging parents to explain and elaborate, and directing by offering support and guidance (Child Welfare Standards, Values and Practices, 2015).

Health professionals tasked with preventing harm to children are routinely involved in child safeguarding work, and as evidenced by serious case review reports often have to interact with manipulative and deceptive parents. However, despite this there is little evidence that the Royal College of Paediatrics and Child Health adequately prepares healthcare staff to be able to identify and respond to deceitful behaviour. Instead the essential competencies for health staff working with parents include being able to assess the role of parents and offer them support and help as needed, seek information from parents in order to gather as much information as possible about a child’s wellbeing, and not to accept automatically a parent’s account without talking to the child and if possible, other family members or close friends (RCPCH, 2014). Arguably, although corroboration is an important part of the information gathering process, the shortage of resources and pressures of time, and the fact that other witnesses including children may be frightened or
forced to lie by manipulative parents (SCR H, 2010; SCR G, 2013), means that it is somewhat doubtful that health staff are likely to seek corroboration in every instance unless they challenge parents with more focused deception-detection methods. Additionally, it is also reasonable to expect that a child safeguarding professional would attempt to challenge and verify any statements by a parent, even in the absence of collaboration.

Furthermore, trusting and supportive relationships between a social and health worker and parents are communicated through motivational interviewing widely utilised in child safeguarding practice both in the United Kingdom and United States. Originating as a therapeutic intervention for substance users, it is deemed to be useful and consistent with a social work evidence-based practice approach (Forrester et al., 2012; Miller & Rollnick, 2002; Wahab, 2005) that promotes a non-judgemental and supportive relationship (Beck, 2005), unconditional positive regard (Rogers, 1959) and is based on principles such as “rolling with resistance” so as to allow the parent time to become ready for change (Wahab, 2005, p.49).

In the midst of strong support for motivational interviewing in healthcare and social work practices (Hettema et al., 2005; Forrester & Harwin, 2011; Miller & Rollnick, 2012; Hammer, et al. 2009), Forrester et al. (2012, p.128), propose that it may not enable practitioners working with parents “to address resistance in all its forms” as it can shift the focus from a child to a parent. Despite this important consideration the authors nevertheless maintain that empathetic techniques of motivational interviewing are necessary in paving the way for a partnership-like relationship with parents, and go as far as to suggest that “an overarching focus on the child’s welfare is central to the use of Motivational Interviewing in child protection work” (Forrester et al. 2012, p.127). Whereas it is
supported by research that motivational interviewing is an appropriate intervention for building a trusting relationship, which is arguably of paramount importance for social workers who are trying to promote positive changes in their clients, its efficacy in being a useful tool in practitioners’ interactions with parents who resort to resistance as a deception tactic is yet to be evaluated in research.

Consequently whilst on the one hand social work research seems to encourage social workers to be empathetic, non-confrontational, sensitive and supportive with parents in order to gain their cooperation, it also recognises that in order to assess risk to the safety of a child it is necessary to apply a set of ‘investigative’ skills and “an eyes-wide open”, boundaried, authoritative approach, thereby ensuring that the child’s needs and outcomes stay in “sharp focus” (Fauth, et al., 2010, p.9). Marshall (2011, p.91) suggests applying a “common sense” approach and keeping “a sceptical mind”. For example, although rapport building is seen as extremely important in child and family social work, it is accepted that it may not be always achievable particularly with resistant clients (Trevithick, 2005). Additionally it is shown in research that a good relationship is not a sufficient condition for effective interviewing and that sometimes it is advisable to use confrontation to unveil discrepancies (Kadushin, 1990; O’Sullivan, 2007). Kadushin (1990, p.162) further provides that confrontation is meant “deliberately to develop some uneasiness in the client” and that it “may be a necessary intervention with non-voluntary parents who deny any problems and are very resistance to any attempts at helping”. In referring to confrontational methods, Trevithick (2005, p.237) discusses the importance of social workers challenging certain types of behaviour by providing a “low-level, gentle yet firm invitation to face service users with contradictions, distortions, inconsistencies or discrepancies and inviting or stimulating them to reconsider and
resolve the contradictions”. In terms of the interviewing style, social work literature emphasises the use of closed, open and probing questions (Trevithick, 2005) with probing in particular seen as a central skill to interviewing and risk assessments (Egan, 1990). Research also supports the importance of relying on one's own intuition in social work (O’Sullivan, 2005; England, 1986; Trevithick, 2005; Munro, 1996).

In social work practice in the United States, to identify manipulation in parents social workers in Florida are advised to listen for distortions and discrepancies and “confront the distortion and not the person”, and to “specifically and concisely identify discrepancies in a person’s behaviour” (Child Welfare Standards, 2015, p.36). The pre-service interviewing guide provides that social workers should explore the reasons for any excuses given by parents and use questioning that “forces specifics and does not allow generalities” (Child Welfare Standards, 2015, p.36) - a very generic instruction indeed.

In Missouri, USA, the Child Welfare Manual (MDSS, 2007) recommends the use of assertive interviewing in social work practice with resistant families. Such a technique includes active listening, the use of reflections as well as confrontation. The manual further provides that the social worker should be a skilled confronter whose goal is “not to interpret or otherwise explain what the client means, but to point out the problems with the client’s functioning or ability to handle a problem” (MDSS, 2007). The manual however does not provide the interviewer with clear methods of identifying and/or eliciting cues to deception.

Therefore, amidst the limited research into specific strategies utilised by social and healthcare professionals to detect deception in parents
whilst interviewing, there is evidence to suggest that these professionals are urged to probe, albeit slightly, into discrepancies and inconsistencies offered by deceitful parents. However in their roles, more so in the UK than the USA, they are also expected to remain non-confrontational, empathic and supportive with parents in order to gain parental cooperation and build a trusting and partnership-like relationship. With motivational interviewing proposed in the research as the most prevalent and effective method of interviewing parents, it would appear that it is the only method available to social and healthcare professionals to interview for deceit. Although it is supported by psychology research that an information-gathering interview style is a good start to build rapport as it encourages people to talk (Fisher, Brennan & McCauley, 2002), it is also argued that in order to detect deceit it is necessary for professionals to ask surprise questions (Vrij, 2010) and insist on elaborations when a scripted answer is suspected, thus making an interview more cognitive-demanding for a respondent.

The efficacy of cognitive credibility assessment is well researched in psychological literature. It is accepted in research that in order to successfully detect deceit, proficient questioning techniques must be employed (Vrij, et al., 2011; Hartwig, et al., 2006; Mann et al., 2012). Vrij at al. (2006) state that in an interview setting, lying is often more difficult than truth telling, and thus interviewers can exploit this by making the interview setting more challenging. Vrij at al. (2006) further provide that since lying is normally a demanding task, one way to force skilful liars into a mistake and thus to enable the interviewer to detect cues to deceit, is to ask them some very difficult questions, or in other words, impose on them cognitive load. Imposing cognitive load could for example include asking the interviewee to tell their accounts in reverse order, thus interrupting the natural forward order of events. Vrij et al. (2011) suggest that
police often resort to this approach by asking suspects to tell their stories in reverse order; when it is used in conjunction with a strategic-questioning approach which includes asking interviewees unanticipated questions and using sketches to convey information, deception detection accuracy achieves a rate of 80% (Vrij et al., 2011). However as no abusive parents took part in this study, the effectiveness of this method in the child safeguarding context is yet to be determined.

Another successful tool in the cognitive load interviewing approach is the verifiable detail technique (Nahari, et al., 2012). This approach provides that when the interviewees are asked before the start of the interview to tell everything they know, particularly focusing on checkable details, this yields a deception detection accuracy of seventy two percent. This approach is particularly useful as it is based on obtaining strong evidence, which can be the key in risk assessing decisions.

The above argument is supported by Vrij (2010) who suggests that it is imperative for professionals to be well informed about the factual evidence of the case prior to interviewing for deceit, but also argues that they should use any available evidence sparingly, or strategically (Hartwig, et al. 2006; Vrij, 2010) by withholding it from the interviewee, thus testing for evidence inconsistencies.

Another way of imposing the cognitive load includes asking unanticipated questions for which the interviewee arguably did not get a chance to prepare (Granhag et al., 2003, Vrij, et al., 2006). The idea behind this approach is for interviewers to start with expected questions and then move to the unexpected ones. These unanticipated questions could include spatial and process versus outcome questions, whereas the investigator would focus not just on
what happened but also on what led to a particular outcome. Hess (2011) states that asking unanticipated questions is commonly used in interrogation practice in the USA.

Expanding on the concept of cognitive load, Vernman et al. (2014) suggest using collective interviewing. As evidenced in serious case reviews and in agreement with Vernman, et al. (2014) deception often takes place on social as opposed to individual levels, as where both parents are aware of the harm to the child and for whatever reasons, choose not to reveal this to professionals. Vernman’s et al. (2014) research proposes using forced turn-taking because it prompts social exchange between pairs of interviewees and is likely to be more cognitively demanding for deceitful pairs than for truth tellers. Therefore, when asking unanticipated questions forces one person to fabricate a story, the other individual is then compelled to carry on with the fabrication, amplifying cognitive load and hence, forcing the pair into a mistake.

Despite the application of the above mentioned effective strategies to detect deceit in the criminal justice context, many of them are incompatible with the principles of the motivational interviewing approach currently employed in social work and healthcare practices. Amidst the significant gap in the research literature in relation to the specific methods utilised by child safeguarding professionals to interview for deceit, Korpowska’s (2014, p.188) claim that “we [social workers] are likely to deceive ourselves about how skilled we are in doing so [detecting deception in parents]” perhaps comes as no surprise.

Thus given the multidimensional and often conflicting nature of a child safeguarding interview, which involves making the crucial risk determining decisions in relation to the child’s safety, more research
is needed to explore how practitioners working in this line of work can be better assisted in being able to identify and address potential deceptive behaviour in parents. This is particularly important amidst Marshall’s (2011, p.85) argument that [for social workers] “assessing risk to children is always going to be more an art than a science”, and that “in practice, parents and carers are never or rarely inclined to admit abusing, neglecting or injuring their children”. It could be argued, given the catastrophic consequences of a failure to detect deceit in safeguarding that it is unacceptable that such interviewing cannot be supported by science. This research aims to address this gap in the literature by evaluating interviewing evidence-based deception detection techniques used by professionals in the criminal justice arena.

In a policing context, little is reported in police manuals about how officers go about interviewing to detect deception (Hartwig, et al., 2004). The College of Policing has developed a great deal of training for interviewing suspects, victims and witnesses but there is nothing specifically relating to 'non-suspect' interviews with parents of children (College of Policing, 2016). Yet child protection police officers, acting in accordance with their duty under Section 11 Children Act 2004 to “safeguard and promote the welfare of children”, are often required by local protocols to conduct 'welfare visits' sometimes referred to as 'joint visits' with social work colleagues (e.g. Bedfordshire LSCB).

Apart from the 'welfare visit' as described above, the usual purpose of the police interview in child safeguarding practice is to gather evidence from witnesses or suspects to support a criminal investigation. For police professionals in the UK the detection of deception by obtaining accurate and reliable information from victims, witnesses and suspects is achieved by utilising investigative
interviewing techniques based on the PEACE framework (College of Policing, 2016). The acronym P.E.A.C.E describes the suggested 5 stages of the interview process, (Preparation and Planning, Engage and Explain, Account, Clarify and Challenge, Evaluation) and this type of interview tests the interviewee’s statements against what is already known to the interviewer. The method is deemed to be confrontational and persistent in nature as investigators do not have to accept the first answer given, especially if there is a reasonable belief that the interviewee is lying (College of Policing, 2016). Yet, the PEACE model's ethical framework aims to assist “in a search for ‘truth’ rather than proof” (Milne & Bull, 1999; Nash, 2011, p.477) and to protect defendants against fixed notions of guilt or confession (Nash, 2011). The interviewing framework places a particular emphasis on the importance of seeking the corroboration of facts and challenging the interviewee (HM, 1992). It provides that in order to detect deceit, investigators should ask probing questions, aim to obtain finer details and consult any checkable facts.

Elsewhere in police interrogations, deception detection is achieved using the Reid technique (Gudjonsson, 2003) which is based on the police manual by Inbau, Reid, Buckley, and Jayne (2001). Despite criticism of the technique as being heavily reliant on behavioural cues, which are found to be unreliable by the scientific community (DePaulo et al., 2003), the Reid technique is widely used in the United States. This interrogation technique is aimed at determining the truthfulness of the account by the interviewer. It is achieved by the interviewer establishing a baseline reaction of the interviewee during the initial interview by asking them stress-free questions, followed by the interviewer focusing on the facts related to the crime in subsequent questioning, and finally comparing the interviewee’s reaction to the established baseline (Reid & Associates, n.d.). Should the interviewee deviate from the baseline reaction in the subsequent
questioning, they are deemed to be telling lies. A particular feature of this type of interview is that it is meant to create in an interviewee a feeling of discomfort and apprehension (Reid & Associates, n.d).

Whereas the two methods above are used for criminal investigations, an interview by police sex offender managers (OM) whose responsibility is to monitor and visit registered sex offenders in their homes, is likely to be different from usual police-offender encounters. In these cases the officers are urged "to form close, almost personal relationship with offenders in the intimate setting of their home“ (Nash, 2014, p.2). This technique is similar to a social worker’s parental assessment interview in the sense that it aims to assess the offenders’ risk (Nash, 2014). The study by Nash (2014, p.15) finds that OMs use a non-confrontational and rapport-building style of interviewing, rating "good listening skills, awareness of risk factors, being inquisitive, a preparedness to ask sensitive and potentially embarrassing questions and a preparedness to constantly hear awful things” as central to their job. However, despite such a harmonious approach, Nash (2014, p.10) reports that OMs do not cease to maintain the view that offenders “could not be trusted and were always lying”, and "always posed a risk and most would never change”. In conducting their risk assessments, OMs frequently look for physical signs that could determine the offenders’ behaviour as risky and often surprise offenders with week-end visits to be able “to catch offenders out as they were not expected” (Nash, 2014, p.10).

Given the variety of interviewing methods for deceit as discussed in the psychology literature and elsewhere, in relation to child safeguarding practice in the United Kingdom, Broadhurst et al. (2010) identify that professionals in the UK are ‘not engaging efficiently’ with parents and that there is insufficient support to
enable practitioners to deal with ‘ambivalent’ and ‘avoidant’ service users.

To conclude Sections 2.3 and 2.4 above, there is limited literature in relation to child safeguarding professionals’ ability to detect deceit in abusive parents. However, it is argued in research that professionals are generally ill-equipped when it comes to detecting deception in adults. When trying to assess the veracity of parental statements, social and health care professionals are relying on the strategies of motivational interviewing, utilised mostly for counselling and therapeutic interventions. The police professionals are adhering to the method of investigative interviewing, the PEACE model, when assessing parents for veracity. For the most part however this strategy is employed when parents are interviewed as suspects to a crime.

2.5 The response to known or suspected deceit in abusive parents by child safeguarding professionals

Despite limited research to provide clarification on whether child safeguarding professionals are able to identify deceit in abusive parents, it is nevertheless important to examine the practitioners’ decision-making when parental deceit is known or suspected and what actions they take, if any, when responding to it.

Existing literature provides a fairly comprehensive synopsis of how dealing with deceptive and resistant parents affects the professionals’ decision-making in relation to the child. Notably, Ferguson (2011, p.167) argues that parents who conceal their abuse through the use of intimidation and aggression “grind workers down psychologically, causing them to act in ways similar to hostages held...
in captivity”, whereby they feel incapable and unable to challenge parents. In support of this argument, Laird (2014) notes that the workers’ response to uncooperative parents is often a withdrawal from any interactions with them so as to avoid rather than confront them, referred elsewhere as a ‘flight’ rather than ‘fight’ situation. Research into the effect of parental aggression on workers in child protection by Littlechild (2002; 2003) provides that when confronted with aggressive parents, who often use this as a diversion tactic to allow them to continue with abuse of the child, social worker and health visitors get “paralysed by fear” (Littlechild, 2008, p.142); a situation that significantly impairs their ability to carry out parental assessments. This phenomenon is also associated with professionals experiencing ‘learned helplessness’ (Seligman, 1975) that results in their not wishing to disturb the status quo for fear of making things worse. Hence when confronted with suspected deceit that is accompanied by aggression, the response of health and social care professionals is one of paralysis or withdrawal of any action for fear of making things worse for themselves, the family and the index child.

Ferguson (2010, p.169) claims that when faced with potential ‘disguised compliance’ by parents however, instead of acting authoritatively, professionals tend to identify with abusers thus becoming a “neglectful bystander to the abuse of the child”. Fault et al. (2010) argue that professionals working with potentially deceptive parents would become exceedingly optimistic about any small changes exhibited by parents as they were unable to determine between those who were genuinely engaging in service-making changes and those who were feigning compliance. Moore (1985, p.50) suggests that when ignoring the fact that cooperation of parents does not imply improvements, professionals can get “disarmed” by service users and “make the irrational assumptions
that telling makes it all right”. Hence contrary to their response to the deception-aggression mix in parents, professionals tend to reward cooperation in seemingly compliant parents by offering their unconditional support and cooperation.

In addition to individual factors, Munro (2004; 2010) argues that organisational cultures can also deteriorate the practitioners’ view of their own authority as well as confidence to be assertive in their practice with parents. For example, inability to challenge parents is linked to the culture of “defensiveness” generated by public inquiries into children’s death and the blaming of professionals involved (Munro, 2011). In a sense, every failure to save the child contributes to the worker’s sense of impotence and powerlessness, whereas practitioners “doubt [their] skills, and frantically search for the method that will be the solution, only to be disappointed yet again” (Moore, 1985, p.48). Additionally, Brandon’s et al. (2009) research highlights that strengths-based approaches utilised by organisations that emphasise parents’ strengths divert the attention of professionals from parental shortcomings, and consequently to appropriate challenges.

Ferguson (2011) states that the right of parents to make formal complaints against workers may stifle the professionals’ ability to act authoritatively with parents who are suspected of deceit. In support of the above and citing the findings from a Serious Case Review where management’s response to receiving successive complaints from a parent was to “transfer the family to a different social worker on several occasions,” Laird (2014, p.1977) argues that complaining against workers become the parents’ “resort to stymieing any challenge to [their] parenting or effective action by social workers”.


Furthermore, the progression of professionals’ response to known or suspected deceit in parents in England is best illustrated in the overview reports generated by Serious Case Reviews. This research draws its support from such cases in order to provide a reader with a more comprehensive review of practitioners’ actions to suspected deception. The reviews seek to understand how and why the abuse took place and to establish what lessons might be learned by the professionals to safeguard better and promote the welfare of children (HM Government, 2015).

2.6 Part Two: Evidence from Serious Case Reviews (England)

This research provides a review of summary findings of eight Serious Case Review (SCR) overview reports that are selected to reveal the extent of deceptive and resistant behaviour in parents and carers when in contact with child safeguarding professionals. For any reader of this thesis who might be less than familiar with front line child protection work, the descriptions below will provide an insight into the environment in which many child safeguarding professionals work every day. The method of effectiveness of using a case study approach was noted in Yin (1994) who supports the single-study, multi-study approach as mean of investigating social phenomena that cannot be easily evident otherwise.

In conducting such a review the research aims to examine the professionals’ ability to detect deception and any specific methods utilised to enable this, and evaluate the safeguarding professionals’ subsequent response to suspected and/or confirmed deceit. Table 1 below provides a summary of these findings.
The review aims to highlight any gaps in skills and knowledge among practitioners in their encounters with deception in parents. The research focuses on the post- Victoria Climbié era (Laming, 2003) when arguably many of the recommendations of the Inquiry highlighting the harmful effect of parental deceit when undetected by professionals should have been embedded into practice. It is also based on reviews that were initiated on or after June 2010, when Local Safeguarding Children Boards began publishing full overview reports, albeit anonymised and containing no identifying details (HM Government, 2015).

**Table 1. The professionals’ ability to detect deceit and their consequent response in Serious Case Reviews**

<table>
<thead>
<tr>
<th>Serious case review</th>
<th>Deceit suspected or identified</th>
<th>Professionals being deceived</th>
<th>Response to parental deceit by professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCR A (The child died)</td>
<td>No</td>
<td>Health and social care professionals, school staff</td>
<td>Became intimidated by the father; failed to challenge verbal accounts; accepted explanations without verifying; shifted focus from the child to parents; left the family alone.</td>
</tr>
<tr>
<td>SCR B (Chronic neglect)</td>
<td>No</td>
<td>Social care professionals</td>
<td>Became intimidated by parents; failed to challenge statements and explanations; sought parental cooperation and abided by ‘family policy’;</td>
</tr>
<tr>
<td>Case</td>
<td>Role</td>
<td>Suspected/No</td>
<td>Description</td>
</tr>
<tr>
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<td>-------------</td>
</tr>
<tr>
<td>SCR C</td>
<td>Police and social care professionals</td>
<td>No</td>
<td>Disregarded and dismissed contradictory information; largely relied on self-reports from parents without verifying information; developed a relationship with mother that was based primarily on “a belief in permanent and enduring change.”</td>
</tr>
<tr>
<td>SCR D</td>
<td>Health and social care professionals</td>
<td>Suspected</td>
<td>Accepted the mother’s statements without challenging; allowed for the mother to become the only source of information about the child.</td>
</tr>
<tr>
<td>SCR E</td>
<td>Health and social care professionals</td>
<td>No</td>
<td>Relied on self-reports from the father without challenging or verifying information; accepted ‘disguised compliance’ as improvements.</td>
</tr>
<tr>
<td>SCR F</td>
<td>No</td>
<td>Police, health and social care professionals</td>
<td>Became intimidated by the mother; sought partnership; allowed for the mother to become the sole source of information about the child; relied on self-reports from the mother without verifying or challenging information.</td>
</tr>
<tr>
<td>------------</td>
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<td>---------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>(The child died)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCR G</td>
<td>No</td>
<td>Police, health and social care professionals, school staff</td>
<td>Became intimidated by the mother; allowed for the mother to become the sole source of information about the child; relied on self-reports from the mother without verifying or challenging information.</td>
</tr>
<tr>
<td>(The child died)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCR H</td>
<td>No</td>
<td>Health care professionals</td>
<td>Accepted ‘disguised compliance’ as safe home environment; took the explanation by parents at face value without challenging information.</td>
</tr>
<tr>
<td>(The child died)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A more detailed description of deception tactics utilised by parents to hide their abusive behaviour toward children, and the child safeguarding professionals’ response to these is provided below.
SCR A

SCR A (2012) examines the circumstances leading up to the death by hanging of a ten-year old girl in 2011. Children’s Social Care (CSC) had been in contact with Amy at various points since 2006 regarding allegations of sexual abuse by members of her extended family as well as physical abuse and neglect. The school expressed numerous concerns about her unkempt appearance; neighbours reported on Amy’s sexualised behaviour in public. Amy herself confirmed the allegations of sexual abuse by a family member. All evidence was pointing to the fact that the girl was being abused.

Her father, however, despite initially agreeing for Amy to have a Common Assessment Framework (CAF) assessment, an evaluation that would have identified Amy’s needs and determined how professionals in local authorities (DfES, 2004) could have been able to help the girl, was adamant that “he would not co-operate if there were any involvement from CSC” (SCR A, 2012, p.10). The CSC gave in to the father's wish unquestioningly and the agencies agreed that there would be no CSC involvement. As a result of this decision the CAF assessment was delayed for 6 months. No professionals challenged why the father “should allow this to impede the arrangement to help his daughter” (SCR A, 2012, p.13).

Throughout the involvement with the agencies the father frequently utilised avoidance and distraction tactics; consequently, practitioner’s interviews with him focussed primarily on financial issues whereby “the family financial situation became a leading concern, although their poverty and its consequences were accepted at face value” (SCR A, 2012, p.22).
The father avoided professional involvement when numerous attempts were made to set up an initial meeting between the family and professionals, despite agreeing to progress with this course of action earlier. The agencies’ response was to allow the father time to eventually come to the agreement.

The father vehemently denied allegations of neglect. Ignoring multiple risk factors but taking the father’s word at face value, the CSC agreed to take no action without taking steps to verify the veracity of his account.

The father trivialised the allegations of Amy’s sexual abuse perpetrated by an extended family member by stating that “these people were no longer considered part of the family and would not be visiting the home” (SCR A, 2012, p.11). This pacified the school safeguarding workers, yet no verification of whether it was the truth was obtained. Despite these serious allegations, but in response to the father’s “animosity” (SCR A, 2012, p.12) and "overt hostility to social worker” (SCR A, 2012, p.12), it was agreed by the professionals for the social services not to be involved.

The father, who appeared to be “the dominant figure in the household” (SCR A, 2012, p.23) also resorted to aggression tactics. In response, school staff were intimidated and largely left the family alone, preferring to communicate with the mother when it was necessary. Professionals did not challenge the aggression- in fact, by colluding with this arrangement they effectively endorsed it (SCR A, 2012).

The father’s use of avoidance, aggression and intimidation proved to be successful at covering what was really going on in Amy’s life to the professionals involved, and a great deal of information in agency
records did not lead to investigation and assessment. The father remained vigilant and maintained control of the situation at all times so that the illusion was maintained, often using resistance to cover a lie (Derksen, 2012; Ekman, 2001).

**SCR B**

SCR B (2012) reviews the agency involvement in the chronic neglect of a number of children in Family Z (aged 8 months to 16 years) over a period of seven years. Both parents were convicted and the children were removed by police and placed in local authority care – an outcome that succeeded years of volatile and dishonest relationship between the professionals and the parents.

Throughout the life of the case, numerous attempts by social workers to visit the family “were met either with closed door or with open hostility” (SCR B, 2012, p.11). The family also ensured that the father, who reportedly lived separately from the rest of the family, was “there whenever a social work visit was planned” (SCR B, 2012, p.11) to insult and threaten them. He had never allowed professionals access to the children’s bedrooms. In response the practitioners became frightened and intimidated; neither did they identify the parents’ obstruction and aggression as effective methods to hide abuse, nor challenge it. Instead the professionals’ priority became obtaining parental cooperation, which in its turn took their focus off the child (Munro, 1999). Hostility and aggression were not the only tactics used. Reportedly, prior to the final Child Protection Review conference there was "apparent and sudden co-operation of the parents” –“...the home appeared clean and tidy; the children looked clean and well nourished” (SCR B, 2012, p.11). This demonstration of disguised compliance (Reder et al., 1993) was
nevertheless perceived by social workers as sufficient effort and made them believe that “there was no longer a child protection issue” (SCR B, 2012, p.11) resulting in deregistration of the case (despite the children not being registered with a GP- a requirement of the Child Protection Plan). Following the cessation of the Child Protection plan however the parents resorted to hostility. When the children failed to attend school the parents again denied the school officials access to the home. In summary, the report found that the practitioners from CSC had “no effective challenge to the barriers to effective intervention that the family put up” (SCR B, 2012, p.28). The family’s control over the situation was evidenced by the professionals accepting the so called “family policy” whereby agencies were prohibited from going beyond the downstairs area of the home (SCR B, 2012, p.28).

**SCR C**

SCR C (2012) was initiated in response to the death of a six months old baby J killed by his father. The case involved a series of incidents of domestic abuse with the father being the aggressor.

During the life of the case, the parents were engaged with professionals in what seemed at the time as “open and honest” relationship (SCR C, 2012, p.15), and it was not until the child’s death that it was discovered that they were demonstrating disguised compliance (Reder et al., 1993). The parents attended all meetings and agreed with concerns raised by the professionals.

According to the report, the parents were very skilled at controlling the information that was known and shared. The professionals in the meantime relied on self-report from parents without challenging them and without seeking corroborative evidence. For example,
when the mother denied her previous assertions that she was afraid of the father in order to cover the extent of the violence at home, social workers believed her. They also believed the father when he denied allegations about the mother stabbing him, saying that he was “misquoted by the police” (SCR C, 2012, p.23). When the mother tested positive for opiates, her lies that it was a result of her taking strong medication was accepted unreservedly by social workers. Despite the concerns of the parents’ abusive behaviour toward each other, the professionals continued to be reassured by both parents that everything was fine in the family. Deceit by parents went unquestioned by social workers who continuously disregarded or dismissed contradictory information. More so, “the professionals seemed blinkered by their hope that this mother, whom they liked, would succeed this time, be a good enough parent, and improve her life” (SCR C, 2012, p. 10).

The emphasis in the Core Assessment was focussed solely on self-report from parents about their plans and their ability to meet the plans of the baby. The professionals misjudged the parental capacity so badly that the child was assessed as needing family support instead of being subjected to a child protection inquiry. Risk factors such as nine post birth domestic abuse incidents attended by the police, physical tussles over the baby, both parents being arrested during disputes, the evidence of mother’s increased misuse, the background of mother having previous children subject to the care proceedings because of neglect, long history of drug and alcohol abuse, poor mental health and extensive criminal history, were blatantly disregarded. This environment, in which parents switched unpredictably between hostility and helplessness, abuse and neglect, was particularly dangerous amidst violence and abuse (Howe, 2005).
SCR D

SCR D (2011) concerned the death of a two-year-old Child 24, hours after she was found unresponsive at home. She could not be saved and had her life support withdrawn after the pronouncement of brain stem death. Prior to her death she was living with her mother, the mother’s partner and another child. A number of concerns were expressed about neglect of Child 24 with another child at home already being a subject of referrals to CSC. Concerns began when Child 24 was taken to hospital with an apnoeic episode when she “stopped breathing and turned blue” (SCR D, 2011, p.10). She was re-admitted to hospital on two subsequent days with “breath holding” and “blue” (SCR D, 2011, p.10). There was “a possible bruise on her left shin” (SCR D, 2011, p.10). On each of these days she was discharged to her mother. When the child remained in the hospital with her mother whilst being observed, no such apnoeic episodes took place. In the meantime, CSC were getting referrals about the overwhelming state of neglect in the house and the mother’s inability to take care of her children. In response the mother dismissed those allegations as malicious and “probably from her ‘ex-partner’” (SCR D, 2011, p.12); consequently, no further action took place by CSC. When additional referrals kept on coming and the apnoeic episodes continued it was decided to engage the mother in volunteer services. The mother agreed. However, as was learnt at a later stage, this was one of the examples of her disguised compliance (Reder et al., 1993) as the mother never engaged. In fact she informed the volunteer services that no help was required as she “no longer had the children” (SCR D, 2011, p.13). This assertion was not challenged by volunteer services workers. Yet when the health visitors questioned the appalling state of the mother’s flat, the mother’s response that “someone [from volunteer services] comes regularly to help” (SCR D, 2011, p.13) was an
outright lie (DePaulo, 2003). Once again this information was not verified by the professionals. When the police visited the parents in response to yet another domestic violence incident between the mother and her new partner, they sent a referral to CSC expressing their concerns about the “incredibly disgusting” (SCR D, 2011, p.14) state of the house (both children were covered in dog faeces) and the children being put at risk of violence. When questioned by social services the mother denied being in any kind of trouble adding that she, her mother and the partners were appropriate carers for the children. Additionally, she became angry with CSS for taking these concerns. In response social workers left her alone. For the most part however, the mother’s behaviour fluctuated (Brandon et al., 2009) between being aggressive to avoidance to displaying disguised compliance; all in order to deceive the professionals about the abuse that was taking place. For example, during one planned visit a social worker found the flat much tidier and children fed and the mother presented herself as “motivated and keen to get parenting advice” (SCR D, 2011, p.14). She was offered appointments which she never attended. Both children remained largely unnoticed by health professionals as “the mother complied [with their expectations] just sufficiently” in order to keep them off her back (SCR D, 2011, p.15) and reassure them of improvements. The report stated that the mother had “explanation for all concerns” (SCR D, 2011, p.15) and unfortunately these explanations were taken at face value. Amidst a number of causes for concern the professionals believed the mother to such an extent that she was accepted to be the sole source of information about the circumstances of her and the children’s lives, even when she was suspected of being untruthful.
SCR E

SCR E (2014) examined the circumstances preceding the death of a 15-year-old boy who died following abuse of drugs available in his home. At the time of his death he lived with his father, who was receiving mental health services. During the three-year period of service engagement the boy’s father went out of his way to avoid contact with professionals. He missed appointments, did not answer letters and was openly hostile to children’s services by accusing them of “trying to break up the family” (SCR E, 2014, p.14) - all whilst Andrew was missing school and using drugs. However when the practitioners threatened to take action in response to a lack of progress the father did just enough to prevent issues from escalating to the implementation of the child protection procedures or legal action due to school non-attendance, exhibiting disguised compliance (Reder, et al., 1993). The father’s strategy was to reassure the professionals that Andrew was going to go back to school; a promise that was never fulfilled. The father openly minimised issues within the family, yet every time he promised change the professionals chose to believe him, displaying a so called ‘rule of optimism’ (Brandon et al. 2009). The professionals’ inability to assess the father’s motivation for non-engagement as well as respond to the latter’s open hostility resulted in withdrawal of services and missed opportunities to save the child. There was no evidence in the Serious Case Review to suggest that professionals were aware that they were being lied to or were able to deal with various avoidance strategies. Arguably there is sufficient data to imply that the father’s changing tactics in response to challenge by professionals might have created some doubt in the practitioners’ minds that he could have been deceitful with them.
SCR F

SCR F (2013) reviewed the case of a four-year-old girl who was murdered by her mother. During the child’s life there were numerous concerns of the mother sexually abusing the girl. For example, the girl was only eighteen months old when her mother stated that the girl “wanted to have a sexual relationship with her” (SCR F, 2013, p.15). There was evidence of the mother being overly protective towards the child by isolating her from others and the girl exhibiting sexualised behaviour. With the girl’s father residing abroad, there were signs of the mother effectively trying to hide the child from the outside world and did not let her “out of her sight” (SCR F, 2013, p.36) by intending to home-school her, refusing outside help and being hostile with neighbours and health professionals when they offered assistance and support. She was reluctant to engage in a parenting programme, which was a central component of the child protection plan. The mother refused contact with her extended family, a member of which she at one point accused of sexually abusing her child; consequently the family withdrew. Yet despite all these warning signs she was the sole source of information about the family. Because some of the mother’s claims appeared so bizarre (she claimed that her television was making ‘sexual innuendoes’), the assessment of social workers focussed on the mother’s mental illness (she was assessed and was found mentally fit) instead of the safety and wellbeing of the child. To hide the abuse the mother also utilised deflective tactics with the police, to whom she made numerous claims about being harassed, but failed to say when and by whom.

Despite the report’s findings that the death of the child could not have been predicted, there was clear evidence of the involved agencies not challenging the parent’s behaviour to uncover the true
situation within the family. Instead, in response to difficult work with mother, the professionals’ involvement became about trying to achieve “a partnership” with her (SCR F, 2013, p.56).

**SCR G**

SCR G (2013) dealt with the circumstances leading to the death of five-year-old Daniel Pelka. The findings of a pathologist confirmed that the child was subjected to abuse and neglect over an extended period of time; he was severely malnourished, suffered a serious head injury and was covered in multiple bruises all over his body.

According to the report’s findings, it was unmistakable that Daniel’s mother and stepfather acted deliberately when they deceived the professionals to cover the abuse they were inflicting on Daniel.

Subjected to domestic abuse by all of her three partners, the mother did nothing to get out of these abusive relationships to protect her children; she refused professional help. The first time Daniel was admitted to the hospital with an injury when he was eight months old, the mother’s explanation of a laceration over his right eye was that the child accidentally hit his head on the corner of a table when she was changing him; in response, doctors believed her unquestioningly. When a health visitor spotted a bruise to a three-year old Daniel’s head, the mother explained that “he fell over” (SCR G, 2013, p.19). Despite the ongoing violence at home the mother’s version of events was accepted. A few months later, when Daniel was admitted to A&E with a spiral fracture of the left arm as well as multiple bruising on the same arm, a bruise on his left shoulder and a bruise on his lower stomach, the mother said that the boy “fell off his bicycle” (SCR G, 2013, p.20); this was accepted as plausible by doctors. The mother was relentless at trying to deceive the
professionals in order to conceal the abuse to Daniel; she compelled her six-year-old daughter to corroborate her lies. When Daniel, who was being deliberately starved by his parents, was found eating from other children’s lunchboxes and the roadside bins, the mother’s response to the school staff was that the child had a great appetite and ate well at home. When Daniel’s sister, who was prepped by her mother, verified this version of events, professionals did not seek corroboration from other sources.

The report found that the mother “presented as plausible in her concerns, presented on many occasions as a capable and caring parent (when not in the midst of domestic abuse incident – although she was constantly) and took an assertive stance with professionals. Her manipulation, avoidance of contact with practitioners, deceit and actions were not recognised for what they were and her presenting image was too readily accepted” (SCR G, 2013, p.70). No corroboration or contra indicators were sought during interviews with the parents or by intra-agency investigation.

**SCR H**

SCR H (2016) examined the circumstances of surrounding the death of a seven-month-old girl Child Q who was attacked by a family Pit Bull type dog whilst in the care of her maternal grandmother. She died as a result of many severe injuries. Consequently, both the Child Q's mother and maternal grandmother were prosecuted for being in charge of a dangerously out of control dog which killed a child. The family had a history of domestic abuse and numerous referrals about the family had been made to the police about the incidents involving the mother and her parents as well as the mother and her previous boyfriend. Concerns had been raised to the police about the mother owning a banned Pit Bull type dog in the house.
The dog was so fierce that the dog’s treating vet refused to examine it unless it was first fully sedated. Additionally, there have been numerous concerns about the grandmother’s alcohol dependency, history of depression and self-harm.

The report concluded that “...had more professional curiosity been shown to the family as a whole [by midwives], and questions asked about the proposed caring arrangements for Child Q, perhaps a risk assessment would have revealed her [Maternal Grandmother] unsuitability to baby sit the baby and Mother might have been advised accordingly” (SCR H, 2016, p.22)

The report found that the mother "engaged in a strategy of deceiving professionals who were attempting to work with her in a trusting partnership” (SCR H, 2016, p.27) and failed to disclose to health visitors about the whereabouts of the father when he had been sent to prison. Instead, she claimed that “he was a builder or roofer who worked long hours” (SCR H, 2016, p.27).

The mother largely succeeded in “creating an illusion” (SCR H, 2016, p.28) that all was well and ‘perfect’ in the family, yet she continued to deceive the professionals about the absence of the father, by using different surnames and failing to bring the Child Q for her immunisations and giving different reasons to different practitioners for this. She was “fully aware that her own Mother had alcohol related problems yet she went out for the evening leaving her in sole charge of the baby” with the dangerous dogs in the house (SCR H, 2016, p.36)

The report concluded that had the professionals involved with the family been more inquisitive and objective in their risk assessment of the family, they would not have had an "overly positive view of
life within the home” (SCR H, 2016, p.37) by failing to identify factors pointing out to Child Q’s vulnerability.

As the summaries of the serious case reviews above demonstrate, in cases where the parents sought to deceive the professionals working with them, the practitioners often relied on self-reports from parents and rarely challenged parental statements and explanations. In some instances, when faced with resistance and hostility, they were too intimidated to challenge the veracity of parental accounts. In others they were blinkered by the parents’ apparent engagement with agencies and mistook ‘disguised compliance’ for improvement.

As mentioned earlier in this thesis, these findings, although useful, do not explain why the professionals responded in the way they did. The current research aims to address this gap.

In the United States, where there is no statutory requirement to carry out reviews into the death or serious abuse of children, the extent of parental deception and the professionals’ response to it is best learned through isolated child fatality reports and media articles. A number of examples below illustrate that US child safeguarding (or markedly, child welfare) practice is not immune from the deceitful behaviour of parents and careers.

As reported by The New York Times (Barker, 2014), prior to being found with cut wrists, an extremely malnourished and severely beaten twelve-year-old Maya was repeatedly abused by her parents. She was a social services’ client for more than a year. Fearful of repercussions, the girl herself denied allegations when confronted by the police and social workers. The report provided that the child welfare agency accepted what Maya said at face value, instead of interviewing everyone in her circle and gathering evidence. The
father fabricated claims that a family relative abused Maya; this was never explored. Maya was kept locked in her room and used as a maid. But every time the social worker visited, the family appeared at their best displaying disguised compliance (Reder et al., 1993). Maya was also kept isolated from her extended family and kept on changing schools. When taken to a hospital with a swollen face, dirty clothes and weighing fifty-eight pounds (approximately 26 kg), her parents provided that she had fallen from a ladder and that she did not like taking baths; this went unchallenged by child safeguarding professionals. The parental deceit did not stop even after Maya was found in her kitchen with cut wrists, when the stepmother offered to emergency services that the girl had tried to kill herself, an allegation that was later found out to be an outright lie (DePaulo, et al. 2003).

When investigating The City Administration for Children’s Services’ response to abuse allegations in relation to six-year-old Zymere Perkins, who was killed by his mother’s boyfriend, The New York State Office of Children and Family Services (NYS OCFS) reported that during the six-year period of services involvement, the child safeguarding professionals failed to “correctly assess the family functioning” (NYSOCFS, 2016, p.3). Additionally the review highlighted that the social workers’ and child abuse investigators’ interviewing was of “poor quality” demonstrating “significant lapses in the investigative process”, and that the practitioners failed “to contact collateral sources”, relying on the mother as the sole source of information (NYSOCFS, 2016, p.3).

To conclude the chapter, the review of child safeguarding literature indicates that parents are successful at concealing child abuse from child safeguarding professionals both in England and the USA. In confirmation with Brandon et al. (2009), the parents’ deception tactics are rarely constant, often fluctuating between avoidance,
disguised compliance and hostility. In other words, resistance, whether passive or aggressive, is a likely course of action of parents who are intending to hide the truth. What these findings also show is that child safeguarding practitioners, notably social care, healthcare and police professionals, are not proficient in detecting deception. These professionals are not skilled in identifying signs of ‘disguised compliance’ which is often mistaken for improvements. When parental deception is suspected, the professionals’ response is largely similar to the decision-making that takes place when parental deceit is unsuspected – parental explanations are often accepted at face value and remain unchallenged and the assessment of risk to the child is reliant heavily on self-reports from parents.

Based on the existing literature, the current research aims to examine how child safeguarding professionals attempt to detect deception in parents and what techniques if any are utilised to aid this process, and the underlying rationale that guides the professionals’ decision-making when parental deceit is suspected or known. This will be explored in the analytical chapters Four, Five, Six and Seven. The following chapter details the research methodology which led to the findings included throughout this thesis.
Three The methodological journey

The purpose of this chapter is to tell the story behind the research journey undertaken by the researcher to produce, one would hope, a "coherent, over-riding ...argument that embodies a research insight" (Petre & Rugg, 2010, p.13), otherwise referred to as the thesis.

3.1 The research design and justifications of methods used

Any reliable and valid research is influenced by philosophical assumptions of existing paradigms (Gilbert & Stoneman, 2016). According to Kuhn (1977), a paradigm represents a set of shared beliefs and values amongst researchers; it is a framework through which a research question is formulated and consequently answered.

Much research concerning child safeguarding is informed theoretically by the perspectives of the time within the various disciplines that constitute the professional arena.

For example, in relation to children’s social care, a discipline that is instrumental in safeguarding children, Skerrett (2000) argues that in response to the political situation and society’s values, social work has undergone a number of paradigm shifts. Skerrett (2000, p.70) also feels that the recently emerging paradigm of care management places a social worker as “business manager” concerned more about processes, outcomes and performance indicators rather than interpersonal communications with service users.

Júlíusdóttir (2006) agrees with a paradigm shift in social work, suggesting that the current epistemological change is based on
evidence, knowledge and information-based practice. The same author suggests that moving away from “a semi-profession’s paradigm ….lacking in professional maturity commonalities and coherence to a collective meaning” (Júlíusdóttir, 2006, p.38) would facilitate integration of developmental processes.

In examining the interface between health services and children’s social care, White et al. (2015) argue that child safeguarding is dominated by an approach “which privileges process over practice,” a so called process paradigm, with an emphasis on enhancing performance through standardisation of processes.

Based on the assumptions above, this current research is rooted in constructivism and interpretivism whereby through ongoing interactions between individuals (Bryman, 2016), and interpretation of surrounding issues as well as their own decision-making, the professionals are involved in construction of their meaning of shared values (Myers, 2009; Appleton & King, 2002).

According to Crotty (1998), research design is based on epistemological and philosophical stances that inform the research, and the methodology employed to collect data in order to answer the research question. Rugg and Petre (2006, p.6) propose that “research design ….is about finding things out systematically”.

As indicated in the earlier chapters, the objectives of the current study are to examine child safeguarding professionals’ experiences of dealing with deceptive parents, to explore current practices used by professionals to detect and respond to deceit in parents of abused children, to identify their views about the appropriateness of these
techniques, and to establish any barriers that may inhibit their ability to detect and respond to deceit.

Hence the underlying assumption of this study is based on the following ontological and epistemological positions that a) “reality is a social construct and cannot be understood independent of the actors who made that reality”; and b) “this reality could be construed only through in-depth examination of the field which it forms a part of” (Urquhart, 2013, p.59).

This study employs a purely qualitative approach based on interview and observational data in response to Barbour’s (2014, p.15) claim that qualitative research “allows access to ‘embedded’ processes by focusing on the context of people’s everyday lives where such decisions are made and enacted”. The context within which a child safeguarding professional’s behaviour takes place is of particular value to the researcher as it poses a question as to its significance. As the research study examines the perspectives of professionals from distinctly different organisational cultures, the researcher aims to discover what particular influences these have over the participants’ views. In fact, Barbour (2014, p.16) adds that “[a qualitative approach] also excels at illuminating process, whether this is organisational change or individual decision-making, since it allows us to examine how changes affect daily procedures and interactions. This may lead to us uncovering unintended as well as intended consequences of new arrangements”. Additionally, Higgins (2009) argues that qualitative methodology allows the researcher to stay connected with their participants.

Rooted in rich and detailed data (Mason, 2002), qualitative research enables the researcher to interpret the world through participants’
eyes (Bryman, 2016) and that facilitates "holistic forms of analysis" (Mason, 2002, p.4).

The current study utilises three separate but related data collection methods. The first method utilises data in published government reports. The second method entails interviewing child safeguarding professionals. The third method involves observational fieldwork. By employing more than one method to investigate data, also known as 'triangulation' (Webb et al., 1966), the researcher was able to interrogate the research methodology and develop a more robust approach to data analysis.

Although used in qualitative research, increasingly ‘triangulation’ is being referred to as “a process of cross-checking findings” drawn from a mixed methods approach, and is deemed by some researchers as not feasible and even inappropriate (Bryman, 2016, p.386).

In response to Mason’s (2007) concerns about the uncertainty associated with combining different approaches, Uruquhart (2013) talks of ‘corroboration’, whereas Richardson (1994) speaks of a concept of ‘crystallization’ (as opposed to triangulation) which involves using different datasets to examine the events through a different prism. Ellingson (2008, p.11) offers that crystallization is a mechanism for the researcher to obtain more detailed findings, and to "encounter and make sense of data through more than one way of knowing”.

By utilising the methods above the researcher attempts to use multiple sources of data to be able to consider alternative as well as contradictory accounts. As Morgan (1993, p.232) argues, 'if research finds differences between the results from (different methods) then
the methodological goal should be to understand the sources of these differences”.

Analysis of data available in publicly published reports offers many advantages. According to Barbour (2014, pp.15-17), using pre-existing documents allows the researcher to "reconstruct policy decisions" and can “thus afford a window into the processes and sense-making activities”. Additionally, data rich reports afford the researcher the opportunity to reanalyse the findings and offer new interpretations (Bryman, 2016). However, the current researcher is mindful about the originally intended use of the documentary sources of data and the way they describe particular events. Finnegan (2006) warns about not falling into the trap of making wrongful conclusions based on findings and/or recommendations made in government reports as they do not necessarily provide evidence for the researcher’s study.

The interview approach used in the current study is a widely utilised method in qualitative social science research. Bryman (2016, p.466) suggests that a qualitative interview allows the researcher a considerable degree of freedom to follow the voice of the respondent, often encouraging them to "ramble“ and "go off at tangents" into the directions of newly emerging issues. The interview style utilised in the current study is semi-structured as the researcher is interested in exploring broad themes rather than investigating a specified set of research questions.

The role of the interview guide is to provide a tentative list of issues to be addressed which are generated by the research questions (Lofland & Lofland, 1995), albeit not so rigid as to limit alternative perspectives that might result from the data collection. The interview guides, otherwise referred to as schedules, for this
research study were composed and developed in accordance with Bryman (2016).

Figure 2. Formulating questions for an interview schedule (Reproduced from Bryman (2016))

To illustrate how the Bryman (2016) figure above was implemented in the interview schedule development, the researcher, guided by the research area and corresponding research questions, identified a number of topics which led to the formulation of initial interview questions (See Appendices B and D). For example, the initial schedules included questions that aimed to explore general research topics related to the practice of child safeguarding, deception detection, interviewing to detect deceit, the role of child
safeguarding professionals. As data collection and analysis began to yield research areas and concepts that were not identified initially, the interview schedules were revised to reflect these newly emerging themes (See Appendices C and E). Examples of this include the concepts of ‘a relationship in child safeguarding’, and ‘the organisational culture’, both of which emerged as a result of the initial interviewing. Following this discovery, the interview schedules for key and frontline professionals were adopted to include questions to explore these new concepts (See Appendices C and E). This was consistent with the principles of Grounded Theory (Charmaz, 2006) that is grounded in the data (Urquhart, 2013).

The observational approach allowed the researcher to utilise "the systematic description of events, behaviours, and artefacts" (Marshall and Rossman, 1989, p.79) in order to understand the rationale that guides the professionals’ decision-making through observing them in their interaction with each other in an informal, low-pressure and low-consequential setting. These professionals were participants of a child safeguarding training event. Although such an event did not involve these practitioners dealing with live cases or making any critical decisions, it nevertheless facilitated meaningful discussions about their experiences and challenges in child safeguarding and allowed them to reflect on their practice. Lewis (2016) argues that it is often challenging to engage the participants in certain open discussions during interviewing due to the power imbalance between the participant and the researcher. Thus, in order to give the participants an active voice (Marshall & Rossman, 2006), the researcher adopted a participatory perspective that valued their experiences and interpretation of situations through ongoing interaction (McWilliam et al., 2009). Furthermore, observing participants helped the researcher to develop "a holistic understanding of the phenomena under study that is as objective
and accurate as possible given the limitations of the method” (Dewalt & Dewalt 2002, p.92).

This study sought an insight from child safeguarding practice in the United States in order to explore any alternative strategies to deal with potentially deceptive parents. The researcher applied the same methodology in the interviews in order to provide meaningful comparison (Hantrais, 2009). The aim of providing such an insight is twofold: to identify constant factors and variations between the countries to be able to explain the phenomena, and to evaluate the solutions proposed to deal with common problems and draw lessons about best practice (Hantrais, 2009).

### 3.2 The research process

The current study is informed by secondary and primary data collection.

**Secondary data: Serious Case Reviews**

The purpose of utilising secondary data from the Serious Case Reviews in this study is twofold.

The previous chapter provides a summary of key findings provided by these SCRs in order to reveal the extent of deceptive and resistant behaviour in parents and carers when in contact with child safeguarding professionals, and offers an insight into the environment in which these practitioners operate.

Additionally, secondary data drawn from Eight Serious Case Review (SCR) overview reports is also utilised to inform the analytical discussions within this research in both confirmatory and non-
confirmatory ways in relation to data produced by primary source collection. As was discussed in the previous chapter, an overview report is the end product of a learning review which often takes place after a child has died or been seriously harmed. Therefore these overview reports, based on an analysis of individual agencies’ internal reviews, tend to provide "powerful illustrations" of events in the life of abused children (Brandon et al. 2011, p.3), identify decision-making steps by professionals and highlight the deficiencies in agencies’ performance practice.

Having been made available to the public since June 2010 (HM Government, 2010), the reports within the sample are selected from the NSPCC National Case Repository using ‘criterion purposive sampling’ (Bryman, 2016). This sampling method is appropriate as it allowed the researcher to select from the 400 or so reports held within the database only those SCRs that included issues of deception of professionals, or deceit by parents and carers. The researcher focused on more recent cases from 2012 until 2016. Although, the researcher identified twelve such appropriate reviews initially, she decided on the optimum sample size of eight, which was informed by the concept of data saturation as indicated by e.g. Glaser & Strauss (1967) and applied in the Grounded Theory approach adhered to in this research. In other words, the researcher felt that no additional data was found to lead to more information in relation to the research question (Seale, 1999) beyond the analysis of eight SCRs as the similar concepts kept re-emerging over and over again. This led the researcher to believe that the categories reached a point of saturation and prompted the end of SCR data sampling.
Primary data: Interviews

Primary data was collected through interviews with child safeguarding professionals in England and the US, including ‘key participants’ sometimes referred to as ‘key informants’ (Reiger, 2007), and a sample of frontline staff.

According to Morse (2007, pp.229-231), it is imperative to implement the “astute and efficient” methods of sampling of data when building a theory and use “excellent informants” in order to obtain “excellent data”.

Using convenience sampling, approximately twelve ‘experts’ in child safeguarding practice were identified and approached by the researcher as potential ‘key participants’ in the study. Indeed, these ‘experts’ represent the types of ‘excellent informants’ discussed by Morse (2007, p.231) as being experts in the experience being studied, who are “reflective, willing, and able to speak articulately about the experience”. Out of these twelve, eight participants agreed to participate in the study.

Bryman (2016, p.187) suggests that convenience sampling strategy is appropriate “where data [from a convenience sample] represents too good an opportunity to miss” and “[the findings] provided a springboard for further research”. In addition to providing in depth expert information on the subject being researched, the use of such key participants is particularly important in exploration of less well-researched topic of interest (Werner & Schoepfle, 1987; Dey, 1993; Harding, 2013). Hence, the current researcher feels that utilising the proposed key participants enabled the framing of pertinent and relevant questions to frontline professionals.
This sample of key participants includes experienced academics, policy makers, strategic leaders, SCR authors and child welfare specialists, and they are selected because of their recognised unique roles and positions in the field. It is also acknowledged that the analysis of their data offers some limitations and this is further discussed below.

A number of key participants were selected for the study using the researcher’s personal contacts and knowledge in the area; others, as a result of a snowball effect with provisionally agreed participants suggesting other participants (Bryman, 2016; Morse, 2007).

The recruitment of the key participants as well as frontline professionals from the United States was conducted using a targeted, direct approach. However, the sample was a process of continuous refinement in order to meet the overall progress of the study. For example, a number of ‘experts’ that were identified initially were consequently removed from the list of participants as it was felt that they could not contribute a more comprehensive account due to their role and position limitations. In response to emerging phenomena and upon the identification of the ‘trajectory’ of the project, the convenience sampling strategy was changed to purposeful sampling to allow so called ‘confirmation of the trajectory’ (Morse, 2007, p.237) where the participants were selected in the study based on their particular characteristics, experiences, and knowledge in the areas/concepts that were coming out from the analysis of interviews (Gilbert & Stoneman, 2016).

Additionally, the interview sample was selected to ensure a mix of roles from within child safeguarding, and also a geographical spread which included professionals from different parts of England.
Consequently, the following eight (N=8) key participants were interviewed as four (4) declined to take part in the study. Table 2 below provides a summary of these respondents’ roles and experience.

Table 2. Key participants interviewed

<table>
<thead>
<tr>
<th>Key participant</th>
<th>Role</th>
<th>Level of experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>KP01</td>
<td>Social work academic, former social work professional</td>
<td>30 + years</td>
</tr>
<tr>
<td>KP02</td>
<td>Former social work professional</td>
<td>40 years</td>
</tr>
<tr>
<td>KP03</td>
<td>Reviewer of SCRs, police strategic leader</td>
<td>30+ years</td>
</tr>
<tr>
<td>KP04</td>
<td>Paediatrician, SCR reviewer, academic, policy maker</td>
<td>10+years</td>
</tr>
<tr>
<td>KP05</td>
<td>Child safeguarding trainer, former police professional</td>
<td>15+ years</td>
</tr>
<tr>
<td>KP06</td>
<td>Designated nurse in child protection, trainer</td>
<td>25+ years</td>
</tr>
<tr>
<td>KP07</td>
<td>Child safeguarding trainer and police professional</td>
<td>20 + years</td>
</tr>
<tr>
<td>KP08</td>
<td>Former social work professionals, child safeguarding trainer, policy maker</td>
<td>30 years</td>
</tr>
</tbody>
</table>

The researcher was mindful that the key participants, particularly policy makers, may have a vested interest in giving biased information especially if speaking about policy they have created.

To safeguard against potentially skewing the analysis and findings, the researcher aimed whenever possible to corroborate their information with other sources, specifically from frontline child care participants.

The recruitment of the main research sample of ‘frontline practitioner’ participants was conducted by the researcher sending the invitation letter (along with appropriate information sheet and informed consent form) to four local authorities (England) via appropriate ‘gatekeepers’ to invite child safeguarding professionals to participate in the research. Although access to the sample may have been inadvertently mediated by the gatekeeper to address the
potential risk to the image of the organisation from which the participants were recruited (in other words by the selection of ‘stooges’), the researcher ensured that no influence was exerted by the gatekeeper on the investigation of the study in terms of the focus of the study, the questions to be asked, the interpretation of findings, etc. (Bryman, 2016).

This resulted in thirteen (N=13) professionals being recruited from three local authorities in England. They are represented by six social workers (N=6), two health visitors (N=2) and five police officers (N=5). The size of the sample was dependent upon levels of data saturation. Two child safeguarding professionals were recruited from child protection agencies in two States in the US and are represented by a social worker (N=1) and a child abuse investigator (N=1). Their roles and level of experience within child safeguarding are summarised in Table 3 below.

Table 3. Frontline professionals interviewed

<table>
<thead>
<tr>
<th>Frontline participant</th>
<th>Role</th>
<th>Level of experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP01</td>
<td>Social worker, England</td>
<td>5+ years</td>
</tr>
<tr>
<td>FP02</td>
<td>Social worker, England</td>
<td>1-3 years</td>
</tr>
<tr>
<td>FP03</td>
<td>Social worker, England</td>
<td>5+ years</td>
</tr>
<tr>
<td>FP04</td>
<td>Social worker, England</td>
<td>1-3 years</td>
</tr>
<tr>
<td>FP05</td>
<td>Health visitor, England</td>
<td>3+ years</td>
</tr>
<tr>
<td>FP06</td>
<td>Health visitor, England</td>
<td>1-3 years</td>
</tr>
<tr>
<td>FP07</td>
<td>Social worker, England</td>
<td>5+ years</td>
</tr>
<tr>
<td>FP08</td>
<td>Social worker, England</td>
<td>5+ years</td>
</tr>
<tr>
<td>FP09</td>
<td>Police officer, England</td>
<td>1-3 years</td>
</tr>
<tr>
<td>FP10</td>
<td>Police officer, England</td>
<td>3+ years</td>
</tr>
<tr>
<td>FP11</td>
<td>Police Officer, England</td>
<td>3+ years</td>
</tr>
<tr>
<td>FP12</td>
<td>Police Officer, England</td>
<td>30 years</td>
</tr>
<tr>
<td>FP13</td>
<td>Police Officer, England</td>
<td>25 years</td>
</tr>
<tr>
<td>FP14</td>
<td>Social worker, USA</td>
<td>15 years</td>
</tr>
<tr>
<td>FP15</td>
<td>Child abuse investigator, USA</td>
<td>1-3 years</td>
</tr>
</tbody>
</table>

Prior to interviewing respondents from the main sample the researcher conducted a pilot study. Polit et al. (2001, p.467) argue that a pilot could serve as "a trial run done in preparation for the
major study” whilst Teijlingen van et al. (2001) note that a pilot could highlight any potential deficiencies with the feasibility of the main research project and allow the researcher to test the proposed methods or instruments.

A small set of three respondents (N=3), who were comparable to the participants of the main sample, was selected for the pilot. They were interviewed using a non-standardised approach (Fielding & Thomas, 2016) so that the researcher could identify any confusing questions or poorly worded instructions to participants, and “detect any tendency for a respondents’ interest to wane at certain junctures” (Bryman, 2016, p.260).

Following the pilot study the interview guide was revised and honed to focus on more specific areas. The main sample of respondents was interviewed using a semi-structured focused interview approach, also known as non-standardised interview. It is considered the most appropriate method of interviewing as it allowed the researcher “…to find out what kinds of things are happening rather than to determine the frequency of predetermined kinds of things that the researcher already believes can happen” (Lofland et al., 2006, p.208). The researcher used an interview guide which included a list of topics to put forward to respondents, but at the same time allowed freedom to phrase the questions as was necessary at the time, “taking their own path” (Fielding & Thomas, 2016; Bryman, 2016).

The average time of the pilot interview was one and half hours which was approximately twice as long as the average main sample interview. The researcher encouraged the respondents in the pilot study to speak for as long and as openly as they liked, often allowing them to touch on the areas they felt were pertinent to the research
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study. This strategy was employed to allow the researcher to develop a better understanding of the nuances surrounding child safeguarding professional practice, and it provided most illuminating findings about some of the ‘sticky’ areas involving the topic of deception and organisational response. It is however worth noting that this freedom was frustrating to the researcher at times due to the unstructured nature of the interviews and the researcher’s apparent lack of control over the flow of questions which resulted in respondents wandering into areas that were irrelevant to the study.

In relation to the main sample, with the exception of three participants (one from England and two from the US) who were interviewed over the telephone, all the interviews were conducted face-to-face. It is argued by some social researchers that telephone interviews can be useful in soliciting more information specific to the research as this form of contact prompts people to stay on topic (Fielding & Thomas, 2016). However, accepting that it may sometimes be more convenient for the respondent to undertake a telephone interview, the experience gained by the current researcher would support a view that, on balance, face to face interviews are generally more productive. In fact, the researcher felt that telephone interviews can not only inhibit the flow of information, but they also tend to make respondents guarded about certain topics, and suspicious of questions. Although in the case of the current research the telephone participants did not withdraw from the interview, they were reluctant to share details or provide additional information. Given the sensitivity around the topic of deceit and the professionals’ ability to detect it, the researcher resorted to minimal probing as she intuitively felt that a number of questions were seen as troublesome to the participants. It could be argued that the inability to share ‘non-verbal’ forms of communication such as facial expressions and body language is an
inhibiting factor in telephone interviews, but having said that, a telephone interview is undoubtedly better than no interview at all providing the researcher considers any limitations when analysing the data gathered.

Compared to telephone interviews during the fieldwork for the current research, face-to-face interviews were found to be more appropriate in providing an extended response. Sturges and Hanrahan (2004) note that interviewing face-to-face is in fact particularly useful where the topic is sensitive and trust needs to be invoked to allow the respondent to be more confident in making disclosures. This was therefore the preferred method utilised for this study.

The majority of the interviews were digitally recorded and transcribed, although the researcher also maintained notes to allow quick recall of key observations. Hence the primary data was collected through two avenues of inquiry: interview transcriptions and researcher field notes. All interviews took place between March 2016 and April 2017.

**Primary data: Observational fieldwork**

This aspect of fieldwork took place almost by chance. Whilst carrying out a pre-planned interview with one of the key respondents in England, the researcher was invited to attend a Level 2 training course on *Working with Hostile Families and Disguised Compliance* being delivered by a Local Safeguarding Board in England to child safeguarding professionals, which was due to take place within the next few days. The one-day course aimed to provide the practitioners with the context and their responsibilities when working with resistant parents as well as those who use disguised
compliance. Additionally it was set to offer professionals with specific techniques and approaches to deal with these types of parents. Furthermore, the course was meant to be immersive in nature to allow the participants to engage in a role play whilst navigating through simulated “real-life” scenarios involving deceptive and resistant parents. Hence the participants were tasked and expected to act in the simulated environment in the same way that they would have been operating in their day to day practice, albeit in a low-pressure/low consequence environment.

Considering the relevance of this subject in relation to this current research, as well as the unique nature of a training course, the researcher agreed to participate in the observation of the event in order to gain meaningful insight into some of the rationale that underpins professional decision-making.

Amidst the relative lack of understanding of deception in the child safeguarding context as well as limited appreciation of professionals’ behaviour in challenging situations when dealing with parents, the participation in the training session which utilised the immersive approach allowed the researcher to understand how certain decisions are made (Gray, 2009) by frontline practitioners when they are confronted with potentially deceptive parents. Thus, this type of observation allowed the researcher to draw inferences about the effect of an ‘exposure’ (simulated ‘real-life’ situation involving potentially deceptive parents) on practitioners. In fact, one of the ground rules set out by the trainer who opened the event was to fully discuss what it is really like to keep children safe in the house where parents try keep the professionals at arm’s length” (OB).

Additionally, as discussed in the following section on Researching within closed professional groups, the researcher wanted to examine
whether data produced as a result of the behaviour observation was going to be different to self-report data produced by the method of interviewing. Thus, the observation data was used in a confirmatory way to interview data.

Out of twenty two (N=22) practitioners who were booked to attend the course, fifteen (N=15) practitioners attended. These were represented by two (N=2) home visitors, eleven (N=11) social workers and two (N=2) family workers. Throughout the event they regularly engaged in discussions of their experiences of working with potentially deceptive parents. During the role play they had come with strategies and methods of identifying deception and demonstrating subsequent steps whilst explaining their rationale.

This was an ethnographical/participant observation whereby the researcher became a member of the group under study and the observation took place with the agreement of all participants and the trainer. The researcher revealed her identity and related the purpose of the study. Such a transparent approach was adhered to in order to avoid ethical issues related to deception of participants, yet allow adequate observation and recording of data.

Yet with participants knowing they were being observed, there was a possibility of the Hawthorne effect whereby participants could have altered their behaviour. To mitigate against this effect, the researcher described the purpose of the study in more general terms so that participants were not fully aware of the intricate details of the study, and therefore could not react to these (Forcese & Richer, 1973). Hence the researcher explained the purpose of the study as ‘Exploring issues with professionals identifying and responding to resistant and deceptive parents’.
Additionally, to ensure that the participants did not feel they were watched constantly, the researcher took notes of the conversations and interactions intermittently rather than continually (Forcese & Richer, 1973). This was considered by the researcher to be the least intrusive method to capture data.

Hence this observational fieldwork enabled the researcher to gather supplementary rich data whilst using a participatory perspective. In addition, whereas interviewing provided a fragmented view of the professionals’ practice, the observational method allowed for the research to be informed of the comparatively “realistic” environment within which child safeguarding practitioners operate as well as multiple complexities this work entails.

The notes of the participants’ behaviours, utterances, views and decisions to simulated ‘real life’ scenarios made by the researcher during the observation were comprised into one document entitled ‘Working with hostile families observation’, imported into NVivo and for coding purpose, used as one unit of analysis (OB).

3.3 Researching within closed professional groups

A number of studies point out that certain professionals are reluctant to participate in research. For example, a report into health professionals’ views on quality improvement initiatives (The Health Foundation, 2011; Bjertnaes, et al., 2008) identifies that workers within that sector are reluctant to engage in research activities and the report cites a lack of resources, organisational culture, fear of being challenged, the pace of organisational change and frequent mergers leading to ‘initiative fatigue’, as some of the barriers to engagement.
Reiner (1991, p.44) notes that police professionals are hesitant about being tape recorded as a part of the interviewing process “...in case it fell into the wrong hands”.

More recently, when referring to ‘outside insiders’, in the context of former police officers and staff who had become academics to engage in research on policing, Thomas (2014, p.8) suggests that despite having “ultimate inside knowledge of policing, as academics, [they] are still viewed with some suspicion as they now operate outside the police culture”.

Given the increased media attention to child safeguarding professionals who reportedly fail to protect children from harm in high profile cases, it was considered possible that a number of participants in the current research might have felt that they were once again being scrutinised over their practice and decision making. This phenomenon was evident during the fieldwork as many respondents took on a defensive position before, during, or after the interview, and the researcher detected that others may have been guarded in their responses.

Information about the proposed research and its parameters was provided to the participants through an information sheet. It was communicated to the participants prior to and during the interview that their participation in the research was voluntary. They were informed prior to, and during the interview, of their right to withdraw without any adverse consequences.

During the data collection stage of the research project it took the researcher several attempts, sometimes over a period of several months, to conduct interviews with the frontline professionals who had initially agreed to participate in the study. To explain their
unavailability, many of them cited pressures of time and heavy workloads. The perseverance of the researcher was met by comments such as, “I am so busy right now but it does not look like it is going to get better any time soon”, “I am not sure if my views are still important” or “I thought it [responding to an interview request by the researcher] was too late for you”. Out of three individuals who initially agreed but consequently declined to participate in the study, two suggested that they ‘did not have anything new to contribute to the study’. The researcher felt that frontline professionals, social workers in particular, often wanted to ‘appear small’ as professionals and had a low opinion of the value of their potential contribution to the research.

It is recognised that the location of an interview might have an impact on the quality of the participant’s responses (Elwood & Martin, 2000). Conducting an interview in the respondent’s office may inhibit them, especially if the office is ‘open plan’ or does not offer privacy. Conducting an interview in a public place, especially for child safeguarding professionals, creates issues around confidentiality due to the danger of being overheard. Other factors such as the formality of the interview and nervousness (both on the part of the interviewer and the interviewee) had to be accounted for (Bygnes, 2008).

It was recognised by the researcher that in order to collect rich data it was important for the respondents to feel comfortable, and it was accepted that the location of the interview should where practicable be decided by the interviewee. In the end, within the current study most of the frontline practitioners chose a semi-public venue for the interviews, usually in a café setting located within the premises of their organisation but with no access to the general public. It was the researcher’s impression that the respondents were comfortable being away from their work area but wished to be situated amongst
their colleagues nevertheless. This was particularly evident during the observational fieldwork. The professionals who attended the training event were visibly laid-back and comfortable in the ‘safe’ environment. Also it was felt that they were particularly outspoken and bold in providing their true views whilst being surrounded by like-minded people who understood what they were going through in their day-to-day jobs.

Prior to the commencements of interviews the researcher was often met with some nervousness and apprehension and was asked once again to reiterate the research aims. It was generally the case that participants became more relaxed and animated once the researcher introduced herself as a former child safeguarding professional. The complexities of researching within one’s own profession (even the former one) are discussed later in this chapter.

The researcher took every step to avoid undue intrusion by creating an undue burden on participants either by conducting longer than necessary interviews or discussing issues outside the areas specified on the previously provided information sheet. Yet despite insisting on the duration of the interview to adhere to the agreed limit of 30 to 45 minutes, most participants, once engaged in discussion, were able to talk freely without expressing any concern about time.

It is important to mention that prior to approaching the respondents or conducting the fieldwork, the researcher sought, and was awarded, a favourable ethical opinion by the Research Ethics Committee of the Faculty of Humanities and Social Sciences at the University of Portsmouth. In the proposal the researcher highlighted the importance of some of the potential risks to the respondents (including a psychological risk) and offered a number of mitigation strategies to address these.
Hence the researcher anticipated that revisiting the topic of failed professional practice in response to deceitful parents might have an immediate and/or delayed impact on the emotions of the participants. Indeed the interview generally followed a loosely defined pattern of practitioners being guarded and minimalistic in their responses, gradually warming up to the researcher, and opening up to provide detailed and rich accounts.

During the latter stage of the interview the participants often commented to the researcher, “Well, you know how it works” or ‘You’ve probably been through that’. However, there were times when the researcher felt that she ‘pushed too far’ by asking a provocative or difficult question as it resulted in the respondents reverting back to being cautious with their words and a reluctance to elaborate. Hence, the researcher aimed to develop and utilise her awareness of cues and/or signals by which the interviewee was indicating distress. It was important for the researcher to comment on the strengths of the interviewee, whilst at the same time allowing the interviewee to terminate the interview if too distressed (McCosker et al., 2001).

All participants were assured of their right to confidentiality and anonymity, and most frontline professionals chose to remain anonymous in the study.

3.4 The background of the researcher

It is important to contemplate whether by being a former child safeguarding practitioner herself, the researcher has been able to bring the necessary level of objectivity to this current research.
Malterud (2001, pp.483-484) notes that "a researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions". Whilst it is inevitable that each researcher may choose to approach the study from a different position (Koch & Harrington, 1998), the researcher in this study mitigated against possible researcher’s bias by adhering to mix-methods research design, by having an ongoing reflexive dialogue with her supervisor and by maintaining a reflexive journal during the research process.

Literature findings support the use of practitioner research (McKay, 1992; Hubbard & Power, 1999) to allow for familiarity with key processes and the decision-making these involved and to avoid making errors in interpretation of findings due to limited understanding of the context.

Having a professional background had a number of advantages. Primarily the researcher was able to gain access to a wide range of key participants who may have been reluctant to participate in other circumstances. This is not to imply that the researcher knew any of the respondents personally, but perhaps they felt more comfortable in assisting research being conducted by a ‘kindred spirit’. Additionally, the interviewees often explored finer details of their practice and intricacies of organisational culture, perhaps being assured that they would be understood. However in order not to appear collusive to the respondents and not to fall into this trap herself, the researcher more often than not asked the participants to clarify their point, which allowed for the clear demarcation between the researcher and the participant and promoted the
perception of the researcher as being an academic, rather than an expert.

Additionally, this study has a number of limitations.

This study was situated within the discipline of criminology and social science. A psychological study examining the ability of child safeguarding professionals to detect deception in parents as well as their subsequent response is much needed in order to complement or contradict the current findings.

Equally, the views of parents on strategies and approaches they adhere to when deceiving child safeguarding professionals need to be reflected when the dynamics of the relationship between parents and professionals are examined.

3.5 The analysis

Qualitative research involves observation, description, interpretation and analysis of the way the participants experience the world around them (Bazeley, 2014). Analysis is referred to as, "a close engagement with one’s [data], and the illumination of their meaning and significant through insightful…work” (Antaki, et al., 2003, p.30).

Whist adhering to qualitative methodology, the data analysis adopted in this study is supported by the qualitative data analysis pioneered by Charmaz (2006), who draws on works of Glaser, Straus and Corbin’s (1967) on Grounded Theory Method (GTM) as being “a systematic, inductive, and comparative approach for conducting inquiry for the purposes of constructing theory” (Bryant & Charmaz, 2007, p.1).
Constructivist Grounded Theory “emphasises how data, analysis, and methodological strategies become constructed, and takes into account the research context and researchers’ positions, perspectives, priorities and interactions” (Bryant & Charmaz, 2007, p.10). Charmaz (2000, p.523) states that “the constructivist approach does not seek truth—single, universal, and lasting. Still it remains realist because it addresses human realities...” and it assumes that objective knowledge and truth are based on people’s perspectives of these.

One of the advantages of using GTM is that it allows the researcher to stay in “persistent interaction with [her] data, while remaining constantly involved with emerging analyses” (Bryant & Charmaz, 2007, p.1).

A decision to utilise GTM is made for the theory building purposes rather than limiting its use to a systematic analysis of data only. Orlikowski (1993) argues that using GTM in theory building is particularly appropriate when studying processes and where the existing domain is changing. It can be deduced that given the ongoing development of child safeguarding in the UK, the use of Grounded Theory in this study is particularly appropriate.

It has been argued that analysis of qualitative data is the kind of analysis that people conduct in their everyday life as it requires acute observation, clear thinking and considerable creativity (Bazeley, 2014).

Although the current study has undoubtedly been carried out to better understand personal experiences of working in child safeguarding practice, and to quite possibly substantiate what the
researcher has discovered, the foundations for it are underpinned by the philosophical and methodological perspectives adopted.

Hence the study was designed for analysis before the data were gathered (Bazeley & Jackson, 2013), and the problem was deconstructed into a number of researchable questions.

The researcher carried out analysis with the assistance of a type of Computer Assisted Qualitative Data Analysis Software (CAQDAS), known as NVivo, primarily to carry out initial coding in order to deal with vast amount of data. The appropriateness of using CAQDAS in order to facilitate a grounded theory investigation has been documented in research literature (Bringer et al. 2006).

The NVivo project was populated by data records represented by interview transcripts, observational field notes and serious case overview reports. The researcher kept a summary journal to document the accounts of the journey as the ideas were developed (Richards, 2009).

Framed by the research questions, three sets of data thus were collected through serious case reviews, interviews and observation where practitioners related their experiences and perceptions and imported into NVivo.

When analysing data in this format, responses were not grouped according to pre-defined categories, but rather relevant categories of meaning and relationships between categories were originated from the data itself through a process of inductive reasoning known as coding units (Stemler, 2001). This process involved breaking down the data from all three sources into ‘units’ (Lincoln and Guba, 1985) and coding them to categories. These categories were
significant in relation to the research question as these allowed the researcher to seek theoretical insights (Lincoln and Guba, 1985) into what it is like to deal with deception in the child safeguarding context.

Categories underwent changes through cycles of coding, and the appreciation of the properties of categories and the relationships between categories were developed and refined over the course of the analytical process as demonstrated in phases below. As described by Taylor and Bogdan (1984, p.126), “the researcher simultaneously codes and analyses data in order to develop concepts; by continually comparing specific incidents in the data, the researcher refines these concepts, identifies their properties, explores their relationships to one another, and integrates them into a coherent explanatory model.”

There were five phases of analysis. These phases involved three separate cycles of coding and two cycles of managing codes, one of which was for initial categorisation of open codes and one for data reduction through consolidating codes into a more abstract theoretical framework and three which uses writing itself as a tool to prompt deeper thinking of the data (Bazeley, 2009) leading to findings from which conclusions may be drawn.

**Phase 1: Data collection** involved transcribing interview transcripts and observations and importing these together with SCR reviews into NVivo.

**Phase 2: Initial Open Coding** involved broad data from the interviews, observation notes and SCR reviews being driven by open coding into initial non-hierarchical codes supported with definitions so as to deconstruct the data into initial general codes. In order to
avoid being “trapped” by early work with data (Bazeley & Jackson, 2013), coding provided a method of working and building knowledge about data (Strauss & Corbin, 1990). Qualitative data gathered for the current research were large and complex with each transcript generating approximately 30 pages of single-spaced text. To age the data effectively, each of the respondents in the interviewing and each SCR were utilised as a unit of analysis. Each of the interview cases was allocated an attribute based on their gender, experience and role.

Because it was impractical to identify individual participants at the training session and guided the intended use of observation data as confirmatory to interview data, observational fieldwork data was identified as one unit of analysis as a whole in order to stay connected with the research design.

A code was a way of identifying a theme in the text and included descriptive (Urquhart, 2013) as well as analytical concepts. Units of meaning (text segments) were attributed to these codes and a total of 60 codes were created (See Appendix F 1). For example, the codes included ‘Effect’, ‘Empathy’, ‘Investigative interviewing’, ‘Ability to detect deception’.

This process took place over four months although the process of data analysis began as soon as data became available. As the new codes continued to develop, the researcher continued to engage in data collection (through interviews) based on these emerging concepts whilst tailoring interview guides to reflect this. Following this, additional concepts were developed through this constant comparison with additional data.
Data collection stopped when no new concepts were observed to be developing and further coding was no longer possible as the same exact themes or codes continued to emerge from data, otherwise referred to in this thesis as data saturation.

**Phase 3: Identifying and Developing Core Categories** – involved re-ordering of themes identified and coded in Phase 2 into categories. The researcher started with general categories. The researcher was looking for overarching themes first (Bernard & Ryan, 2010). Hence the subsequent coding involved identifying the text in large paragraphs and often coding the already coded data. This was done to identify areas relevant to the study, or those which were about to become relevant but did not appear immediately so. Thus it was coding that supported analysis (See Appendix F 2)

**Phase 4: Focused Coding (Data consolidation)** involved consolidating and refining codes into a framework of codes. For example, the initial category of *Support* became a more focused category of *Training* in relation to deception detection (See Appendix F 3).

**Phase 5: Analytical memo, validation and synthesis** involved writing *analytical memos* against the higher level codes to accurately capture the content of each category and its codes (See Appendix F 4 for an example) as well as validation and revision of analytical memos into a coherent, cohesive findings report.

Thus, the original 60 open codes were consolidated into four core categories and although not analogous with the chapter headings, these categories helped form the basic structure of the thesis:

1. Common tactics of deceptions used by parents
2. Ability to identify deception
3. The role of relationship
4. Organisation

The timeline of key activities and decisions including the methods used and justification for these is captured in Table 4 below.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Key activity</th>
<th>Method decision</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct- Dec 2014</td>
<td>Research Question formulation</td>
<td>Constructivism/interpretivism</td>
<td>Appropriate approach</td>
</tr>
<tr>
<td>Jan- Feb 2015</td>
<td>Research design and methodology</td>
<td>Qualitative informed by secondary (SCR reviews) and primary (interviews and possibly observations) data</td>
<td>Appropriate given that the focus was on decision-making and people’s interpretation of deception</td>
</tr>
<tr>
<td>Apr 2015</td>
<td>Ethical approval granted</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Jan 15-Apr 17</td>
<td>Literature review</td>
<td>In 2 stages (prior and after data collection)</td>
<td>Initial review provided background and gaps, subsequent one connected to emerging data</td>
</tr>
<tr>
<td>Jan 2016</td>
<td>Data collection: Pilot study</td>
<td>Semi-structured interview of 3 key participants</td>
<td>Helped formulate interview schedule for the main sample</td>
</tr>
<tr>
<td>Mar-June 2016</td>
<td>Data collection: Main sample</td>
<td>Interviewing of key participants</td>
<td>Data framed interview questions for</td>
</tr>
</tbody>
</table>
Understanding and responding to deceptive practices by parents and carers in the child safeguarding context

<table>
<thead>
<tr>
<th></th>
<th>Data collection: Main sample</th>
<th>Interviewing of key and frontline participants (UK and US)</th>
<th>New concepts emerge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept – Nov 2016</td>
<td></td>
<td>Observational fieldwork</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phase 1 of analysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan – Feb 2017</td>
<td>Analysis of SCR reports, observation notes, key participants and frontline participants begins</td>
<td>Phase 2 of analysis</td>
<td>Concepts continue to emerge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar- Apr 2017</td>
<td>Data collection: Main sample</td>
<td>Interviewing of key and frontline participants</td>
<td>Revised interview guide is used for interview</td>
</tr>
<tr>
<td></td>
<td>Ongoing analysis</td>
<td>Phases 1 and 2 of analysis</td>
<td>No new concepts are emerging</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phase 3 of analysis</td>
<td>Data collection stopped</td>
</tr>
<tr>
<td>May 2017</td>
<td>Analysis</td>
<td>Phases 4 and 5 of analysis</td>
<td>Core categories finalised</td>
</tr>
<tr>
<td>Mar- Sept 2017</td>
<td>Write up</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The product of this methodology, the four analytical chapters, are now presented below.
Four How deceit is understood

4.1 Introduction

Having explored in previous chapters the context in which safeguarding professionals operate in England and the United States, the literature review surrounding the occurrence of and the response to deceit as informed by Serious Case Reviews, and the methodology underpinning this current research, this first of four analytical chapters begins by examining what constitutes parental deception in the context of child safeguarding practice. Furthermore, it explores how deception by parents is rationalised by the child safeguarding professional. It then considers the extent of deceit by parents and carers as evidenced by Serious Case Review overview reports as well as the evidence reflected in the experiences of police, healthcare and social work professionals working within this area. The most prevalent tactics employed by parents to deceive the practitioners, as drawn from the responses of both the frontline staff and senior managers, are identified. Following this, the professionals’ ability to identify these signs of deceit is explored in detail and the discussion as to whether or not existing research contributes towards professionals’ recognition and understanding of these tactics as deceitful is developed. Although the findings in this chapter are informed mainly by child safeguarding practice in England, an insight into the US-based child protection practice is offered to identify any significant variations across the two systems.
4.2 What constitutes parental deception in child safeguarding

Previous research explored deception in a wide variety of social contexts, such as personal and professional communication (DePaulo et al., 1996; Hancock et al. 2004), digital media (Hancock, 2009), politics (Galasinski, 2000), legal and criminal (Vrij, 2000) business and organisations (Schein, 2004). However, the literature remains largely silent on the motivational and activation factors that trigger parental deception in the context of child safeguarding, and whether these are fully understood from the professionals’ standpoint. In this research parental deception is conceptualised as intentional withholding of information by parents via physical and non-physical interaction in order to create a false belief in the professional as to the present or past wellbeing and safety of the child. This definition is largely adopted from Ekman’s (2001, p. 41) view of deception as a “deliberate choice to mislead a target without giving any notification of the intent to do so” and is consistent with most definitions of deception. The definition above creates no distinction between lying and deception, whereas the former is a form of the latter (Vrij, 2008, etc.). Hence both concepts are used interchangeably throughout this thesis.

The professionals who participated in the current research generally share the view of the previous research by Masip, Garrido, & Herrero (2004) that deception comes in different forms including falsification, omission, and evasion, distraction.

However, one of the findings of the current research is that there are significant variations in the perception of parental deception amongst the police, social care and healthcare professionals engaged with parents in a child safeguarding context.
The studies of Knapp, et al. (1984), and Coleman and Kay (1981), which both examine how lying and deception are conceptualised by ‘ordinary people’, support the idea that social and healthcare workers in both the UK and the US are similar to lay people in that they view deception according to their perception of the reprehensibleness of the lie. In other words, they mentally place the deception somewhere along socially acceptable and socially unacceptable ends of the “harmfulness dimension” spectrum (National Research Council, 1991, p.180).

A notable distinction is made between parents who lie in order to cover up ‘intentional harm’ they are causing their children, and those who deceive because they are reluctant to be open with professionals for perceived less sinister reasons, including the possible concealment of poor parenting. It is acknowledged by the practitioners that whilst the parents in the second scenario are likely to be exhibiting unpalatable behaviour towards their children, it is not intended to cause them ‘intentional harm’. Within this study these two types of deception are conceptualised as ‘malicious deception’ and ‘benign deception’, although it is perhaps true that the term benign only applies because parents and professionals may see this type of deception as relatively harmless. It needs to be recognised that this conceptualisation does not imply that any deception is acceptable, because there may still be adverse consequences for children. An example of benign deception could perhaps occur when a toddler accidentally bruises its head whilst not being watched, but in a misguided attempt to stop a doctor thinking that the parent had committed some criminal or neglectful act, the parent fabricates what they believe may be a plausible explanation, such as a sibling knocking the toddler over. Whilst the parent may feel there is no harm in the ‘white lie’, in fact a falsification of the history could result in a child receiving the wrong type of medical
testing or treatment. This distinction becomes particularly relevant when professionals rationalise parental deception in order to decide on subsequent intervention response.

It is the view of a majority of social and healthcare professional respondents that malicious deception often takes place in sexual, physical and emotional abuse cases, whereas benign deception is more prevalent in cases of neglect. This notion is demonstrated by the following utterance by a social worker:

"In sexual abuse cases, for example, parents are doing intentional harm and in those cases, a parent will obviously set out to deceive because they don’t want to be found out... There is also unintentional harm where parents [find themselves in a situation] not by choice. Most people do not choose to become addicted to drugs. They don’t choose to be with an abusive partner. They find themselves in a situation of neglect. It is not intentional. They don’t want you to know everything" (FP03).

This view illustrates what this thesis is largely set to examine, which is that a professional’s response to potential or known deception in parents is influenced by their understanding and rationalisation of a lie. In the example above, a professional is consciously aware of the presence of deception, but after having an internal argument as to whether or not it is intended to cause harm to a child concludes that a lie is justifiable as being harmless.

What ultimately is missing from this rationalisation is that parents who find themselves in unfortunate circumstances ‘not by choice’ are equally as capable of hurting their children. Lines between intentional and non-intentional harm are often blurred in families
that experience domestic violence, substance misuse or mental health issues. Hence, they are as capable of lying in order to cover their abuse as any other deceitful parents.

The view that the two types of deception need to be differentiated is shared by a consultant paediatrician who states that in relation to parents:

"...deception more commonly arises out of parental anxiety, not understanding the system and basically, being fearful and therefore, not coming out with everything upfront. But it has only been my perception that this is far more common, that it is coming out of parental anxiety and fear rather than deliberately setting out to be deceitful. Whereas there have been other situations where I felt parents have come with a nice polished version of events... And those ones I would be more concerned about” (KP04).

One of the implication of this viewpoint is that to explain their lies, too much emphasis is placed on the context of the surrounding environment and the expected behaviour by parents that goes with it. To attribute deception exclusively to anxiety and fear, because it is what anybody would have done considering the circumstances, is to dismiss the possibility of a parent actively (and masterfully) covering their abuse. A notable example of it was Magdalena Luczak, who skilfully manipulated a number of professionals by appearing genuinely upset, anxious and fearful in order to hide her abusive behaviour toward Daniel Pelka (SCR G, 2013).

Consequently, the perception of what constitutes deception influences these professionals’ attitude towards it. In other words, parental deception is viewed through the effect it has on the
professionals involved. Malicious deception is more often than not rationalised as being harmful to children, and is therefore viewed disapprovingly by social and health care professionals.

For example, healthcare professionals in this research feel that those who lie to cover ‘intentional harm’ do not generally experience any sense of anxiety or remorse when they are confronted about their lies, thus reinforcing the view of these parents as being wicked and bad. Therefore, if perceived to be lying to cover physical abuse, a father is seen as a reprehensible person. This is particularly evident in cases of child protection where a family of a child, who is established to be at continuing risk of significant harm, is monitored by a number of agencies, as demonstrated by this response from a health professional:

“In my experience, their [parents’] reaction is ‘Oh, well’, they are not very bothered that they have lied, like [families] on child protection plans…” (FP06).

Benign deception on the other hand is accepted as almost permissible as it is not motivated by the intent of parents to cause harm to children and is looked upon in a compassionate way. Therefore, if a parent is lying to cover abuse that stems from their persistent drug use or being a party to domestic violence encounters, the professional’s reaction is of understanding and support.

Such a distinction is erroneous because it ignores deception as being a deliberate act to conceal the truth, and it prompts the professionals to categorise deceptive parents into those who lie in order to hide the intentional abuse of children, and those who lie almost by default in order to cover harm that is mostly accidental. Those in the first category are judged severely and condemned, whereas parents in
the latter category are met with empathy and a validation of their actions. In either scenario the professionals’ objectivity is impaired whereby they are unable to view deception dispassionately and accept it for what it is - a deliberate act by parents to hide the truth about the harm they are inflicting on their children.

Additionally, as supported by literature (e.g. Munro, 2010), abuse is often incremental and fluid in nature; neglect often accompanies physical and/or sexual abuse. Hence when professionals perceive parental deception in cases of neglect as excusable they inadvertently endorse neglect as a less significant form of abuse and lying as a justifying act. Additionally, the implication of this is that it then becomes a basis for professionals’ risk assessment of the child and the family and consequent interventions.

Arguably such rationalisation cannot be examined without considering the impact of relationship-based practice as it provides a foundation of how a risk assessment of the child is made and provides a framework for communication and intervention strategies. This is explored in further detail in Chapter Six.

As mentioned earlier, whilst shaping the framework utilised by social and healthcare professionals to determine motives for deception such an interpretation of parental actions demonstrates a departure from the two-dimensional typology of deception (Camden et al., 1984) reported in previous studies that claim that generally people lie in order gain some benefit (a reward) whether for self, others, a particular cause or a relationship (target of a reward) (Hample, 1980; Metts, 1989).

Interestingly, although acknowledging that parents may not always be forthcoming with information due to feeling nervous or
intimidated, the police professionals in this research do not differentiate between malicious and benign deception and generally feel that:

“parents will lie because they are trying to conceal what they are doing” (FP12).

Although significant, this interpretation should be viewed within the realms of police organisational practice and how empowered these practitioners feel to carry out their roles. This is explored further in Chapter Seven.

Arguably, deception in child safeguarding where the intervention of statutory agencies is necessitated would always involve “high-stakes deception,”...“in which sharing the truth might prove very costly to [parents]” (Walczyk, et al. 2014, p. 22) as opposed to other circumstances where the cost of telling the truth is less significant. Thus, given the possible cataclysmic outcome of having their child removed from the family, it is only to be anticipated that all parents are more likely than not to attempt to conceal information, and therefore resist agency involvement, due to the fear of ‘losing’ their child. However, this unobscured view is not shared by all interviewed professionals. For practitioners in social and health care, deception is contextualised and consequently accompanied by an emotional reaction (either negative or empathetic), whereas police professionals appear to remain detached in their view of parental deception.

In police practice, deception is seen as rather a pragmatic decision taken by all parents, who would consider the value of telling the truth against the consequences - an inherent risk that is embedded in child protection. Undoubtedly, this evaluation can be attributed to a lie
bias by police professionals (e.g. Hartwig et al., 2004), whereby most responses by parents are likely to be judged as potentially deceptive. This is not to say that police professionals always view parents with suspicion; in fact they believe that parents do not always resort to deception if they feel that truth was sufficient enough for them to maintain the advantage, and this echoes findings by Levine et al. (2010).

As reported by a senior police detective:

"They [parents] will be truthful in 99% of what we are asking them about. But the real nugget of what we are trying to drill into, they will just lie about" (KP03).

Nevertheless, parental deception is perceived by these practitioners as one of the strategies used by parents to hide abuse and subsequently avoid agency intervention.

Interestingly it is also accepted by social and healthcare professionals in child protection practice that parents are likely to resort to deceit. However, for these professionals, with parental deception being distinguished between malicious or benign, the former is attributed to certain categories of wicked parents and relatively rare in occurrence. There is a shared conviction that the vast majority of parents do not wish to hurt their children. This is underlined by the response of a designated nurse with 30 years of experience in child safeguarding who believed that she had:

"never met anybody who was lying [with malicious intent]" (KP06).
Thus, it is the belief of social and healthcare professionals’ that parents who lie do not do so to be able conceal abuse of their children, but rather because of their distrust of professionals and their reluctance to be intruded upon in their private lives. However, what is missing from this rationale is that parents view their interactions with, and attitudes toward, their children as part of their private lives too. Therefore, by avoiding an intrusion into family lives professionals inadvertently impede their capabilities and chances of safeguarding the child.

With this in mind and considered against the backdrop of Reinhard’s et al. (2014a) findings that social workers tend to demonstrate a truth bias and generally do not view their clients as liars, it comes as no surprise that many professionals fall prey to ‘disguised compliance’ (Reder et al., 1993). This phenomenon arises in situations whereby in exhibiting certain apparently positive behaviour to appear cooperative with the agencies, parents are able to hide the evidence of harm in order to avert suspicions and consequently preclude any agency intervention. It is reasonable to infer that even when professionals recognise the signs of deceit, they often attribute it to the signs of benign deception, where the risk to the child is assumed to be minimised.

Amidst the variations in the views of child safeguarding professionals as to what constitutes deception, it should be explored in relation to its prevalence in practice, and the discussion in the next section provides evidence.

4.3 The extent of parental deceit in child safeguarding

The current research finds that it is not unusual nor unexpected for a professional in child safeguarding to come across a parent who
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tells lies. This is also a finding within Ferguson’s (2011) work on resistant clients in social work which indicates that over the past 100 years parents have often managed to deceive practitioners.

In relation to malicious deception however, in social and health care practice, deceit by parents gained recognition with the introduction of the term ‘disguised compliance’ (Reeder et. al, 1993). An example of this would be the parents making cosmetic efforts to tidy up the house, change the child’s dirty bedding, ensure that the child attended the planned doctor’s appointment etc., immediately prior to the visit of a professional, or falsely declaring a separation from a violent partner or adherence to a drug-free lifestyle. All these efforts are made only for a short period of time – but just enough time as is necessary to create a false impression that they have seemingly embraced the positive changes requested by the professional. Resonating with the repackage technique used by liars to distort ‘the perceived reality’ in practitioners (Humphreys & Peelo (2013, p.56) in citing Whaley (1982)), these, as well more explicit deceitful tactics, were present in almost three-quarters of serious case reviews (Brandon et al. 2008; 2009) suggesting that such deception is common and widespread.

Yet, despite these findings, certain child safeguarding professionals are reluctant to acknowledge that a parent can lie maliciously. As mentioned above, largely attributed to a truth bias, this reluctance can be explained by the adherence of certain professionals to ‘social conversation rules’ (Reinhard, et al., 2014a) where is it inappropriate to be suspicious of everything that is said and done by a parent, so as to not jeopardise an open and trustful relationship. There is also a belief amongst some of the social work professionals contributing to this research that a close relationship with parents leads to a mutually trusting and honest relationship, a framework that makes
each party confident about recognising each other’s lies, and one that would preclude parents from lying. This is sometimes known as ‘relational truth-bias heuristic’ (Vrij, 2008).

Thus the factors above may offer an explanation as to why deception by parents is often rationalised by social and healthcare professionals as a strategy for such parents to hide their fears, anger, dissatisfaction, shame, addictions, or abusive past, rather than abuse they are themselves perpetrating. Although it is likely that many parents in the child safeguarding context do experience many of the issues above, accepting these as the only explanation for deceitful behaviour inadvertently shifts the professionals’ focus from the child to the parent, as they strive to achieve an honest and trustful relationship. It also removes the responsibility from parents for their abusive behaviour, no matter how ‘unintentional’.

It is argued in psychological literature that professionals’ judgements and decision-making are in fact often guided by them focusing on a particular aspect of problem whilst ignoring other areas, known as heuristics. Kahneman’s (2011) argument that professionals would often see the ‘official’ source of knowledge as more valid, otherwise referred to as illusion of validity, can explain why child safeguarding practitioners choose to accept parents as vulnerable rather than deceptive.

Kahneman and Tversky (1972, p.237) also highlight how practitioners in making decision reply on heuristics "which sometimes yield reasonable judgements and sometimes lead to severe and systematic errors."

Prentsky et al. (2015) warns about dangers of incomplete and/or imperfect knowledge when trying to predict human behaviour
suggesting that professionals step back and reflect on their decisions.

Additionally, Prentsky et al. (2015) discuss affect heuristics arguing that professionals’ actions are often influenced by their emotions, as related earlier in the chapter. Thus in Prentsky’s et al. (2015, p. 214) view, the professionals’ capacity for “holding at bay [their] emotional responses to clients is instrumental to conducting an unbiased, objective evaluation.”

It is of interest that when referring to deception by parents, social work and healthcare respondents use the terms ‘disguised compliance’ and ‘deception’ interchangeably in order to refer to subtle and explicit signs of deception respectively. Police practitioners however are comfortable using the words ‘deceit’ or ‘lies’. This variation in the usage of language will be examined fully in subsequent chapters because it is one of the most important, and arguably concerning, themes emerging from the current research. The phenomenon can be conceptualised using the term ‘misvocabularisation’.

As well as with some rather clumsy or superficial attempts to deceive, this research also reveals that parents are prepared to go to great lengths, and to use considerable ingenuity, to cover their abuse of children who were seriously injured or died, which resonates with prior research findings (Tuck, 2013; Laming, 2003; Laming, 2009). For example, in one of the eight SCR overview reports analysed for this study (SCR A, 2012), the parents of a ten-year-old girl who was found hanging from a window in her own bedroom, explicitly lied about the circumstances of every allegation of sexual abuse and neglect over a period of 6 years. In another report (SCR C, 2012), against the backdrop of the mother’s prolific
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use of alcohol and drugs, mental health problems, extensive criminal record and having other children previously subject to care proceedings because of neglect, the mother and her new violent partner managed to deceive professionals routinely during pre-birth and the next six months of Baby J’s life prior to him being killed. The mother managed to hoodwink the professionals by giving plausible explanations for every incident of substance abuse and violence. The father on the other hand used aggression and intimidation to ensure that professionals were kept at bay, away from the evidence of abuse.

Despite the lack of firm evidence to support a notion that professionals were able to detect deception in the analysis of serious case reviews, this research finds that practitioners are generally aware or suspicious of being lied to by parents in their routine practice.

All the participating child safeguarding professionals, across different agencies, both key respondents and frontline professionals in the UK and the US (N= 23), stated that they encountered parents whom they thought were deceitful with them. The occurrence of deceit is considered to be so commonplace that a newly qualified social worker in the UK, who had been in her employment for no longer than 18 months, suggested that:

“It [deceit by parents] is part of the job” (FP02).

In relation to social and health care practice, this is particularly true for those whom Ferguson (2011) calls ‘involuntary clients’, i.e. those who are perceived by statutory agencies as a risk to their children and themselves, but who do not want offered services, and who resist agency involvement by means of non-cooperation including
deception, as also indicated by Pearson (2009). However, prevalence of deception is believed to be also commonplace amongst voluntary clients who actively seek professional help because they have a problem, but who nevertheless tell lies because they are:

“...in a mess” (FP03).

Thus it is acknowledged that deception in itself is not attributed to certain categories of parent, and in fact is not an exceptional practice.

The view that parental deception is prevalent in the arena of child protection is shared by an experienced frontline child welfare worker practising in the State of Florida, USA, who explained:

“One of the premises that you have to live by in our business - and it has been this way forever - is people lie. There is nothing you can really do about this. Let’s not beat around the bush, people lie” (FP15A).

Hence, similar to their counterparts across the Atlantic, child safeguarding professionals from the United States view deception as commonplace. However, different to the practice in England, there is a sense of firm recognition that deception cannot be helped or eradicated; rather, it should be included as a part of risk assessment. This view may suggest that some of the US based social workers, analogously to police professionals, are exhibiting a lie bias.

From a police perspective, both frontline and key respondents (N=7) are of the view that the majority of offences against children are committed by their parents, their family members, or people who have legitimate access to the children. This is an assertion supported
by the literature (NSPCC, 2017), and the current research indicates that police professionals often have to deal with uncovering the circumstances of parental deceit. This comment by one police respondent is representative of that professional group:

"Deceit is pretty much what we deal with" (FP12)

When asked to describe how often they are lied to by parents, and how it is expressed, another frontline police detective explains:

“Very regularly...The last thing a parent wants to do is tell us that they have committed offences against children... It is when you confront parents they would tell a lie to you to protect themselves or try to protect siblings or keep possession of the siblings or the child. But occasionally, we will come across people that will be telling lies to conceal the ongoing abuse. So, not just when the game is up” (FP13).

Hence it is the view of police professionals that in instances of child abuse, when the stakes are high, such as parents going to prison and/or having the children removed from their custody, they are likely to lie more often and more dexterously for fear of being uncovered.

Furthermore, some social work participants feel that it is not only child safeguarding professionals who are lied to, but that court professionals are equally affected. This is perhaps adequately illustrated by one of the social work participants dealing with parents in child protection cases:

"There are some very able parents, and there are parents who are very able to persuade not only social workers, but
the court, that they will, and they can change, and that their best intention is that they are going to do things, and then they don’t” (FP01).

Although all social care and police frontline practitioners (N=11) acknowledge that some parents are exceptionally skilful at being deceitful and putting up a very convincing performance, a view that is supported by literature (Ferguson, 2011; Trotter, 2006), they feel that those parents who were exposed to agency involvement over an extended period of time are exceptionally skilled at lying. This supports the literature findings that lying is learned and the longer it goes unchallenged, the bolder and more elaborate the lies become (Garrett et al., 2016). When asked about their experience of deceit in parents, the Senior Investigative Officer working on the case of Daniel Pelka, who was brutally murdered by his parents, provided this personal assessment of Daniel’s mother:

“She was able to manipulate most situations. So, essentially, she was just a good liar. And I think as well, because she had a lot of time in her life dealing with professionals, whether it was social services, school staff, or health, you evolve as a liar, don’t you, you become better at it. And if you are doing it on a regular basis you become better at it. You become less intimidated by professionals and you know what works”(FP13).

The correlation between long standing agency involvement and parental ability to become ‘better’ at hoodwinking professionals is noted by a social service professional who feels that:

“...disguised compliance is more seen in the families who have been through the system quite a few times and who
**understand the process and what to say and what to do.**

*That’s where you see it most*” (FP04).

These findings allow an inference to be drawn that the longer parents manage to get away with lying to professionals, the more confident and the more sophisticated they become at covering their abuse, and consequently the more challenging it becomes for professionals to make sense of and confront deceit that they are faced with. Although the latter point will be explored in greater detail in Chapter Six, it helps to recognise that deception by parents in child safeguarding represents a progression from fairly innocuous, non-malicious ‘benign deception’, to serious and calculated fabrication that aims to cover up ongoing abuse and neglect. Arguably it is misguided to think that the progression begins from the so called *benign* type of the malicious -benign deception taxonomy. Instead it is likely that when initially the parents have lied to cover the circumstances of abuse as they know it would bring interventions, they manage to succeed in not being challenged and/or uncovered, and thus become more and more emboldened to pursuing this strategy of engagement. Yet to see benign deception as a starting point upon which deception is built reinforces the view of deception as justifiable in some circumstances, and cripples the professionals’ judgment as to the ability to prevent abuse.

Furthermore, the participants in this research generally express the view that deceitful parents resort to certain particular behaviours when their intention is to hide the signs and circumstances of neglect or abuse, referred to in the current research as ‘deception tactics’.
4.4. Tactics utilised by parents to deceive

This research identifies an array of common tactics used by parents to deceive professionals as recognised by the practitioners themselves. These are illustrated in Figure 3 below. Interestingly, some of these were utilised by parents to attempt to deceive professionals across the spectrum of the social care, health, and police agencies, but some tactics seemed to be specifically deployed against one particular agency’s professionals more than others.

Figure 3. The tactics utilised by parents to deceive child safeguarding professionals
The parental tactics to try to avoid agency intervention and deflect attention from the signs of harm being perpetrated on the child, or making themselves the focus of attention, are commonly shared across the social care and health practices. The participants from these two disciplines observed that it is not unusual for parents who do not wish agency involvement to fabricate not being at home for visits, to fail to respond to any communication, to miss appointments to doctors for the child, or not send children to nurseries or school. In other words, by being very difficult to reach in the first place, parents inadvertently present professionals with an ‘alternative problem’ in need of a solution in order to divert the professionals’ attention from ‘the real problem’ and their ultimate purpose of the intervention, the safety of the child. Consequently, most of the energy, time and resources of professionals is spent on trying to get to see the parent in order to get access to the child.

This is illustrated by a healthcare professional who expressed frustration at not being able to monitor the child in the family:

".. if you get an appointment with someone and they are not in, and then you make another appointment with them and they are not in, and you see them at a meeting the next time and you say, 'Why did you miss those two meetings?'; they would say, 'Oh, I forgot, I just forgot.' And you instinctively know that they did not" (FP 06).

In one of the SCR overview reports, the use of avoidance tactics by parents resulted in professionals spending a lot of time trying to meet with the family rather than actually working in a systematic way with them (SCR D, 2011), and the opportunities to keep the child safe were missed.
Parental avoidance of intervention is cited by another professional, this time a social worker, who states:

"The parents would pretend that they are not in or when they are in, distract you with the crisis which is completely separate from the real reason you are there, deflect you by maybe talking about a neighbour and the concern they’ve got there” (FP08).

In relation to deflection, financial problems within the family often become the main focus on the intervention by social care, although the parents decline any offers of help (e.g. SCR A, 2012). In another instance, to shift the professionals’ focus from the needs and wellbeing of their child, the parents often resort to “distraction behaviours, being argumentative and walking in and out of meetings. [Mother] often displayed physical symptoms of being unwell during meetings” (SCR E, 2014). In SCR F (2013), the mother fabricated a sexual abuse story of her daughter by a relative to cover up her own abuse of the daughter.

One participant, a senior social worker, explains how she has experienced parents’ use of the tactic of attempting to make themselves the centre of attention:

"...some parents will dominate and you end up talking about the needs of the parent. And the child is there, you see them but you are not talking to them on their own” (FP03).

Additionally, within social care practice, in order to keep workers at a distance, parents also appear:

“plain ignorant” (FP 02)
...and use children by:

“...coercing them not to be open and honest and not to trust professionals” (FP08).

In SCR G (2013), the mother coached her young daughter to tell the professionals that her brother “ate more than her and that he was retarded,” whereas in fact the boy was being starved.

Avoidance tactics by parents are often paired with obstruction and aggression toward social workers whereby parents openly refuse them entry to premises by using threats and intimidation, in some case denying entry for months (SCR B, 2012). When parents do not want professionals in their houses to avoid disclosing the true picture, they use intimidation, aggression and hostility to:

“make social worker fearful...” (FP 01)

...and concerned about their own safety, which removes their focus from the child, as supported by findings of Littlechild (2005a and 2005b). This suggests that hostility and aggression cannot be viewed without fully assessing the issue of deception and the relevance of these tactics to the overall deception strategy to cover the abuse.

In SCR G (2013), the Daniel Pelka case, it is reported that when education and welfare officers visited the address to say that Daniel’s attendance at school was at a very poor 64%, the mother cited her own poor health condition, and reported that she found it very difficult to walk long distances. When the education and welfare officers pursued this for a while and offered to make adjustments and help with transportation, the mother became very confrontational and quite aggressive. During the interview for the
current research, the police Senior Investigating Officer in that case explained that it got to the point where she was threatening the education staff by saying:

“If I drop down in the street because I am really poorly and you are making me go to school with Daniel and his sister, I’ll sue you, it will be on your head” (FP13).

Consequently, these professionals backed off as they were intimidated.

These intimidation tactics are largely absent in police visits and it is reasonable to suggest that unlike with health and social care professionals, parents are reluctant to use threats and pressure in their police encounters because they do not consider these to be effective in covering abuse. In other words, and as illustrated earlier, it would appear that parents would adapt their deception tactics to suit their intended audience whilst making a rational determination as to what they would be able to get away with. The intimidation and aggression with health and social care professionals is likely to result in the withdrawal of these practitioners from the scene, whereas with the police it is likely to lead to the arousal of suspicions.

In interviews with health care professionals including health visitors, nurses and a paediatrician, parental deception tactics are perceived to be focused on concealment of the signs of harm perpetrated on the child which include deliberately inflicting injuries in places that are not obvious to the naked eye, providing no explanation for injuries, or ‘pushing’ another explanation.

A health visitor respondent who has been in the safeguarding arena for nearly two years, and was previously an adult nurse for 10 years,
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Understand how parents conceal the harm caused, and how it is linked with avoidance:

“If a parent is going to abuse their children I think they will go to extreme lengths to not be found out. So, I would guess if they did inflict injuries they won’t be anywhere where they could be seen so like the face, the arms. So they’ll do that because I suppose in their eyes they [children] would not be seen naked routinely anywhere, so they could hide things like that, and being clever, I don’t like to use that word, I suppose it is in a way, by not letting professionals in. So they won’t answer the door, won’t turn up to appointments….And so maybe not send their children to a nursery because a nursery always have the opportunity to see the child naked if they are changing clothes.. So, yeah, by putting that barrier up to professionals really and not letting them in” (FP06).

Identifying the common tactics, a designated paediatric doctor offers a detailed account of what it is like to work with deceptive parents:

“I have a situation where a child is presented with an injury. The parents just completely push it aside, so you’ll ask them a question and they’ll go on describing something completely different. I’ve certainly come across that before. Or some parents will give you a detailed account and particularly, where parents have been keen to trying to emphasise how much they’ve been caring for the child” (KP04).

Additionally, this doctor explains:

“In two other scenarios when I do see some deceitful behaviour from time to time is one, when the child is not...
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growing well and we are suspecting some degree of parental neglect and where the parents are pushing and pushing for some medical explanation. That’s certainly something that I’ve seen where I thought they are just not acknowledging or admitting that they are starving the child. I’ve certainly seen that. The other one would be again children who are not attending schools, so other elements of emotional neglect and again, the parents are putting it down to ‘Oh, he was unwell, he’s got ongoing chronic problems,’ and so on. We definitely see those situations” (KP04).

As evidenced in the SCR G (2013), the mother of the starved Daniel Pelka had successfully ‘pushed’ his treating community paediatrician to believe that a rare family genetic disorder explained Daniel’s rapid loss of weight and his ‘obsession’ with stealing food in school. As it later proved, the ‘disorder’ was entirely fictitious.

Within the research sample, some health visitors and nurses working with families also explain that they think the parents are not truthful when:

“...they either do not go into enough detail or just provide exaggerated symptoms” (FP 05).

The fact that both behaviours can attribute to deception indicates how difficult it is to identify it, and the lines between what constitutes benign or malicious deception are blurred.

Another sign of deception is recognised through collusion between parents, and the ‘united front’ they put on in order to deceive professionals following the serious injury or death of their child or the child’s admission to a hospital. It is natural for parents to seek
each other’s support in a crisis, particularly when it comes the death of a child. However, it is the in-separateness in a physical and emotional sense of the word that is perceived by police professionals as sometimes masking deceit. This could be evidenced by the comments of a police respondent – a detective investigating allegations of child abuse, who discussed one of the cases he recently encountered:

"When she [mother] gets to the hospital with baby, death is pronounced, father pushes in there and literally, stands side by side with mother. The recurring thing for this case and others that I’ve dealt with is they do not leave each other’s side. So it’s not the case of mother goes off and father wanders off. It’s the case both of them want to stay by each other’s side. The only time they have a slight break is when the father is on the phone...But he is in line of sight of mother. And at times when mental professionals then come back to mother, he terminates phone calls and goes straight to her. So if there are any questions, they answer them both together.... And throughout this case and the others, both parents have maintained that they were going to stick together and say that verbally to the healthcare professionals, ‘We are sticking together, we are not going to be separated, we are in this together’(FP12).

This theme is continued by another police respondent, a Detective Superintendent:

"When collusion is present, it sometimes takes a while to get going. They [parents] may well have heard before we knock on the door that something is going on, they may well have heard that we are going to be alongside social services, be
asking them some tricky questions about what’s been happening in their lives and they’ve had an opportunity to collude together. And again, if you got two accounts that are pretty much identical, you can end up being conned into the fact what they are actually corroborating each other here, that adds a certain amount of weight to both of their stories, whereas actually they could be very good at covering up because they’ve had an opportunity to collude” (KP03).

Interestingly, the same behaviours that may be perceived as benign deception which stems from fear and anxiety by parents, as viewed by social and healthcare professionals, are recognised as signs of malicious deception by police professionals, who show a lie bias.

In order to deceive, parents are also seen to exploit cultural differences. In relation to Daniel Pelka’s case, as reported by the Senior Investigating Officer working on the case, the mother:

“...would exploit the language, the fact she would say that she needed time to think about a response, when she was put on the spot. Again, she would use the fact that she was Polish, pretend she could not quite understand what we were saying, when in fact her English was perfect” (FP13).

The same respondent also mentions another case he had been involved in whereby in order to deceive the professionals into seeing her as a victim, rather than a perpetrator, a religious mother who wore a full-face veil, presented to health care professionals and the police as someone who was very intimidated by men and was very nervous around them. Despite portraying herself as meek and vulnerable, she was found by the police to be:
"...lying throughout the investigation. She was actually having an affair with another man, and she and the man she was having the affair with worked incredibly hard to influence witnesses, destroy evidence, persuade neighbours to remove CCTV” (FP13).

As demonstrated by Figure 3 above, parents also exploit the multi-agency approach to child safeguarding and are found to be playing professionals against each other to cause mistrust and confusion amongst professionals and ultimately to cover the signs of abuse.

This also involves sharing a particular piece of “very selective information” with one professional to imply their engagement and working with the system:

"...but actually there is a whole raft of information that they haven’t shared and they haven’t been open about” (FP 08)

As related by all participants in the current research, it is common for parents to employ ‘passive-aggressive’ tactics to appear cooperative and compliant (Dale et al., 1986; Calder, 2008) and consequently steer professionals away from their families and the child. As discussed earlier, in social work research, these deception tactics are associated with ‘disguised compliance’ (Reder et al., 1993), or ‘pathological communication’, and were observed to have a paralysing (Ferguson, 2011) effect on social workers as to their ability to recognise them as deception. This phenomenon is supported by a police respondent:

"It was the nice people that manage to manipulate the whole situation. They sound plausible...” (FP09).
Interestingly, no fixed definition is offered to explain what constitutes ‘nice’. However generally it is shared across all child safeguarding professionals that a ‘nice’ parent is someone who comes across as cooperative and agreeable, shows remorse, is willing to change and appears to love their children. Arguably all of these qualities can be, and are, disguised by parents in order to hide abuse and therefore should be viewed with scepticism.

When asked to share her experience of ‘disguised compliance’ in parents, a senior social worker working with children and families states:

"I’ve become very aware of families who have appeared to comply with what has been asked of them. I’ve seen cases where parents are extremely pleasant, friendly, seemingly cooperative with social workers and their managers, where they’ve agreed in court that they will do certain things, and then actually failed to do that” (FP01).

As stated previously, ‘disguised compliance’ is frequently used by families who have a long-standing involvement with services and therefore have learned how to ‘play the game’. Interestingly it is noted by both social and healthcare professionals within this study that these tactics are sometimes accompanied by overt resistance to any kind of interventions, and parents are quite open about their refusal to cooperate. Bizarrely it seems that some parents operate a ‘carrot and stick’ approach to manipulate professionals. This is illustrated by a response of another experienced social worker:

"I also have that in my current role where there is evidence of families stating quite clearly that they’d be happy to have social services out of their lives. So they just say, ‘Yes’ to
what’s needed and then don’t do it… I then directly in the last couple of years, maybe 3 years, I had to work with a father who was quite clear that he had agreed to do what the social workers wanted him to do but only to get them quote ‘off his back’. But he clearly faulted everything they’d asked him to do. He was quite open about it. He had no intention of doing that” (FP07).

Although it is feasible to contemplate that this father’s strong resistance to cooperate was a result of his “anxiety because of the seriousness of the accusations” (Shemmings et al. 2012, p.131), it is also not unreasonable to infer that such a combination of tactics was recognised by the above professional as being utilised as an effective way to continue to deceive professionals over an extended period of time.

Thus, it would appear that in relation to ‘disguised compliance’, professionals often do suspect or are acutely aware of parental strategies and behaviours associated with this type of deception.

However, despite the fact that most child safeguarding professionals are aware of and able to identify a number of tactics utilised by parents as deceitful, they do not appear to be entirely confident in their ability to recognise deceit when confronted with it.

4.5 Ability to detect deception in parents as perceived by child safeguarding professionals

One of the main challenges associated with professionals recognising deception by parents using particular tactics is that the tactics rarely stay the same, indeed they are subject to continuous change as
dictated by ever evolving circumstances. These findings echo the previous findings by Brandon et al. (2009). In fact the tactics become associated with deceit only with the benefit of hindsight, rather than when they are utilised by parents “live”.

When asked of the social care respondents whether they are able to spot the signs of deception, a senior social worker noted:

"Do any of us in a way? I don’t know if we always do. Because we [child safeguarding professionals] don’t always see it in the same way and professionals don’t always get it right 100%” (FP01).

Another social care professional supports this view by stating:

"I don’t think you will ever know hundred percent“ (FP04).

When enquired about possible reasons as to why this might be the case, a respondent provides:

“"I think it’s because people basically are trusting of other people” (FP01).

On the surface this supports the findings of Reinhard et al. (2014a) that social workers tend to trust their clients and refuse to see them as liars, which as previously discussed is known as a truth bias. Yet what is emerging from this research is that lying in child safeguarding practice is rationalised by some professionals as sometimes acceptable and sometimes unacceptable, and the relationship between what constitutes deception and the ability to detect it is not straightforward.
As the earlier findings demonstrate, it is likely that despite being aware of a variety of deception tactics by parents, a professionals’ ability to recognise deception is guided by a rational decision-making process closely intertwined with the type of response that follows. Such a decision might be conscious, when practitioners are recognising the signs but are able to rationalise deception as understandable and acceptable. An example of this would be for professionals to attribute deception by a parent to the latter’s drug problems, mental health issues or the history of child abuse. Equally, this decision may be unconscious, when professionals suspect they are being lied to, but refuse to believe that the lie exists.

A feeling of empathy directed towards parents and their unfortunate circumstances is found to be another reason why social care professionals feel it important to rationalise deception, as indicated by a newly qualified social worker:

“Sometimes with the initial families as well, they might be quite guarded with what they give because it’s quite intimidating. I would be intimidated myself if social workers come into my house and question me. I would guard the information as well” (FP04).

It is possible to infer that the empathy felt by social workers towards parents can have a debilitating effect on their ability to recognise parental deception, and this is evidenced by the response of an experienced social worker who stated:

“Actually sharing things is very, very difficult. They [parents] feel very threatened by Children’s Social Care and they quite often close down. So, whether it’s a hidden issue of a child that
Understanding and responding to deceptive practices by parents and carers in the child safeguarding context

they have not admitted to having been removed historically, or substance misuse, or domestic violence, all these kind of things are very much a hidden story behind the permanent concerns” (FP08).

However, all child safeguarding professionals speak of somewhat greater confidence in their ability to detect deceit by relying on their intuition and practice wisdom, as well as by looking for cues for deception. This finding supports previous research that provides that expert persons tend to demonstrate bias toward perceiving deception (Vrij, 2008; Bond & DePaulo, 2006; Kassin et al. 2005).

Despite research findings that argue against verbal and non-verbal cues as reliable in deception detection (Vrij, 2005), all child safeguarding professionals rely heavily on these signs in their assessment of parental veracity. For example, when asked if they were able to tell when parents are untruthful in their accounts, a social worker who has been working for Children’s Services for almost 8 years, stated:

"It’s kind of gut feeling and the practice wisdom. I don’t think you are telling the truth. And we know our parents, well, we don’t know them very well. But you kind of see most parents, every 3 weeks, so you get a good feeling of their tell-tales, them looking up, avoiding eye contact, looking down, they are kind of shoving past the subject” (FP02).

This evidence supports the findings of research by Reinhard et al. (2014a and 2014b) with regards to social care professionals who argue that due to ‘relational truth-bias heuristic’, the professionals have a tendency to believe that by having a close relationship with people, they are better able to identify signs of deceit. Yet as
provided by the same group of researchers (Reinhard, et al., 2014a),
the situational familiarity is likely to improve the professionals’ ability
to identify truthful accounts, but not lies.

The same research participant further elaborates on the role of
intuition in deception detection by saying:

"The gut feeling, and I did a reflective piece of it, is comes
from somewhere. It is based on your knowledge, skills, and
practice wisdom, your experiences. You cannot just have a
gut instinct that comes from nowhere...“ (FP02).

Yet there is also notable realisation of the limitation of such an
approach, where a professional concluded:

"Sometimes you do have to let things play out because
sometimes you might be wrong. If you are not sure” (FP02).

As the viewpoints of the above social care professionals and
subsequent analysis demonstrate, although the practitioners are not
entirely confident in their ability to detect deception, many of them
do suspect they are being deceived by parents. Notably, as reported
by a healthcare professional:

"It was easy to see if the parents had something to hide
because of their body language - I think, their hesitation when
answering questions”(FP06).

This is an assertion disputed by Granhag and Hartwig (2008) who
claim that liars are rarely unprepared for interviews, and therefore
unlikely to be caught off guard. Nevertheless, healthcare
professionals speak of their perceived ability to detect deception and
cite a number of indicators that help them ascertain whether the parents are lying. These are largely related to the lack of congruence between what could have been seen as medically plausible and the parental explanations of such. Therefore it is felt by healthcare professionals that they are:

"...are good at that [deception detection]” (FP05).

and that:

“...sooner than later we will find out if the parents are lying to us” (FP06).

A police participant is also confident that cognitive interviewing training helped him to detect deception, and he also mentions the use of non-verbal cues:

"So when they cannot tell detail, there is something wrong. And [also] it is their body language, the way they speak to you. I did a really interesting course in a university about how you can tell when people are trying to deceive you. In my experience, it’s defining details” (FP10).

The intuition, among verbal and non-verbal cues for deception, is also relied on by other police professionals, as demonstrated by a child abuse investigation team detective, whose extensive response is reproduced below:

"I think I am [able to detect deception]. You watch their eyes, and how, if people look left, it is not true. But it is about what people don’t say. And you watch that, you watch their body language, you ask them the question and you see their eyes
and how they respond. If they answer the questions straight off without having to pause or think, you know you’ve got the parents who say, ‘My child was 12lbs 14” when was born’, so you know that that parent has got a strong interest in the child. So in my experience it is not what people say, it is what they do not say. When there is a suspect or a parent and you get your gut reaction, you always follow your gut reaction. And it is whether you can read the reaction and what you do with that information afterwards is difficult” (FP09).

The same participant is equally certain of the deception detection abilities of his colleagues in social work. He further provides:

"I think that the mindset has changed completely. There are a few parents who will be after manipulating the system, but generally social workers and the police always know when people are lying. Very rarely I think that a parent can manipulate the situation. You learn quite quickly. In the police, you get to find out things with that. So I think now people are more aware”(FP09).

This rather optimistic assertion is not entirely supported by the evidence from the sample of SCR reports. It is likely to be the case that this police officer has worked alongside a social worker with a particularly keen ability to detect deception, but as has been discussed, some others find that difficult.

Yet not all police practitioners appear so confident in their ability to detect deceit, confirming the research findings that lies are often embedded in truthful accounts (Leins, Fisher & Ross, 2013; Vrij, 2008) and are difficult to detect. This is explained by a police participant:
“If the parents are asked to describe perhaps serious head injuries to the child and you ask them to account for a period of an hour and a half. The hour when we know this incident occurred and half an hour before and a half an hour after, they will tell us 59 minutes and 30 seconds of truth and shaking a baby could take 30 seconds, and that’s the 30 seconds of untruth, in the middle of 59 and half minutes of truth. It makes it very difficult therefore to disprove that 30 seconds of lying within 59 and half minutes of a truthful account because it is not all police work trying to find corroboration of what people say. You may well find corroboration through all sorts of means for the 59 and half minutes that they are telling us the truth. It is very difficult to just then from a lack of corroboration and to be able to disprove the 30 seconds where the head of the child hits the wall” (KP03).

Therefore, despite the claims by some respondents that they are able to detect deception, this is not borne out by others, and it is agreed by participants across all child safeguarding professionals that it is relatively easy for parents with disguised compliance to hoodwink the professionals. A representative utterance from the group who feel this way is offered by an experienced social worker:

“Yes, perfect clients...they can get away with it. It is really easy for the parents for deceive” (FP03).

The sentiment is also supported by a senior police professional who states:

“I think we are more likely to disbelieve people who are aggressive and nasty to us and don’t cooperate, don’t answer
questions, or just generally exhibit negative traits. Whereas if somebody is quite openly inviting you to the house to look around, give you consent to take samples from them and their children and show quite a positive relationship with you it can lull you into finding it very difficult to believe that they can do nasty things” (KP03).

As discussed earlier, the implication of the finding that it is recognised by all child safeguarding professionals that it is often ‘nice’ parents who would resort to disguised compliance tactics. However, despite this inference, ‘nice’ parents are rarely challenged. This is largely attributed to a truth bias, relational truth-bias heuristic for social and healthcare professionals and a reliance on intuition and non-verbal cues for police professionals. Yet this cannot be understood without considering how these tactics are rationalised by professionals initially.

Interestingly, evidence emerges from the study which supports an inference that applying their own sense of morality in trying to make sense of the alleged abuse of a child by the parent is detrimental to the professionals’ ability to detect deception. This is observed across all agencies. When asked whether she is able to detect parental deception, a police detective replied:

“That’s a big question, isn’t it? I would like to think so but I do not know. I would like to think I can tell if somebody is lying but I am sure that on many other occasions I’ve been sucked in because some people can be so manipulative and so clever. Because you obviously judge people based on your own morals, don’t you? So whereas you think, ‘Oh, I would never lie about something like that’, some people do. So I am
sure they pulled the wool over my eyes sometimes. I’d like to say no” (FP11).

A social care manager also shares this view:

“\textit{I think, social workers feel, ‘Well, it comes with the territory, and if parents are willing to fight for their children then it means they’ve got some emotional commitment’, which they do. I understand that. But actually, that clouds people’s judgements}” (FP07).

Arguably one of the explanations for impaired judgment may be due to the fact that this reasoning precludes suspecting parents of equally fighting for their own interests, including their determination to remain undetected in their abusive practice.

Through their professional experiences, two police detectives interviewed for this research feel that professionals in medicine particularly struggle to make sense of signs of deceit in parents due to their truth bias, as well as their refusal to believe that parents are capable of deliberately hurting their children.

In trying to explain how overlaying one’s own morals can be seen as an impediment in social care practice, a senior manager offers:

"\textit{There is this view that a new-born baby is cherished by parents, and there is also a stereotypical view that every child is wanted and is loved. And I suppose if that is your outlook, then you would not look to detect the underlying behaviour or abuse against the child}” (FP12).
This argument is extended by a police detective who feels that in order to promote scepticism amongst professionals and enhance their ability to determine the truthfulness of parents’ actions and communications:

“there has got to be a recognition that actually some parents do abuse their children” (FP13).

In social work literature the promotion of scepticism is associated with the term ‘healthy scepticism’ (Laming, 2003). It has been argued elsewhere that ‘healthy scepticism’ implies balancing the needs of parents and not being too heavy-handed with them, and that it can lead to deep mistrust and mutual suspicion (Munro, 2010). Yet this research finds that there is a sense of ambiguity amongst professionals about how much scepticism is ‘healthy’. On one hand they are tasked to seek cooperation and build a relationship which is based on trust and respect for privacy. On the other, in doing so, they fall prey to deceptive parents.

This is particularly relevant amidst the shared belief by all professionals that in order to be able to detect deception it is necessary to be sceptical and suspicious, particularly when encountering ‘nice’ parents that may be displaying the signs of ‘disguised compliance.’

To conclude this chapter, for the child safeguarding professionals, parental deception constitutes a deliberate act by parents to hide the truth from the professionals in order to avoid agency intervention. However, for social and healthcare practitioners, it is rationalised through a benign-malicious taxonomy, with the former being attributed to parents that are lying for reasons other than inflicting harm deliberately, and the parents in the latter category doing so in
order to cover the intentional harm to children. The parents that lie maliciously are condemned, whereas the parents that engage in benign lies are viewed with empathy. The prevalence of deception is commonplace in child safeguarding and the professionals are aware of a vast array of tactics used by parents to deceive, a view that is shared with practitioners in the USA. This research demonstrates that practitioners often suspect or are aware of parental deception but choose to rationalise it in order to formulate their subsequent response to deceit.

Despite being familiar with deception tactics used by parents however, the professionals generally feel that they are unable to recognise most of them in real life situations. There is a mixed response as to the professionals’ perceived ability to detect deception, with the majority of respondents specifying ‘disguised compliance’ tactics as the most challenging to spot. Professionals across all agencies cite using non-verbal cues and intuition to help them detect deceit. Social and healthcare professionals exhibit a truth bias and relationship truth-bias heuristic which affect their judgements in rationalising deception. All professionals working in the child safeguarding context discuss applying their personal morality judgements as to trying to reconcile in their minds the capacity of a parent to be abusive with a child. When assessing potentially deceitful parents; they believe that ‘overlaying their own morals’ is an impediment for the development of a sceptical way of thinking, which is a prerequisite in deception detection.

The overriding finding contained within this analysis chapter is that safeguarding professionals are not naive. The available evidence shows that generally many safeguarding professionals do know how to detect deception in parents but it would be advantageous if all professionals had that skill.
Key points summarising this chapter relation to child safeguarding professionals are presented in Table 5 below.

**Table 5. How deceit is understood by child safeguarding professionals**

<table>
<thead>
<tr>
<th>Professionals</th>
<th>Awareness of deception</th>
<th>Perception of deception</th>
<th>Occurrence of deception</th>
<th>Progression of deception</th>
<th>Most common deception tactics Used by parents</th>
<th>Ability to recognise deception as reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police, UK</td>
<td>YES</td>
<td>A way to conceal information Lie bias present</td>
<td>Very common</td>
<td>Parents get more skilled if undetected for long</td>
<td>Being 'nice' Playing professionals against each other</td>
<td>Aware of signs but mixed detection response</td>
</tr>
<tr>
<td>Social care, UK</td>
<td>YES</td>
<td>Benign (truth bias) vs malicious</td>
<td>Common for benign but not so for malicious</td>
<td>Parents get more skilled if undetected for long</td>
<td>Shouting and screaming Being 'nice' Playing professionals against each other</td>
<td>Aware of signs but mixed detection response Difficult to spot in 'nice parents' Linked to rationalising deception</td>
</tr>
<tr>
<td>Health, UK</td>
<td>YES</td>
<td>Benign (truth bias) vs malicious</td>
<td>Common for benign but not so for malicious</td>
<td>Parents get more skilled if undetected for long</td>
<td>Exaggerating Being 'nice' Playing professionals against each other</td>
<td>Aware of signs but mixed detection response Difficult to spot in 'nice parents' Linked to rationalising deception</td>
</tr>
<tr>
<td>*Police, USA</td>
<td>YES</td>
<td>A way to conceal information Lie bias present</td>
<td>Common</td>
<td>Parents get more skilled if undetected for long</td>
<td>Being 'nice' Playing professionals against each other</td>
<td>Aware of signs but mixed detection response Difficult to spot in 'nice parents'</td>
</tr>
<tr>
<td>Social care, USA</td>
<td>YES</td>
<td>A way to conceal information Lie bias present</td>
<td>Very common</td>
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<td>Aware of signs but mixed detection response Difficult to spot in 'nice parents'</td>
</tr>
</tbody>
</table>

*Child abuse investigator/former police professional

As will be discussed in a later chapter, it is convenient for some to rationalise that they do not know how to detect deception because if they know someone has deceived them, they have to challenge the parent and act upon their belief which may cause an awkward
confrontation. Being aware of the signs of deception by parents arguably represents just one side of the coin in child safeguarding, as it requires a consequent response by child professionals in relation to making the necessary steps to ensure the safety of the child. The extent of the response is explored later in Chapters Six and Seven.
Five  How deceit is detected

5.1  Introduction

This chapter broadens the discussion about the ability of safeguarding professionals to detect deceit in parents, and delves into some of the specific strategies and methods available to practitioners working with families. In order to scrutinise how information is being collected and evaluated the chapter starts by examining the role of the assessment and its essential component, the interviewing process. The role of the curriculum within training is discussed to consider how this contributes to the development of professional competencies.

5.2  The role of assessment

When undertaking family engagement and assessment, social work and healthcare professionals may use various tools e.g. ‘Signs of Safety’ (Turnell and Edwards, 1999) in order to help the detection of parental deceit in the child safeguarding context. There is little consistency amongst local authorities in the use of such tools, but most assessments are underpinned by the principle set out in the key Government guidance ‘Framework for the Assessment of Children in Need and their Families’ introduced in 2000 (DoH, 2000). The 109 pages of guidance offer a variety of questionnaires, models, scales and forms to assist in assessing children (Horwath, 2010) and promote a holistic view of the family by encouraging professionals to evaluate the child’s needs within the context of the child’s family using the three family domains of child’s developmental needs, parenting capacity and family and environmental factors. In the post
Climbié era, the notion of ‘safeguarding being everybody’s business’ was heavily promoted by the Government, and the Assessment Framework principles informed the Common Assessment Framework, which was originally developed by the Department for Education and Skills (DfES, 2006) to enable all safeguarding professionals to use the same tool, thereby promoting integrated working.

Furthermore, the relevance of the Assessment Framework and its usefulness for professionals working with parents is communicated by the Working Together to Safeguard Children guidance (HM Government, 2015) which outlines how professionals should work together to safeguard children in accordance with the Children Acts 1989 and 2004.

Based on the premise that safeguarding is the responsibility of every professional who comes into contact with a child, including social workers, police, health visitors, GPs, nurses and others, the purpose of the assessment is to ensure the safety of the child by evaluating any risk or harm done to them by gathering “important information” about a child and the family (HM Government, 2015). The reference to ‘important information” does not offer further clarity however as to what constitutes important and what is meant by information.

For the participants in this study, what is considered important is open to subjective interpretation, professional and individual curiosity, and framed by the boundaries of organisational practice. This inevitably results in variations across individuals, organisations and locations.

Furthermore, for social and healthcare professionals, important includes references to the three domains of the Assessment
Framework and represents any details related to child’s development, family strengths as well as weaknesses, parental capacity, and measures of motivation and change in parents. Although it is agreed amongst social and healthcare professionals (N=9) that relevant information is indeed important, it is felt by these professionals that the right balance has to be struck so as not to appear too intrusive with parents when collecting all relevant information and/or questioning its validity. It is recognised that it is often difficult for parents to talk about:

"some of the horrible things they experienced and witnessed” (FP08),

and thus there is clear evidence that sometimes professionals wish to avoid awkward conversations, and as such do not pursue every line of inquiry that could be relevant to the risk assessment.

It is recognised that a compassionate attitude towards parents is enshrined in social care practice. However, when aligned with a culture of having to establish a good rapport with parents, as a result of which professionals find it difficult to probe for information or challenge seemingly implausible explanations, this undoubtedly inhibits the practitioners’ adeptness to proactively gather important information, a point which will be explored in detail in Chapter Six.

Nevertheless, the majority of social and healthcare respondents in this research consider themselves inquisitive by nature when it comes to gathering important information for the assessment. It is argued by a healthcare professional that:

"You cannot be in this line of work and not be a little bit nosy. So, in the land of safeguarding, it would be very difficult to find
someone who is not curious and a little bit nosy, or wants to find a little bit more” (KP06).

Although respondents like to feel they are prepared to be inquisitive, serious case review findings continue to demonstrate that this assertion is highly debatable when put into practice. There is ample evidence that professionals continue to miss the signs of deception and/or do not wish to probe for additional information. For example, in SCR H, the ‘rule of optimism’ underpinned the risk assessment of the family environment which lacked depth and contributed to health professionals having an “overly positive view of life within the home” (SCR H, 2016, p.37); information was never sought and/or challenged.

In another review, SCR B (2012), “the judgements about parenting capacity were made entirely on the presentation of the children” and “the social report was essentially unprobing.”

This research finds that curiosity is perceived to be a personal trait that is attributed to some individuals but not others. It is argued by a social worker that:

“some people are just born to be inquisitive” (FP08).

Additionally, those who consider themselves “nosy” in life (KP02) find it easy and natural to apply the similar type of thinking in their professional careers and feel that it enables them to develop and maintain ‘professional curiosity’ when working with parents, so often called for in serious case reviews (Brandon et al. 2008). As illustrated by a health visitor:
“You have got to be a certain type of person. I think you’ve got to dig. And it’s all about asking those extra questions. Some of the things I don’t want to go there because it is going to open a can of worms, but it’s about being brave enough to go there, just dig that a little bit deeper” (FP05).

This is supported by another social care manager who feels that his life experience and a previous career of being in combat prior to coming to social work taught him to be inquisitive and thus “brave” to question evidence:

“By having done stuff that normal social workers would not do before, allows me to feel, the moment I walk in, that something is up and be brave enough to start asking questions” (FP08).

In fact, a US social work manager goes as far as to suggest that an individual’s curiosity should be addressed and evaluated during their selection process for a job, in order to identify what he described as the “blue blood social workers”:

“If people are hiring predominately blue blood social workers, then you are going to run into a problem because they have a tendency to get involved emotionally with parents and it’s all about ‘I want to help, I want to help.’ And they don’t have that critical reflection going on. That is my professional opinion and I’ve interviewing thousand people over the years and watched the results. If you have a blue blood social worker that’s what they want to do, they want to do social work and that does not have anything to do with kids’ safety all the time” (FP15A).
The comment above is interesting as it alludes to some of the inherent incompatibilities that exist within social work. It challenges the capability of social care professionals working in the child safeguarding context to be empathetic to and helping with parents, as well as suspicious of abusive behaviour at the same time, in order to evaluate the risk to the child. As noted by the practitioner above, it is feasible that many social workers go into the profession because they want to help those who are disadvantaged and empower them to change. Arguably working in child safeguarding requires much more, including self-reflection of one’s own empathetic approach to working with parents if it is being exercised at the expense of the child’s welfare.

Additionally although it is likely to present a challenging and difficult task to measure the level of curiosity in people during the recruitment process, the limitations or willingness of some professionals to want to drill further needs to be tackled, either through better selection or training or a mixture of both. Indeed in respect of social workers in particular it is reasonable to infer that a genuine ability to demonstrate a degree of healthy scepticism and probe for evidence as to the veracity of information, should be seen as not just a desirable trait but rather a core competency for effective children’s social work. The fact that some professionals seem to aspire to being ‘nosy’, but do not actually apply their ‘nosiness’ during an assessment, may provide a useful explanation as to why serious case review reports continue to point to a lack of “professional curiosity”. In fact, to use an unfortunate cliché, there is some evidence that professionals still ‘talk the talk’ rather than ‘walk the walk’.

For the police respondents, child safeguarding concerns are often linked to a criminal investigation of parents whereby these
professionals are involved in the assessment of veracity in relation to parents to determine the occurrence of a crime against children. However, it is also generally acknowledged that their involvement with parents also extends to non-criminal matters whilst they are working in partnership with other agencies, and the relaying of their concerns to other agencies for information sharing purposes and/or planned interventions. Thus the police have to carry out their assessments in relation to the child’s safety which then result in a referral being made internally to the child abuse investigation unit and/or externally to social care as appropriate. One of the outcomes of such assessments for example could include police using their emergency powers under Section 46 Children Act 1989 to remove a child from premises to ensure their immediate protection (HM Government, 2015).

Thus for these professionals important information relates to everything pertinent to the parents, whether offending or non-offending, in making these decisions. This is demonstrated by a response of a police participant:

“If we are looking at prosecuting people, then we need to get all the evidence to go to the Crown Prosecution Service. But equally, there are often cases when we investigate them and we either cannot prove that something has happened or we actually don’t think that something has happened. But it is still always about gathering all evidence, previous disclosures, witnesses, CCTV, any third party material, mental health, anything can affect our decisions” (FP10).

With regard to what actually constitutes information, Mingers and Standing’s (2017) definition of information seems to be most appropriate in the context of this research. In conducting a review
of theories of information, they (Mingers and Standing, 2017) claimed that information represents material that is objective, as not being subjected to individual interpretation, and verdical, or otherwise true and correct. To expand it further, it is thus argued that all information is misinformation unless verified to be valid.

Yet overwhelming evidence from serious case reviews, as well as respondents in the current research, suggests that information offered by parents is not always verified by professionals. For example in SCR E (2014), in the case of neglect, a Health Visitor’s assessment was based on the uncontested account of the mother who explained the neglected state of her children by stating that, “Child A and another sibling were copying their father and not using the bathroom and toilet appropriately and that bedrooms were sometimes soiled.”

Additionally it is related by a paediatrician involved in child abuse cases that when it came to verifying information:

“It probably does vary depending on the individual doctor, their seniority, their experience in child protection. I am sure you will get some doctors in acute hospital settings particularly who are really hesitant to go down that line of trying to confirm or refute something and express their views. Others, who have more experience in child protection, who actually will be a lot more systematic and say, ‘Ok, we need to investigate these, we need to try to get some confirmation’” (KP04).

This suggestion of a reluctance by doctors to check out information is amplified by an SCR (Child I) discussed by a police respondent, whereby a baby who was taken to hospital and pronounced dead was found to have bruise-like marks on his abdomen. The parents
were asked by a paediatrician about the origin of the marks and they claimed that they had already taken him to their GP who had given an opinion that they were abnormal blood vessels. This explanation was ‘considered likely’ by the doctor, but neither he nor any other hospital professional made a simple phone call to the GP to check. Had they done so it would have been apparent that the parents had lied to the hospital doctor because there had been no such GP visit. These parents were eventually convicted of killing the child and were undoubtedly devious in their attempts to cover up their crime. However, it would appear that in this case a modest amount of professional ‘nosiness’ about the parent’s explanation of the origin of bruise-like marks on their baby could have quickly demolished their story.

In relation to the police, although it is argued by a police respondent that:

"All detective work is down to testing what someone told you. So, if a parent has told us something we do not just take it for granted” (FP13).

It is also acknowledged by the same participant that when it comes to evidence offered by health professionals, including paediatricians, the police sometimes demonstrate a lack of scrutiny in relation to the authenticity of this information, and take it at face value. This is further illustrated in the SCR (Child I) referred to earlier by a police respondent. The Police were involved at the hospital and were told by the doctor that the baby’s parents had said that their GP had examined the bruise-like marks and concluded they were abnormal blood vessels. Despite their original belief that the baby had bruises, the police were swayed by this doctor and did not themselves either suggest, or independently make, a simple telephone call to the GP
to confirm the parent’s story. The outcome of this case is that it was not until a post mortem examination several days later that it was confirmed that the bruise-like marks were in fact bruises caused by an assault. The SCR Report was quite critical of the police for taking the doctor’s view at face value, and the police officer admitted to the SCR team that he:

“...found it difficult to challenge a qualified Consultant Paediatrician’s assessment” (KP03)

Thus with regard to the assessment process the lack of clarification in relation to “important information” in the Working Together guidance does affect the professionals’ decisions as to what needs to be included in a robust assessment, which consequently limits their deception detection judgements. Although it is not explored within the scope of this research, a call for more prescriptive guidance or a communicated shared understanding among the child safeguarding professionals needs to be considered in order to assess the decision-making.

One of the most commonly employed methods utilised by child safeguarding professionals in their assessment of risk to the child is an interview.

5.3 The interview

It is agreed by all research participants that an interview with parents forms a part of the assessment process that contributes to deception detection.

When it comes to interviewing, in order for the police to detect deception the research by Hartwig (2006) suggests utilising
techniques of strategic interviewing. It argues against any confrontational approach and proposes that police practitioners withhold any incriminating information until the last stage, after having fully planned and prepared for the interview and solicited a free call from a respondent. These strategies are reflected in the investigative type of interview utilised by the police as supported by the PEACE framework in relation to offending parents as well as non-offending parents. This is illustrated by a response of a police respondent below in her recent encounter with non-offending parent:

"I have not gone into much conversation, just said, ‘Right, I am going to speak to your daughter’ but I have not given him key information because I do not trust him” (FP10).

In fact, apart from the caution element, most of police respondents in the research (N=6) argue that there is little difference between their approach to victims, witnesses or suspects in relation to how they sought to gather information through interviewing. The police tend to have a clear interview strategy before interviewing parents, as argued by one of the police respondents below:

"You are going to plan and set up your interview in all instances” (FP12).

Following this, the parents are invited to provide their explanations of events which includes “asking the types of questions that parents are expected to answer”(FP12) about the child, moving consequently to more specific questions. The suspected lies are not contradicted:

"So, you listen to what they don’t say. And I am happy for them to talk. I am happy for them to tell me things. Because
I know they are not true and they are easy to prove they are not true. So I just allow them to lie. And then you start unpicking each element of it with them” (FP09).

Once this information is collected it is processed and evaluated, and then, followed by a ‘challenge’ stage. This is illustrated by a police respondent below:

"We have developed tactics whereby we don’t necessarily confront people straight away. We will talk to parents, try to engage them, to get them to talk to us, just an initial account without any challenge. Once we gather a few points without challenge, we would gather all evidence from all sorts of sources, then start the challenge phase. By the time we get to challenge phase the parent then might clam up, because they suddenly realise, ‘Hold on a minute, I am now being accused of actually not telling the truth’ or "My account is not being believed when I thought for the last two days I’ve been talking to people they haven’t reacted in a way which made me think they were disbelieving my account.’ And obviously that’s the strategy we wanted to employ. It would be stupid to be too confrontational from the outset to cause people to clam up and not give us any account whatsoever” (KP03).

It is acknowledged by police professionals that the challenging stage often results in a break of relationship and it is perceived that the parents may feel “betrayed.” (KP03). That outcome does not appear to be detrimental to police encounters with parents; in other words the police often have little investment in a ‘relationship,’ so breaking it causes them little difficulty.
The social and healthcare professionals report that they adhere to a non-confrontational motivational interviewing strategy that encourages transparency and openness and is aimed at creating the desired changes in parents. This premise is supported by the literature (e.g. Wahab, 2005) and illustrated by this utterance by a social worker:

"I tend to go in and I always stay under the radar. So when I meet the family I go in really quiet at first, very much working together, very calm, I explain that we work together, we are very open with parents towards relationship, very trust oriented. But then when I am in, I am able to go and challenge. But if you go and challenge from the beginning, shutters are down. If you go headway in the beginning, you’ve lost it. And then you’ve got no idea of what’s going on” (FP03).

Another social worker feels that the main goal of the interview is to engage with the parent and elicit a conversation about change. Apart from confirmed cases of child protection, this is a general approach utilised in all other assessments, as illustrated below:

“Because initially we go in, so we are doing like the front door stage. We’ve got the original concerns, we are going to the home. I would raise these concerns with parents over the phone and say, ‘I would like to discuss this with you. Is it okay if I come out?’ That’s where we start. That’s how I would start. And then I would go into the house and then just allow them just to speak to me. I’ll just listen. And if I pick things up, I’ll just talk to them about that” (FP04).
When asked if the fact that parents have been involved in proceedings previously has an effect on the way interview is approached, a social worker responds that:

"It does go to your mind. But when you go into the situation I think you have to go open-minded, however, if there is real significant stuff in the history we will take that into account, look at the situation now and access as a whole” (FP04).

Hence it is agreed by social workers in this research that going to interview parents having done the preparatory work would have been appropriate and desirable. However, there is also evidence in this research that at times the history of parenting in relation to previous children is ignored or minimised. This results in the professional not conducting the interview within the overall context of the family environment context and being sceptical of what was being said.

It is expressed by social workers that due to the unpredictable nature of their work it is unrealistic to prepare for an interview, in terms of having an interview plan or strategy. This notion is explained by a less experienced social work professional:

"Because you don’t know what they are going to say. You don’t know what you are going to get. You can prepare your session and you can go in and you can know that some facts from the assessment framework, family history, and do a family tree. You don’t know what is going to come out of that. You don’t know if they are going to give you loads, nothing, or something that might be really distressing. Because you cannot prepare for the unknown” (FP02).
There are a number of similarities between police, social and healthcare professionals when it comes to trying to elicit information. However when it comes to contesting parental accounts there is evidence to suggest that there are also differences amongst them when it comes to challenging parents. For example, there is an indication in this research that for some practitioners, empathetic attitudes toward parents and apologetic views in relation to their roles get in their way of being able to challenge parents objectively and dispassionately. An example of this is provided by this less experienced social worker:

"Actually, sometimes it might feel to them as if I am interrogating them. I feel like that actually. I don’t really know if they feel interrogated. I guess by some things they would be. I would feel it. I am going by what maybe I’d feel if someone was coming to my home, I’d feel like I was being interrogated regardless of how nice they were, how open they were. I would still feel very probably intimidated” (FP04).

Hence the progression to the challenge stage is seen in a negative expression of the word interrogation and is generally treated with caution as it is perceived to have an intrusive and confrontational and therefore detrimental effect on parents. Although acknowledged as necessary for assessing a risk to the child, challenging parents on their accounts is understood by social and healthcare practitioners to be oppressive to parents and conflicting with the principles of motivational interviewing that promote collaboration, not confrontation.

Instead it is preferred to approach an interview as a conversation, a chat, and avoid "direct” (FP02) questioning as is seen to be utilised
by the police. As shared by a health visitor, an interview with parents represents:

"Just a conversation, with a few prompts. It just flows. It will be based on the answers they give to questions" (FP05).

This is corroborated by another health visitor who said:

"You need to learn as you go along as to how to word things so they don't sound like you are being intrusive. So that the family would not back off. You say things in a kind of inviting way" (FP06).

Police professionals share this approach with respect to the conversational nature of the interview. Additionally they also place a value on setting clear goals and intended outcomes of the interview:

"Interviewing should be more of a conversation in a way it is delivered, but there will be an agenda, and things that we would have to find out" (FP10).

The health visitors participating in this study have a more scientific approach, and like the police feel they would have a clear strategy prior to engaging in an interview with specific things to find out, such as what and how much food the child has each day. These types of questions are primarily guided by the child development needs, and when a health visitor concludes an interview, they hope to have obtained answers to a specific set of questions. Despite this clear strategy however the evidence provided by the respondent above would tend to indicate that they still accept without challenge whatever answers are given. Thus, if a parent claims that a baby is being fed breast milk, even if there is a feeding bottle nearby with
infant formula therein, the health visitor might feel it would be ‘intrusive’ (FP06) to challenge the parent.

It is acknowledged by police and health care professionals that social workers have a challenging task when trying to assess across the three domains whilst trying to be “everything to everyone” (KP08). This last point is explored in detail in Chapters Six and Seven.

Conducting a robust assessment including an interview largely depends on professionals’ skills and knowledge and their ability to work with the family as well as their professional perception of abuse and the understanding of the situation, which sometimes leads to them being hoodwinked by parents (Horwath, 2007; Munro, 1999; Reder et al., 1993).

What is emerging from the data provided in this section is that although the wellbeing of children relies heavily on the detection of any deceit by a carer, the three key groups of professionals attempting to assess that wellbeing have three distinctly nuanced approaches to their professional interviews. This is provided in Table 6 below.

<table>
<thead>
<tr>
<th>Professional</th>
<th>Preparation for interviewing</th>
<th>Challenge of parental statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>Interview is planned, clear strategy</td>
<td>Challenge inconsistencies</td>
</tr>
<tr>
<td>Health</td>
<td>Interview is planned, clear strategy</td>
<td>Not prepared to challenge if it is detrimental to relationship</td>
</tr>
<tr>
<td>Social care</td>
<td>Informed of basic facts, no interview plan</td>
<td>Not prepared to challenge if it is detrimental to relationship</td>
</tr>
</tbody>
</table>
Thus as Table 6 above summarises, in order to detect parental deceit the police are prepared and plan for an interview with parents. They adhere to a clear strategy, have a distinct idea of what questions to ask and are prepared to challenge any inconsistencies. They are empowered to do so as there is no perceived need to maintain a long-term relationship with the interviewee.

In relation to healthcare professionals, they also adhere to an interview strategy and have a clear idea about what questions they want answers to. However, they are not prepared to challenge any inconsistencies if it seems intrusive and distrustful to parents as they feel they need to maintain a good long-term relationship with the interviewee.

Social care professionals prefer to interview parents in a fairly flexible way with no interview plan and based on the available information on the family circumstances. They are also less likely to challenge inconsistencies with parents if it may be detrimental to a necessary ongoing relationship.

The key element which seems to influence the difference in approach seems to be the perceived need amongst two professional groups to maintain a good relationship with those being interviewed. Whether that is actually beneficial, or detrimental to the welfare of children, will be explored in depth in the subsequent chapter.

5.4.  Professional skills and training

Research suggests that training is of paramount importance when it comes to developing or improving professionals’ deception detection abilities (Colwell, et al., 2006).
With no formal educational requirements to enter the police, basic police skills are developed through the initial ten-week training. However, some forces require candidates to undertake the Certificate in Knowledge of Policing course prior to joining, which covers among others areas, social and community issues, responding to incidents and basic knowledge of interviewing suspects and witnesses.

With the introduction of Workforce Modernisation in the police, a large number of police staff become involved in the child safeguarding process, all of whom are required to have appropriate competencies and skills. A number of different structures are in place within police forces to reflect how child safeguarding enquiries are responded to and managed. A number of forces across England set up child abuse investigation units in the 1990s, with many of these now also involved in a wider scope of responsibilities such as public protection, sex offender management and domestic abuse. Ordinarily these teams lead the investigations or assist the Senior Investigating Officer (SIO) and liaise with child safeguarding professionals from social and healthcare, and investigators within these teams either support or take full responsibility for investigations either exclusively or in conjunction with the force’s major investigation team.

In relation to assessing the veracity of parental accounts, police professionals involved in investigating allegations of child abuse are expected to undertake the Professionalising Investigative Programme (PIP) accredited by the College of Policing, having demonstrated at least two years of experience as detectives (PIP Level 2). In addition they are required to undertake a Special Child Abuse Investigator Development Programme (SCAIDP), as well as
multi-agency training provided by the Local Safeguarding Children Boards (LSCB) and training with children’s social care professionals in investigating cases that necessitate a joint response.

Included in this programme is generic new or refresher interview training for those who engage in all aspects of interviewing involving victims, witnesses and suspects. Thus all detectives supporting operations on major crime level, which includes child abuse, should have received Tier 2 training that enables professionals to apply cognitive and investigative approaches to interviewing people. Although undertaken by all detectives involved in child safeguarding, this level of training does not apply to a first on the scene police officer, or someone who may be conducting a joint welfare visit with a social care professional.

No specific training on detection of parental deception is offered to investigators in child abuse teams or practitioners dealing with parents who are suspected of abuse of their children. However it is felt by the police professionals in this research that this is not necessary as the detection skills are already addressed across all training and teaching programmes as being ones of the most relevant across investigations. It is illustrated by a police respondent that:

“When police officers are trained as detectives they will be trained to interview suspects and part of that will be trying to identify deceit, trying to manage an interview strategy, to trying uncover that deceit. it does not matter whether they are interviewing someone about fraud or whether they are interviewing someone about child sexual abuse or whether they are interviewing someone about burglary. The training
will be the same, because the actual tactics employed by suspects would be the same” (KP03).

Thus detection of lies is perceived by the police professionals as a core police activity which enables them to feel competent to rebut lies and confident to practice confrontation and challenge parental accounts in order to see the signs of deception. In fact, all police investigative training emphasises the ABC principle in relation to assessing the veracity of information. In this context ABC means:

- Assume nothing
- Believe no-one
- Challenge everything

Despite this mantra however, and supported by the findings in the research that police would not challenge the opinions of medics, a lie bias (Garrido et al., 2004) exhibited by police professionals does not translate into their deception detection accuracy of only 54%, comparable to the total accuracy of a layperson (Bond & DePaulo, 2006; Vrij, 2008).

Nevertheless the role of training is acknowledged as instrumental in police practitioners’ developing competencies, as explained by this police respondent:

"Training helps you recognise deception. Many times, I suspected that parents were lying, but until I did training I did not understand how to spot it, what it was about. But once I spotted it, I could then work on parents, or challenge them to say, 'I asked you that one question and you reacted so and so - Why was it?’” (FP11)
It is argued by a police senior investigating officer that in relation to interviewing parents, training he received throughout his career allows him to develop as many hypotheses as possible in order to avoid an ‘anchoring effect’, discussed by Rutter and Brown (2015), of inclining to rely too heavily on one piece of information when making judgements. Additionally, training is viewed to be equally important to help police professionals to avoid exhibiting confirmation bias.

The professional above feels that training allows him to develop an open mind and be critical of evidence, especially when working with doctors. He stated that police often fall prey to a bandwagon effect (Rutter & Brown, 2015) that is characterised by supporting the judgements of medical professionals irrespective of their own views, thus disregarding the possibility that:

“...often, healthcare professionals are unable to give a one hundred percent clinical diagnosis, thus erring on the side of medical caution and discounting child abuse or inflicted violence by parents” (FP12).

Therefore, undertaking training in interviewing suspects and witnesses represents an essential component of police good practice as it allows these professionals to develop their competencies when dealing with parents, increases their confidence to challenge, and emboldens them to make decisions. It must be noted that as discussed earlier the police are not inhibited in their interview style by the perceived requirement to maintain a long-term relationship with a family.

With regards to health visitors, to qualify as one, qualified and registered nurses or midwives have to complete the Specialist
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Community Public Health Nursing Health Visiting (SCPHN/HV) programme aimed at allowing those professionals to recognise the risk factors, and signs of abuse and neglect in children (NMC, 2017).

Although health visitors undertake a number of training programmes and practical exercises, none of it is focused around interviewing parents for the purpose of detecting deceit. Instead the majority of training programmes aim at working with adults, and maintain a strong emphasis on the value of care and compassion by the professionals towards parents. Training in interviewing parents is limited to primarily motivational interviewing. When asked whether they felt equipped to gather important information from parents, a health visitor replied:

"No, not really."

(FP05)

Another health visitor in this research shared her experience of attending a training course on “Believing your gut feeling” and she finds this particularly useful in her experience of interviewing parents. As is demonstrated below:

"You cannot really evidence your gut feeling but you can take that on and think, 'Actually, is there something going on here?' After years of training to be a nurse as well you get that intuition. If you have that feeling it is always something to be explored even if you cannot prove anything by it”

(FP06).

Whereas there is much to be said for listening to one’s inner voice, there is a danger that this approach can lead to confirmation bias judgements, which in the context of child safeguarding practice is unacceptable. Yet there appears to be a shared feeling amongst
health care professionals that some kind of training is needed in order to enable them to be more proficient in detection of deception.

Furthermore, it is felt that in respect of paediatricians there is good level of awareness of child development and identifying signs of child abuse and this is obtained through training for doctors at national and local levels. Some training covers authoritative practice in child protection with a focus on being able to balance support and challenge whilst remaining empathetic to the views of the child and the family in the so-called partnership working. However, as a paediatrician explains:

"There is very little in terms of risk formulation, decision making and so on. So I don’t think that is done particularly well. I think the whole thing of joint decision making with formulation seem to sporadically come out in training and has not a huge amount in it. Training for frontline practitioners on their working in partnership and yet holding professional challenge and scepticism but also reflective practice - this needs to come out more. I am not sure how much of it is embedded, not very much I think. I think those are the areas whether we can do a lot more” (KP04).

Interestingly, as the excerpt above demonstrates, it can be inferred that the lack of training in the area of confident decision-making may explain why so many professionals are struggling to dispute parental accounts and challenge their behaviours. As with deception detection, healthcare practitioners are in need of training to enable them to respond to deceit effectively.

Unlike police officers, social workers working with children and families are required to obtain a specific undergraduate degree. The
vocational course is approved by the Health and Care Professions Council (HCPC) and when qualified, future social workers have to register with the HCPC in order to practise. The degree course allows students to develop practice skills to the requirements of the Professional Capability Framework (PCF) and Health and HCPC Standards of Proficiency (SOP). These standards of proficiency set out what a social worker should know, and include being able to draw on appropriate knowledge and skills to inform practice, be able to communicate effectively, be able to practise as an autonomous professional, exercising their own professional judgement (HCPC, 2017).

The social work curriculum provides a strong emphasis on communication skills for future professionals with some of the areas focusing on motivational interviewing, transactional analysis, communication styles, non-verbal, verbal communications, and cross-cultural communication:

"...so that they [social workers] get a taste of various styles of working with people and tools to enhance communications that they would have to undertake“ (KP01).

In addition to communication that “cuts across all of the courses” (KP01), the curriculum stresses the importance of social work practitioners practising evidence-based approaches, whereas the issues surrounding deception detections are “kind of moulded into the teaching considerations” (KP01). Additionally, decision-making and risk is discussed and a significant number (up to 20) of different assessment tools are introduced. It has been related by a social work educator interviewed as part of this research that throughout their course, future social workers are taught to become resilient in their practice to:
“knock on the doors of difficult clients, not to avoid awkward conversations and do not apologise for difficult messages that have got to be delivered” (KP01).

When asked whether there are any interview techniques used by the police which might be cross transferred to social work training, this social work educator argues that a cognitive interview style discussed by Fisher and Geiselman (1992) is:

"one of the useful techniques I’ve picked up from the police“ (KP01).

Although this is not part of the formal course curriculum for social workers, this particular lecturer introduces the concept to students and encourages social work students to ask questions broadly in order to get a full narrative, and then “forensically” to deconstruct the conversation with the parents in relation to inconsistencies.

It is useful to stress that training in this technique is not part of the national social work curriculum as set out by the HCPC, and the choice to introduce the technique in one university is individually motivated by the social work educator participant. However, given its appreciation by this educator (who before becoming an academic was a social work practitioner) it could be argued that there is scope for making it a mandatory element of the curriculum. Amidst the research findings that social workers find it particularly challenging to confront parents in a rigorous and systematic way, training these professionals in interview techniques such as Cognitive Interviewing, that is accompanied by putting in place an interview strategy (or a plan of what to ask and what to achieve at the end), soliciting free
narrative from the parent and promptly following this up by detailed probing, would be beneficial, if not essential.

Generally, it is felt by the social work respondents within this study, that:

"the university set [them] up really well" (FP04),

and that they:

"were told how to engage with parents effectively using [their] communication skills” (FP02).

Interestingly, communicating effectively with parents was translated into being able to build a rapport with them and obtain information. The extent of training in communications skills points to some limitations when it comes to equipping social workers with appropriate approaches to challenge suspected or confirmed deceit.

A variety of post-qualification training courses are offered to qualified social workers by their LSCBs, and these include motivational interviewing techniques. However, it is a clear theme emerging from the social work participants that their training in whatever form does not teach them how to be inquisitive or how to develop an investigative mind set.

They are adamant that there is no specific training offered to social workers in the detection of deceit by parents. This research finds that no practical advice is offered to practitioners on how to interview resistant parents, thus confirming Forrester’s, et al. (2012) findings. Whereas social workers undertake child interview training it was felt that:
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"...nothing in the training relates to how to interview resistant parents” (FP02).

Instead parental engagement is covered in courses on communication and introduced as part of the assessment process. Within these courses, social workers who become suspicious of deception by parents are encouraged to utilise multiagency collaboration rather than try and tackle the apparent deception themselves. Thus social workers adhere to the approach whereby they will:

"Listen to what the parents have to say and then take that on board unchallenged. But then you seek information from other professionals and use that to either say, ‘Well, this is not actually quite my understanding of it”, or else it comes together and it sounds okay” (FP04).

Whereas multiagency collaboration demonstrates good practice and is highly desirable (Munro, 2011) it cannot be seen as an alternative to effective evidence gathering that social work practice requires in the context of child safeguarding.

A number of social work respondents express that:

“training is being pushed aside” (OB).

and the staff are being told to manage heavy workloads by their managers. One of the social workers notes that:

"We did not have training for a year. There is definitely a lack of training opportunities. E-learning is used a lot but it is not
effective. Yet, 60-70 percent of social workers are newly qualified. They have to learn so much in their first year. They are not confident. They need to learn the trade. I guess teaching them how to work with deceptive parents is not on top of their list training” (FP07).

The above example may offer an explanation as to why many social workers do not feel confident and competent in working with parents. The lack of training opportunities, coupled with the research findings by Burton (2009) which suggest that people find it difficult to make sense of conflicting information, especially amidst the emotionally demanding nature of social work, are bound to produce errors in reasoning and judgement.

However some of the social workers contributing to the study have been exposed to a multi-agency targeted training course which addresses risk assessment and decision-making when working with resistant and hostile families. This short course organised by their LSCB also promotes authoritative practice among professionals. To gain a clearer understanding of post-qualification training for social workers in England, the researcher accepted an invitation to attend and observe this course. Although it was perceived by one social work respondent who previously attended the course that :

"...more informative in nature, and not providing one with skills and tools to deal with deception...” (FP07),

the researcher actually noted that the course covered a number of interesting and important considerations in relation to deception detection in parents.

Delivered by a registered social worker currently working as an
independent trainer and consultant in child protection, the one-day course that has been run nationwide for the last six years is open to all safeguarding professionals and focuses on how to work effectively in a child centred way with resistant and hostile families. It promotes collaborative learning through the principles of reflective practice, rather than offering a set list of tips and tools on how to detect deception. The trainer explained:

"I would love to be able to give them the manual which I think some people come looking for. But they know in their heart of hearts that there is not a set of rules to follow, that this is some of the most difficult work that they have to do. They are in really tricky territory which relies so heavily on the human relationship within it. Policies and procedures are very limited in terms of how they can assist" (KP08).

As was observed by the researcher during the observational fieldwork, the lack of clearly identified strategies and tools to tackle disguised compliance and resistance left a number of people frustrated as they felt they were not provided the answers they came for. However it nevertheless allowed professionals to share their strategies and discuss what does not work. The course is not focused around deception detection but there is a component within it that emphasises the need to be less apologetic when questioning parents, and more authoritative and confident.

In addition to the researcher, fifteen people attended the course, with a number of social workers failing to turn up. Although social workers were the primary target group for the course, the trainer explained that they frequently dropped out beforehand and were the "least regular attenders" (KP08) This perhaps links in with the
comments highlighted earlier that social workers are discouraged from attending training because of their heavy workload.

Interestingly it was also noted by the researcher that no social worker managers attended the event despite several having signed up for it. When questioned, the trainer explained that having the managers and frontline workers together often inhibits the ability to have an open discussion, where managers “do get a bit defensive” (KP08), yet it was nevertheless acknowledged that:

“I often get approached by people after the session who say, ‘Our managers should be hearing this because we cannot practice in this way without our managers being on board with us.’ I sometimes feel that I am tormenting these poor professionals through the training. Because what I am doing is reminding them what they already know. So it does feel sometimes like I torment them because the system is not allowing them to. So sometimes it does come out, not anger towards me, but people can be complaining to me about that. People will say to me, ‘This is all well and good, but you know we cannot do it’” (KP08).

The above clearly represents a sense of frustration and disillusionment with the messages delivered in training with relation to authoritative practice as professionals feel they are not able to practise ‘what is being preached’ due to the limitations of their organisational practice. Although the impact of such practice will be explored in the subsequent chapters, this points to a possibility that training is likely to have a limited impact on professionals’ competencies to be able to challenge potentially deceptive parents unless doing so is embraced and encouraged within their organisations. It is felt by the trainer that the only advice and
suggestion she could offer to professionals is to continue to preserve their professional integrity and that:

“If we cannot change the system, we need to try to stop the system from changing us in terms of letting go of that desire to be child centred” (KP08).

To conclude this chapter, in order to detect and respond to deception in parents the child safeguarding professionals are relying on assessment tools which are aimed at determining risk to the child. No specific deception detection tools or methods are utilised and, as also revealed in Chapter Four, those professionals who do have a keen ability to detect deceit are able to do so not because of training but because of their practice wisdom, inbuilt instinct, or generally sceptical nature.

The role of the interview is important but limited, as social and healthcare professionals struggle to challenge parents if doing so is likely to cause their relationship with them to deteriorate. Additionally, the nature of motivational interviewing that is predominantly used by these professionals in their practice does not equip them to seek evidence actively from potentially deceptive parents, as it relies on a parents’ willingness to share, and come forward with, information. There is an identified demand and need for social and healthcare professionals to be trained in effective interviewing techniques that would enable them to be proficient in dealing with deception, and more importantly empower them to feel able to probe and challenge parental accounts.

Despite police professionals’ preparedness to challenge parents, they are reluctant to contest the accounts of medical professionals involved with work with parents.
No specific deception detection training is offered to child safeguarding professionals to enable them to recognise and authoritatively challenge deceit. A number of training programmes are undertaken by police professionals to prepare them better to interview suspects and witnesses. A training course on disguised compliance that is offered to social and healthcare professionals is useful in encouraging these professionals to be authoritative in their practice. Unfortunately, it does not equip these professionals with specific techniques to detect or respond to deception. Additionally, it is not well attended by social care professionals, reportedly due to their heavy workloads and the lack of willingness of their organisations to facilitate their learning.

The findings above suggest that the current approaches used by child safeguarding professionals in relation to detection and response to deception in parents are not used systematically or consistently.
Six

Responding to deceit: trapped in a relationship

6.1 Introduction

Having explored in Chapters Four and Five various tactics used by parents to deceive, and the practitioners’ limited ability to identify these signs of deceit whilst using tools available to them to detect deception, this chapter examines the consequent steps utilised by professionals to tackle and respond to deception when it is evidenced. Initially the chapter scrutinises the nature of family involvement with child safeguarding professionals in the context of their organisational practice. Following this, the discussion explores the views of child safeguarding professionals on relationship-based practice. To begin with, the concept of a ‘professional relationship’ is examined, and later the chapter investigates the effect it has on the professionals’ ability to understand and respond to deceit.

6.2 Why a relationship?

It has been established in Chapter Five that child safeguarding professionals’ judgements regarding the presence of parental deceit are based often on information which is partial and disputed, with a high degree of uncertainty, a view that is supported in research (Helm, 2009).

In England these judgements are also made within the context of the policy and legislation framework of the Children Act 1989 that promotes the value of supportive working in partnership with parents in order to achieve the best outcome for children. Similarly in the USA these values are enshrined in the US federal Adoption and Safe Families Act 1997.
All England-based professionals (N=21) interviewed for this research emphasise the importance of working constructively with parents when assessing the reliability of their statements and behaviours in order to make appropriate decisions in relation to the safety of the child. This is supported by the two US (N=2) child safeguarding professionals who also felt that it was important to try and engage positively with parents.

It is established within this research that the work of child safeguarding professionals with parents is carried through short, medium, or long-term relationships, a finding which is supported in the literature (e.g. Pearson, 2009; Peckover, 2013; Burnett and McNeil, 2005). Additionally it is acknowledged in the literature that a relationship can be "a positive vehicle within the change process" (Lewis, 2016, p.1).

A number of theories explain why relationships are developed and maintained. For example, Social Exchange theory (Thibaut and Kelly, 1959) emphasises the value of mutually beneficial cost-benefit analysis with clearly set expectations, where change occurs through negotiation and comparison of alternatives. Uncertainty Reduction theory (Berger and Calabrese, 1975) places a value on communications and finding out about mutual values, thus going through various stages in order to reduce uncertainty.

In this research the term relationship with parents is operationalised in terms of approaches employed by child safeguarding professionals to regard and interact with parents. It is understood by all professionals to be taking place within the context of professional interaction with parents rather than personal interaction, and with the purpose of making decisions in relation to the child or children of concern.
A relationship-based approach is seen by respondents as central to child-safeguarding, particularly in social work, whereby the ability to secure a ‘good’ relationship with service users is understood to be a pathway for professionals to be able to empower a parent and effect positive changes within the family.

This is evidenced by the response of a social work participant claiming that:

"I build relationship with all the families that I work with. I have to say to parents 'Children are my priority, but it’s really important we have a relationship'. Because we are working together and it is about family" (FP02).

The view that it is imperative to establish a ‘partnership’ with the family whilst addressing the concerns for the child is supported by a social work team manager who considered that:

"All social workers have to build a relationship- whether in child in need cases where we are there for a short run, or in child protection cases where we can be working with families for months, sometimes years” (FP07).

The existence of short, medium, and long-term relationships with parents is also evident within healthcare practice as supported by the responses of the two health visitors, the nurse and the paediatrician interviewed for this research.

This argument is also substantiated by the findings of serious case review reports, where in SCR C (2012), professionals worked relentlessly to build a relationship with adults, and "there is evidence
of a great deal of effort in this regard.” In SCR E (2014), the family support worker’s “first priority was to establish a relationship with the parents to begin to address the needs of the children” as social and health care workers tried desperately to get the family to engage.

In relation to healthcare professionals, particularly as far as paediatricians and paediatric nurses are concerned, these professionals are accustomed to a culture of working in partnership with a patient’s family and they firmly believe that, as primary carers, a parent’s role is to ensure the safety and wellbeing of their children. Although this is a safe assumption to make for the majority of parents, this clearly does not apply to those who are involved in child abuse.

Furthermore police practitioners in this research also allude to the importance of establishing rapport with parents. Yet there is a notable sense of reluctance to refer to this practice as a ‘relationship’. When asked if they sought a relationship with parents, a detective for a child abuse investigation team responded:

"Certainly not. At any point, whether we arrest them or we are just going to visit them” (FP10).

This riposte cannot be fully understood without appreciating that for some of these police professionals (N=4), more likely than not, the idea of a relationship is associated with provision of support, an emotive response, and conjured up an image of collaboration with parents, something they feel is entirely outside their remit. This can be illustrated by the reply of another child abuse investigator:
“It is professional. I am very aware that I am here to do a job. I am not here to support them- I cannot do that. I am not a counsellor or anything like that. This is my role, this is what I do and I’ll keep you updated. I think it is very important from the beginning to keep them at arm’s length. I am not there to kind of listen to all their fallout from it as it were but very much to the point. I think it is very important because there are so many agencies that we signpost to, including Children Services, who deal with all this emotional stuff. It would be wrong for me to get caught up in that” (FP11).

Yet, a few police participants acknowledge that at times:

“You have got to deal not only with safeguarding the child and support the child, but also the parent as well...Because if you get that wrong and.... that person is arrested and their whole life can be screwed really” (FP09).

Amidst the different attitudes towards establishing a relationship, it is recognised within this research that indeed, the nature, extent and the dynamics associated with it varied greatly among practitioners.

6.3 The meaning and importance of a relationship in the child safeguarding context

What the idea of a relationship evokes within different professionals, and their perception of its significance, depends largely on the organisational and legal parameters within which these professionals operate.
Specifically, for social and healthcare professionals, a relationship with parents involves having open and empathetic communication with them where:

"We have to talk about everything and anything. It is professional, but there is a certain warmth there. It is not always serious and it has to be human. We are asking parents to talk about most difficult things. You cannot be a robot” (FP02), and

"It is about getting alongside people” (KP02), and

"...it is about understanding hidden stories behind what is happening” (FP08).

Additionally, as indicated by one of the health visitor respondents:

"It’s about trying to be approachable...So to be very professional and letting them know that you are there in a professional role but not crossing a line so that the parent thinks you are more like a friend more than a professional. So, communication... and they are much more relaxed to talk to you about things” (FP06).

It is evident from the responses of social and healthcare professionals that they strive to be compassionate with parents and create minimum intrusion into family lives. Conscious of the power imbalances their engagement with the parents might generate, these professionals are inclined to view adults in the family as ‘flawed yet honest’ rather than ‘erratic and potentially manipulative’, a view that is supported in other research (Ruch, 2012). This also provides an explanation for the ‘benign-malicious’ taxonomy whereby on the
left side of the spectrum parental deception in most instances is attributed to the parents simply wishing to be left alone, rather than to cover abuse. This however makes social and healthcare practitioners feel uncomfortable about exercising their authority and mandate when attempting to gather information or challenge inconsistencies, and this results in what this researcher conceptualises as ‘apologetic professional practice’.

As demonstrated by a social work participant:

“I’d ask questions...but actually, sometimes it might feel to them as if I am interrogating them. I feel like that actually. I guess by some things they would be. I would feel it. I am going by what maybe I’d feel if someone was coming to my home, I’d feel like I was being interrogated regardless of how nice they were, how open they were. I would still probably feel very intimidated” (FP04).

This is echoed by a healthcare professional who states:

"Where we come from, we are products of our life, upbringing- it’s being aware of that. Being aware of what’s normal and being able to not react to anything that’s been told to you in a way that would be detrimental to the person. Like a poker face I suppose. And being able to understand that we are all different and being able to sell it to people in a way they don’t feel it’s invasive” (FP05).

Thus establishing and maintaining an open and compassionate relationship whilst retaining ‘professional distance’, as supported by literature (Turney, 2010; BASW, 2002; Dingwall & Robinson, 1990) is perceived by these professionals as instrumental in promoting a
meaningful engagement with parents. In their view this is the most appropriate approach to ‘lower down any barriers’ to information exchange and encourage parents to be more receptive to agencies’ messages in relation to ensuring the safety and wellbeing of the child. As demonstrated by an experienced social worker:

“I would go in very open minded and let them tell me their story and approach is absolutely working with the family because as soon as they feel criticism and hostility, the barriers will go up” (FP03).

Another social worker felt that the optimum approach is to:

“...create a working relationship with the family in order to provide the best support, then, to create change for that child. If you are constantly going in and having a go, and if you did not have a good working relationship with that parent, that is going to affect the change for that child”(FP04).

As the responses above demonstrate, social workers are convinced that it is only by having a good relationship with parents that they are able to promote positive changes in the child’s life. However in this context good implies non-argumentative methods of communication and involvement with parents whereby workers relate mostly optimistic and supportive messages. It is therefore very difficult for social workers to challenge or ‘call out’ the parent over any inconsistency or implausibility in their statements, and it can be inferred that this type of relationship is not always likely to be healthy for the child, who should be at the centre of professional thinking and risk management.
The notion of achieving a *good* relationship is applicable to both social and healthcare professions who believe they need to have parental consent in order to work with the family, and particularly, health visitors whose provision of service is not mandatory for parents. As evidenced by an experienced health visitor:

"We are a service, we are not compulsory. They don’t know that, we don’t advertise that. But they could opt out at any time. So it is more important for us to be liked by them because they have every right to call up and say, ‘I don’t want the same health visitor any more’ and give their reasons. It is very difficult because you sometimes are given information or you are saying things they don’t want to hear” (FP05).

This demonstrates that an open relationship is grounded in principles of positive regard and passive dialogue, as well as the need to be ‘liked’, as opposed to offering criticism and challenge. This means that for many child safeguarding professionals the framework of the relationship encourages a situation where professionals are taking parents’ accounts at face value.

This is particularly significant as a large proportion of social worker respondents (N= 6) felt that that most of their ‘time and effort’ goes towards working with parents, and that building a relationship is essential in order to promote any desired changes within the family in order to ensure the safety and wellbeing of the child. As illustrated below:

"So much work is undertaken with the parents…and you need to do a lot of direct work with parents. It is proportionally more with parents than the children. You need to build good
relationship. You need to get them on board with the plan. You need to make sure they understand the plan, that they buy into the plan, that it is their plan” (FP04).

This intense effort to engage positively with parents may work in many cases, but it can also be problematic because there is a body of evidence provided by both research (Reder, et.al., 1993; Brandon, et al., 2008) and serious case review findings (SCR A, 2012; SCR H, 2016), which demonstrate that parents often do not ‘buy into the plan’, whether by showing disguised compliance or being openly resistant and hostile to agency intervention.

Yet for many social and healthcare professionals, having a good relationship with parents is necessary to assure their ongoing access to the child. Put bluntly by one of a social work managers and trainers:

"Sometimes the relationship with parents is the only vehicle to get to a child” (KP08).

Hence, social and healthcare professionals ensure that these relationships are not compromised in the belief that this would help promote the welfare of the child. It is argued both by a child abuse police detective and a child abuse investigation trainer delivering joint training to police officers and social workers that:

"Social services end up to have more contact with parents and they have to communicate with them because it gives them access to the child.” (FP10), and:

"They are going to work and befriend the family to work with them in order to get the best outcome for the child” (KP07).
Once again then a respondent speaks of social workers feeling they must ‘befriend’ the family, which is not conducive to critical and sceptical child safeguarding practice.

Moving back to the area of health services, the argument for maintaining a relationship as a means of ensuring a child’s safety is also put forward by a safeguarding nurse who feels that:

"It is important to nurture the relationship, so as to not jeopardise the risk to the child" (KP06).

Additionally, for social and healthcare professionals it is felt by some that the establishment and maintenance of a relationship provides an avenue to collecting pertinent information about the family in order to assess the veracity of their accounts, where such information is not immediately available. In these circumstances too these professionals feel that they are compelled to be acquiescent with parents in order to get any intelligence. As stated by an experienced social worker:

"If they feel you are going heavy handed they will put up the barriers and they won’t tell you anything. So, so much depends on the relationship you’ve struck with the parents“ (FP03).

This is corroborated by another health professional working with families who states that:

"If you are not that approachable as a health visitor they are less likely to tell you things” (FP06).

A safeguarding nurse shares her experience dealing with a hostile grandfather where:
"...every conversation with him was to appease him, and make sure he was all right” (KP06).

This view is mirrored by the US social work participant who feels that in order to obtain any information the best approach is to be open minded and non-confrontational so that one could:

“get sense of what is going and calm the waters” (FP15A).

In the absence of corroborating sources of intelligence, the quality of this information is undoubtedly highly questionable as it is not subjected to scrutiny or scepticism, a discussion point that will be addressed later in this chapter.

In relation to police participants in this research (N=5) it is established that their relationship with parents is indisputably short termed and consequently somewhat different. However, there are some parallels. For example, the importance of open and empathetic interaction is also emphasised by a police child protection investigator who states:

"You always emphasise with them, and you listen to them. I don’t criminalise anybody if I don’t know what it is I am dealing with. I keep an open mind and I treat everybody the same” (FP09).

As demonstrated by the response of a police senior investigating officer below, the police relationship with parents is perceived as:

"...an engagement process, we are still going to speak to parents, we still want to do everything we can to be
proportionate and balanced and sensitive. What really is our ultimate goal is to keep that child safe in the long term. So, the last thing we want to do is to be in complete conflict with the parents because they are not going to speak to us” (FP13).

These views are supported by a child protection investigator from New York City, USA who feels that:

"You have to speak to parents to shed some light on what is going on in there. But people can shut down and not cooperate because they are resentful. It is human interaction and it is a stressful thing” (FP14A).

Hence it is reasonable to infer that during the initial stages of engagement with parents it is pertinent for police officers to remain empathetic and appear open minded in order to obtain information relating to the child. This pragmatic approach is underlined by the response of the senior investigating officer who feels that:

"When you are in your initial stages of information building or fact finding ...you are going to get more from a parent if you are professional. Friendly but professional. The last thing we are going to do is go in and be aggressive and confrontational despite the typical image or the perception of police of getting in with their big boots on and being completely disrespectful to everyone” (FP13).

That is however where similarities in approach between their social and healthcare colleagues end, because unlike them the police seem to progress into the challenging evidence phase of their inquiries. As put forward by a police respondent:
"From the police side of thing we’ll then have less engagement with the parents because if they are suspects they will be interviewed. They may ring and ask us, ‘What is happening?’ and the answer would be, ‘There is still an investigation, we are looking into it.’ So I don’t think police are affected by [needing a relationship with] them” (FP10).

As hypothesised by a police professional this is partly due to the short-term nature and timings of their engagement with the family, yet the difficulty of having to maintain a medium or long-term relationship with parents by social and healthcare practitioners is acknowledged. His extensive and illuminating quote is reproduced below:

"I think the police are in a slightly better position because when we become involved, it is at the higher end, often when the child had been harmed with some significant harm. Whereas I guess with my colleagues in health and social services, they have to work with a family, they are trying to understand what is going on with the family dynamics and so they are having to ‘play the game’ with the parents in some respect. So, they might not be as confrontational or as challenging as us... Because they’ve got to continue working with the family, they’ve got to develop a relationship with the family, whereas we sort of dip in, do our bit and disappear. And of course, social services are left managing that for the future” (FP12).

This is shared by another senior police manager who also felt that:

"...because they [social and healthcare workers] have to deal with families in the longer term they have to foster a type of
relationship with the family. They are probably less challenging in terms of their confrontation...We do not foster that kind of relationship with the family, but we might foster certain relationship with the people whom we are dealing with because we might get the best out of them in terms of how we interview them and how we interact with them...And, I also think that we are probably less trusting than other people from different professions” (KP03).

As explained earlier, police professionals in child safeguarding experience ‘lie bias’ when it comes to the detection of deception, and they exhibit scepticism in their interaction with others, a view that is also supported elsewhere (e.g. Reinhard et al. 2014a; Hartwig et al. 2004).

Additionally, police professionals interviewed for the current research feel that the reason behind their emboldened and sceptical approach to interacting with parents is the "wonderful” (KP13) range of powers granted by the law and the likely effect it might have on potentially abusive parents. For example, they argue that if necessary they are able to arrest people:

“put them in an interview room, make them talk to us, make them listen to us” (KP13),

in order to get parents to provide them with necessary information.

Although police participants claim that they use these powers sparingly, they speculate that the threat of using them, the fact that parents are aware that police have these powers and are prepared to use them if necessary, is sufficient enough to obtain information. Furthermore, as offered by one police respondent:
“If social workers are involved, they are seen as a bit of a pain, a bit of an issue. Whereas if there are police involved, then the parent feels they need to do what we are saying because there are real consequences for not doing it” (KP07).

Thus, an inference can be made that similar to social workers and healthcare professionals, police do view the relationship as a mechanism to get in, and get the parents to give them access to information, but once this is achieved their necessity for having a relationship with parents is diminished. Furthermore, police professionals do not feel they are required to have any association with parents in order to gain access to the child.

Yet social and healthcare professionals are convinced that they have to continue maintaining a relationship with parents because it is the most accepted and straightforward way to continue to get access to information, as well as the child, within the limitations created by their organisational cultures and, in their perception, a lack of legal power.

This is further underlined by the response of a social worker who feels that a good, indeed one could suggest subservient, relationship is crucial to enable them to carry out investigations:

"'Parents have complete control. They can withhold consent. Our hands are tied....but I think if you have not had that relationship in the first place, the parents might not have told you things“” (FP01).
Furthermore, social and healthcare professionals express a strong view that it is fundamental for the relationship with parents to be honest and trusting, echoing research by Reimer (2013).

This is captured in a response by a senior manager in social work who states that:

“You need to build that trust with parents, it is critical” (FP08).

Another social worker felt that:

“What I believe in really strongly is that a parent must always feel their legal rights are being respected, and I think it is easy for us in this job to have upper hand. If you want parents to take responsibilities for their lives and make decisions, they also must have a right to have information in order to challenge it, so that they feel a part of the process” (FP02).

It is also believed by social and healthcare professionals that parents that view them as being honest and trusting are more likely to cooperate, and consequently they were less likely to lie, a phenomenon known as relational truth-bias heuristic, discussed by Reinhard, et al. (2014a).

As demonstrated by an experienced social worker:

“First you have to establish relationship and trust, where honesty is required and they know that you accept the same from them so that you can support them. Because if you don’t know what’s happening you cannot deal with it” (FP03).
It is felt that for a relationship to succeed it must be based on reciprocal trust and respect. Therefore, it is the view of respondents that trust and honesty on their part would inevitably encourage reciprocal attitudes from parents, although it is likely to take time. It is argued by a social worker that:

“I'd rather be thinking that people are being completely open and honest with me. That’s what I said I was going to do with them” (FP02).

Although this view supports the findings by Reinhard et al. (2014) that social workers exhibit truth bias in their ability to detect deception, it also sheds light on the ‘rule of optimism’ (Brandon et al. 2008) phenomenon which suggests that social workers do not question the veracity of parents’ accounts because they want to respect and trust them, and they have blind optimism that in so doing this will be reciprocated by the parent.

Interestingly although social workers themselves feel that they are often disbelieved by parents, this fact further encourages them to continue to express to parents that their intentions are to help them with their difficulties. The rationale behind those strategies is to get a parent on board and ensure their compliance for planned interventions. As demonstrated by a social worker:

"With some cooperative parents it is easier, it forms more naturally because they are willing to come and work with you. With less cooperative parents it is more challenging. You have to really explain your role to them. But we still have to be able to say to parents you are working with, 'I'll be honest with you and I ask you to be honest with me...We don't have to agree but always be honest’” (FP02).
A police trainer involved in delivery of joint police-social work training also feels that social workers:

"can only do their full assessment if the parents are cooperating" (KP07).

Honesty is also an essential ingredient of "good working relationship" (FP 07) for healthcare professionals who feel it is important to be upfront with parents in the hope that they would be honest in return.

The comments above illustrate that forming a relationship with compliant parents is seen by some practitioners as a desirable and rewarding outcome (Holland, 2000) that is likely to lead to honest and truthful communication, whereas deceit is likely to be present in non-cooperating parents. In explaining this view through the prism of heuristics, professionals tend to weigh potential losses as a result of not having ‘a good relationship’ with parents as more important than potential gains of viewing parents from a more objective, deception detection enabling perspective when making decisions (Kahneman, 2011).

Arguably this view is rather problematic as it portrays non-compliant parents as deceitful and presupposes that apparently compliant parents are truthful. Whereas it is feasible that non-compliant parents may be hiding evidence of harm to a child, to assume the compliant ones are not is to become vulnerable to disguised compliance by parents.

All participating police practitioners (N=7) and a majority of social and health professionals (N=11) suspect that this relationship is at times one sided whereby professionals are expected to be upfront
with the family but do not necessarily receive similar treatment in return. Indeed as demonstrated in an earlier chapter, all participants in this research feel that parents do lie and often resort to numerous tactics to keep professionals ‘off their backs’.

Although the social and health care professionals’ inclination to see parents as trustworthy, despite their acknowledgment of parents as being deceitful, is undoubtedly perplexing, it can be explained by their belief that a positive relationship with agency workers would turn the parent into an honest, truthful and therefore a better person through the medium of the relationship.

The validation of such reasoning is based on the commonly shared view that:

"a relationship can only be authentic if there is honesty in it” and that "if you haven’t got honesty then it is not a proper relationship” (KP07).

Thus it is presumed that if there is a good relationship it has to be based on mutual trust and honesty and it is likely to take place with compliant parents.

However social and health care professionals in the current research find that a relationship with parents quickly disintegrates when they ‘violate’ the trust of parent by disclosing information to other authorities. It can therefore be inferred that some parents are seeking a one-sided relationship whereby they hold the balance of power and the professional is subservient to their wishes. This notion is evidenced by the two health visitor participants who explain that in their experience a relationship breaks down:
“when you shared what they [parents] told you. If you don’t do what they [parents] want you to do” (FP05),

and

“...when you get someone else involved” (FP06).

To illustrate the point, a health worker (FP06) discusses a real case example of a mother who repeatedly failed to take her child to a nursery; the child’s speech was underdeveloped and the home conditions were poor. The mother also refused to take the child to be assessed for language and therapy. When after numerous attempts of trying to engage the mother in services she referred the case to the MASH team (which the parent was informed about beforehand), the mother made sure that “the next two times she was not in” (FP06) when the worker made her home visit and consequently complained to the worker’s colleague in social work, “Why did she do that? I don’t want to speak to her anymore” (FP06).

This ended the service provision and the fragile ‘relationship’ was exposed as being based upon the self-interest of the mother rather than a healthy mutual desire to improve the well-being of the child. This is an illustration that the so-called ‘relationship’ can be working well – as long as it is on the terms desired by the parent rather than the professional.

There are other factors revealed which indicate that sometimes the relationship is not healthy but appears in fact conditional upon the parent getting what they want out of it. As indicated by one of the trainers involved in the delivery of joint police-social work training, social workers are reluctant to openly challenge parents on the veracity of information they provide to professionals because of the hostile reaction they are likely to get from parents such as:
“Oh, you don’t trust me? I am not going to do what you want” (KP05).

The effect of this inability to challenge parents often results in professionals feeling powerless and lacking control and they find it challenging to persevere with a relationship. As related by one of the social workers:

“It is hard because you want to be really approachable. But actually, there are times when you cannot be that friendly and approachable because you need to say things that you are worried about that that’s when it does get more difficult” (FP08).

Furthermore, it is discussed by a social care manager that when social workers in Child in Need Teams (that usually necessitate only short-term interventions) are transferred to the Child Protection Teams, they find the experience of having to build a long-term relationship with parents daunting:

“I have difficulty running my team because I sense their reluctance as some Child in Need workers are struggling to do the job of Child Protection members...It sounds like they don’t want to build the relationship” (FP07).

Interestingly despite being firmly convinced that having a relationship with parents is useful if not essential practice to be able to gather information in order to make their risk assessments, most frontline social and health visitors (N=8) express the view that they do not wish to have it. As stated by a former social work manager and current trainer:
“Social workers do not want a relationship with parents. I wonder whether it’s because they feel tricked because they felt they came to work with children and then they are asked to sort out the parents’ problems” (KP08).

Social workers in particular feel that building relationships takes a significant amount of effort and time which they do not have, as illustrated by this response:

“If we are talking about trying to build relationship with families, particularly that are suspicious, and therefore, dishonest, that takes time” (KP08).

The turbulent feelings of emotional ambiguity and competing priorities for social care professionals are eloquently summarised in the following powerful utterance:

“Work with parents, at times, seems like flogging a dead horse. It’s so demoralising... Because it is exhausting being rejected and let down and despised by people who just do not want you there. And we have to keep doing the same thing over and over again. Another parenting class, another this, another that. And it is flogging a dead horse and we know that it is. And that’s when the ‘start again syndrome’ comes in, that’s when we keep repeating stuff. And it encourages disguised compliance. That’s where we are getting this game. That’s what we are all doing, just playing the game. And parents know how to do it. And the professional knows that they are being drawn into it” (KP08).
Additionally, professionals acknowledge the one-sidedness of some relationships and that being open-minded and accommodating can, and does, cloud their objectivity as to the assessment of risk and detection of deceit. The perception of a social work team respondent was that:

“Some parents could perceive friendliness and being approachable the wrong way, and this could get in the way of professional judgement” (FP07).

Evidence from a serious case review corroborates this viewpoint as it highlights the circumstances were “professional safeguarding practices involved a balancing act, with professionals treading the line between needing to accommodate a child and trying to support the parents/carers in such a way as to ensure the child’s safety and welfare within the family home” (SCR B, 2012).

Expressed in the views of frontline social workers and health visitors, a relationship often facilitates conditions where they feel they are enabling parents rather than empowering them. They feel that some parents grow emotionally dependent on them, as illustrated by the two health visitors interviewed for this research:

“Sometimes you can be there a lot for parents depending on their issues. And they can actually become reliant on you. Mums feel attached to you in some way because she may not have any friends herself. So even though we would not see them as a friend, the mum might see the health visitor as one. So, it is about being mindful that you are a professional in that role, remain a professional yet not make it clear to mum, because you cannot just say, “I am not your friend, I am a
professional. Because it might put a barrier up for mum as well” (FP06).

Consequently, this dependence is interpreted by social and healthcare professionals as helplessness, which prompts professionals to reduce parents to victims rather than see them as potential perpetrators of abuse. This apparent need to focus on the parents as ‘needy souls’ further serves to push the subject child into the background.

When parents become apparently dependent on the workers, the emotional payload borne by social and healthcare professional is enormous and of course debilitating. An occurrence of how this parental ‘dependence’ makes professionals vulnerable to their manipulations was also provided by a social care participant from the USA. As illustrated below:

“People know that I am there to do a favour for them, I am there to help them [to be reunified with their child] and they lie flat to my face. And they will lie to me over and over. When social workers get so emotionally involved with what is going on in the case with a kid, with a parent they are trying to help, a lot of times they just blow up because they put some much into it, they cannot believe that this person just went against everything that was agreed that fell off the wagon and went back to the behaviours they were doing before. Most of the people don’t last very long with the job if you get that emotionally involved with the job. It burns you out, very quickly” (FP15A).

Interestingly apart from newly qualified workers (N=2) in this research, social work and healthcare professionals are adamant that
many *parents do not want to have a relationship with them*. These practitioners believe that parents see the child safeguarding professionals with suspicion and distrust because they are fearful of ‘losing’ their children. Ironically, the professionals are trying to do everything possible by working with the family in order not to remove the child.

Hence a social worker feels that parents do not seek a relationship and that it is all about:

“...*knowing how to get the professionals off their backs.*” (OB)

It is argued by another social work participant, that:

“*Parents are quite dismissive of workers and they are seeing it as unwanted intrusion.*” (FP12).

It is strongly felt by a social work trainer that parents:

“*Do not want the involvement, they do not. And therefore, they withhold their consent, for example, for those professionals to seek out sharing information with each other. So by withholding that consent they effectively sabotage what the professionals are trying to do. So in order to try to woo these parents, to win them around, to convince them that it would be a good thing to work with them, that’s where I see a lot of the compromise taking place in terms of being child-centred.*” (KP08).

To a lay person the expressions used by this highly experienced respondent may seem astonishing. The idea that a child protection professional has to try and “woo the parents” or “win them round”
in order to work with them perhaps illustrates how sometimes the vulnerable child, the person who is actually the ‘client’, can be lost in the background of this battle of wills.

Whereas a newly qualified social worker feels optimistically proud that parents think of her as:

“honest, helpful, and being able to get on fine” (FP02),

her more experienced colleague argues that parents consider professionals in terms of their usefulness. This participant feels that,

“*You get that with a lot of young colleagues that you work with. And that worker says, ‘Oh, that’s going well, that parent is getting on well with me’. Don’t take it personally, they can actually use them. And that sounds really brutal but it is worth reminding yourself that clients don’t really want you as their friend, but on the other hand, if you do what they want you to do, you are very useful to them. And that sounds really brutal, but it’s reminding ourselves, ‘Oh that person really likes me’ ‘Well, why do they like you?’ (laughs)” (FP03).

It is felt by experienced social and healthcare professionals that it is important not to allow the parents to think that they could only work exclusively with a particular professional. In other words the feeling of being indispensable often leads to collusion with parents.

When asked whether she thought parents were interested in having a relationship with professionals, a social worker replied:

“Not really. I think some people are really polite and sometimes, you say ‘Oh, I am really grateful for the support
and stuff like that, but I am glad to see you go.’ Some people just really don’t like social workers, end of” (FP04).

Furthermore, the effect of child safeguarding professionals having to build and continue to maintain a ‘good relationship’ with parents is manifested in different ways when it comes to these professionals responding to suspected deception.

### 6.4 The dangerous consequences of a ‘relationship’

It is agreed by all child safeguarding professionals that having a close working relationship with parents interferes with their ability to detect and respond to deceit. The effect of a professional-parent relationship on professionals’ response to deception is captured in Figure 4 below. It identifies the fundamental criteria that are characteristic of a professional-parent relationship (cause) as perceived by practitioners and demonstrates the effect these have on professionals’ impaired response to deception. The top part of the diagram captures the organisational factors of the relationship that are associated with practice-related decisions. The bottom part includes the ‘human’ factors that are present in professionals when they are in a relationship with parents.

![Figure 4. The effect of relationship-based practice on child safeguarding professionals](image-url)
The emotional toll suffered by some professionals, created by working in an environment where there is a management expectation that they need to build and maintain a relationship with an unwilling or manipulative participant, can be debilitating. The inhibitions placed upon professionals in their ability to deal with deception is in itself debilitating. Professionals seem to be torn between different priorities. They know the child should be at the centre of their thinking, they know they should challenge inconsistencies, yet they are inhibited in their ability to do so. This might cause anxiety, sickness, and even a difficulty in recruiting or retaining the child safeguarding workforce. It has been noted by some respondents that many child protection teams suffer from frequent turn-over of staff, and it is therefore not uncommon for many such teams to be staffed largely by agency social workers who may be limited in their effectiveness by short termism and a lack of local knowledge and training.

Building a relationship is of course but one of many pressures faced by safeguarding professionals but the evidence provided by this research indicates that it is a serious and dangerous pressure, as described further below.

6.4.1 Validating deception

It is mentioned elsewhere in this thesis that professionals often empathise with parents’ circumstances. It is also discussed that whereas for police professionals this is viewed as a strategy to obtain information from parents, for their colleagues in social and healthcare setting it opens the doors for an ongoing relationship. As argued by a paediatrician in this research:
“Particularly in case conferences, where parents are present for a lot of the information sharing, professionals will try to present a glossy picture that is less hurting to the parents. And sometimes, in those situations you just have to be lot more upfront but that’s hard for professionals. I am sure I’ve done it myself” (KP04).

Unlike for example in MAPPA hearings that convene to assess the dangerousness of the adult to the community without the ‘client’ being present, the parents are by default invited to attend child protection conferences that meet to assess the risk to their child and plan the response to that risk. If a formal child protection conference is held, the case will usually be at the dangerous end of the spectrum in terms of actual or potential significant harm. One of the options which will always be discussed by delegates is whether to place a child on a child protection plan, further underlining the gravity and importance of these meetings.

Although in rare circumstances the Chair could exclude the parents, for example if confidential information is to be disclosed by the police, there is a presumption that the parents will be present for the whole meeting. It is recognised that sitting in a room full of professionals can be daunting for parents so the Chair and delegates will often want to soften the ‘ordeal’ by empathising with them and paying attention to their needs. Consequently, although the child is meant to be the focus of such a meeting, the parents’ presence may inadvertently dominate the proceedings. In fact, bearing in mind that several professionals around the table may be those who are trying to build or maintain a relationship with the parents, their mere presence may be inhibiting or sometimes intimidating to professionals who simply do not wish to say bad things about the
parents in order to avoid confrontation. The professionals may feel that they are being judgemental about parents whereas all they are doing is reporting facts. This reluctance to be frank can lead other delegates to try and ‘read between the lines’ about what their colleagues are saying. Hence the evidence is not being aired in clear and unambiguous terms because people do not want to voice unpleasant facts to parents’ faces, and this in turn undermines the purpose of the conference which is to allow any concerns to be flagged up and openly discussed. It can be therefore argued that although the exclusion of parents from child protection conferences is detrimental for effective partnership as it does not allow practitioners to communicate to parents their shared concerns about the child, the inclusion of parents in these meetings seems to hamper their ability to be direct and truthful in their messages.

A safeguarding nurse who was interviewed feels that in child protection conferences deception was sometimes overlooked due to empathetic feelings often getting in a way of facts:

"Sometimes we explain away [deception], 'Oh, she’s [mother] got too much on her plate. She’s got to cope with this, this disabled child, and father is not helping, he travels around’. So, sometimes people will try to explain that away because they’ve got good relationship” (KP06).

Being too empathetic also triggers an emotional involvement on the part of professionals where they feel they are able to identify with parents. As explained by psychodynamic theory, this emotional response motivates professionals to believe that parental behaviour is entirely genuine and lacking any malice. This is illustrated by a health care professional who stated that:
“manipulation is far more common coming out of parental anxiety and fears rather than them being deceitful” (KP04).

As the serious case reviews continue to demonstrate, there is no evidence to support this wishful thinking. Yet the views above point to the fact that there is a misconception about what constitutes deception, and that the truth bias is profoundly embedded into the culture and practice of social and healthcare practitioners. Having a well-developed relationship with parents only strengthens this bias by creating an empathetic environment where deception is endorsed and excused, and the professionals’ objective assessment of the situation is absent. Therefore, it becomes clear how seemingly distraught parents, as in the case of Daniel Pelka, manage to hoodwink healthcare professionals by successfully arguing for the accidental nature of children’s injuries. Although with the benefit of hindsight it is too straightforward to reason that the professionals should look for evidence outside the parental engagement to corroborate their accounts, if practitioners do not have cause to do so, having been satisfied previously by parental explanations, it is unlikely that the professionals’ curiosity is triggered. In other words, to be curious requires some amount of scepticism that, as the evidence in this research demonstrates, is not necessarily present in ‘helping professions’ such as social and healthcare.

Furthermore, as demonstrated by the following statement, in response to suspected deception in parents, social workers feel that:

"It comes with the territory, and if parents are willing to fight for their children then it means they’ve got some emotional commitment” (FP01).
Far from being indignant and frustrated about parental resistance and their hostility in response to professionals challenging information provided by parents, some respondents from within social work indicate that it is perhaps justified:

“It must be difficult for them because they thought they could tell you things. And then you may come back and tell them you might have to escalate this because of what you’ve told me, and that it needs to be done. It is difficult” (FP07).

The above also demonstrates that social workers and healthcare are perhaps losing sight of their role and purpose when dealing with parents. Under the framework of a relationship they are constantly forced to play a balancing act between being supporting and understanding towards parents whilst promoting the needs of the child. With these two aspects sometimes being mutually exclusive, and with parents being most vocal in the relationship with professionals, it is not difficult to see why the focus on the child can be lost.

This is also confirmed by the USA social work participant who states:

"I will not tell you that there is no emotion“ (FP15A),

as he accepts that emotional attachment often clouds his judgements.

With regard to police professionals, they feel that more often than not it is Children Services that justify deceitful actions by parents as acceptable because of their investment in an emotional relationship
with parents. This can be evidenced in the response of a police detective below:

"Sometimes I can see when they are getting too involved or when they are going with their heart rather than making suitable decisions. There are cases when you think, 'Why on earth have you done that?' It’s not the right decision" (FP11).

The police professionals also fall prey to empathy and losing sight of their roles, as demonstrated by the response below:

"As soon as the child died or if the child was seriously ill, focus went straight to the parents. Even it involved elements of neglect, the response from some police officers working within child protection, would be very much, 'Oh, poor parents, they’ve lost a child’, ‘There might be some neglect, but really, do we want to prosecute them?’” (FP13)

Another quote from the same professional indicates how the impaired objective assessment of the situation by practitioners as a result of wishful thinking affects child-focused interventions:

"For example, parents would be told explicitly and on a number of occasions not to sleep with a child in a bed because it was a small bed and they were particularly large and they were smoking in the house and they would drink; there were all these contributory factors which we see could be detrimental to the safety of the child. We will be lied to, and we will find out that unfortunately, during the night, the mum or dad would lie on top of the child, the child’s died. And straight away, colleagues would say, 'Poor parents. This child died and they’ve lost their child. We don’t need to punish them"
anymore.’ So, it was really strange that this child did not seem to have any value attached to it” (FP13).

The strong empathetic feelings towards the parents make it difficult for professionals to stay impartial as emotional involvement contributes to collusion, a situation that all child protection professionals are susceptible to as felt by a police participant:

“If there is a professional that would more likely be hoodwinked or convinced or deceived, it would a health professional as opposed to a social worker or police officer. But police officers can be deceived as well as social workers. We see it happening. But in my experience, I think it is more of a domain of health really” (FP13).

The latest quote from the police professional above does not reconcile with his two previous statements that police in fact, similar to their colleagues in child safeguarding, do get deceived by parents when working with them in partnership, albeit short-termed. It is probable that their reluctance to acknowledge this is partly based on the supposition that a lie bias attributable to police officers will make them more resilient to lies. Yet the emotive nature of child safeguarding work that involves both the parents and the child makes it difficult to remain impartial and focus solely on the needs of the child.

6.4.2 Colluding

It is the view of social care professionals that in their aspiration to build and maintain good relationship with parents, they allow themselves to be hoodwinked. An experienced social worker felt that:
"When you’ve known parents for so long you start getting sucked in into their reasoning, ‘Well, that sounds reasonable, her granddad has died, that’s quite reasonable. So on one hand, having a relationship with a client is very important, but obviously when you’ve known someone for years you form a relationship with that person, and that’s then they can lull you into thinking it’s all okay” (FP03).

It is therefore reasonable to suggest that in the event of a long-lasting relationship there is a need for professional practice to be peer reviewed, the so called fresh pair of eyes, in order to not allow professionals to become nose blind to parental deceit. This idea is shared by some of the experienced social workers, one of whom, using her experience, commented:

“This particular parent who’s got a very forceful personality would use a multitude of excuses. And sometimes, I have to pull back and I would go out and do ‘working together’ with another colleague when I feel things are going like this. It’s recognising, I think that’s important thing for social workers is to recognise when you are allowing this parent to lull you into thinking that it is all okay, and actually the things are slipping” (FP01).

Often, as argued by a social worker below, a practitioner working with a parent may inadvertently grow to like them, identify with their circumstances, and inevitably, expect less from them, as identified below:

“You are working with a parent and you expect certain things and over time, if you are not careful, you can actually expect
less and the parents are lulled into thinking that actually it’s all okay. And then you have to put to them that ‘No, it is not’. So you are allowing your personal feelings about that parent to actually let it guide your work. That sounds extreme but in a nutshell, that’s what is happening. I mean I work with parents for 3 years, I know them extremely well. I know sometimes I would perhaps let some things go in a bigger picture and I think if there is a new worker coming in, they would not let this go” (FP03).

This response above demonstrates that long term relationship with parents desensitises professionals to deception and necessitates the impartial view of a colleague or supervisor.

Additionally, the police feel that maintaining a beneficial relationship with parents meant that social workers are sometimes sharing sensitive or even confidential multiagency information with parents. A child abuse investigator argues that he has learned to be very cautious in his communication with social workers because:

“I have not told the parents that but then they [the social worker] had shared the information. They said, ‘Oh, the police said it is not going anywhere’. So this caused me a bit of a problem then” (FP10).

This police respondent was not suggesting that a social worker would deliberately undermine an investigation but rather was illustrating that boundaries can become blurred around ‘friendship’ or ‘familiarity’ with a parent, which can sometimes lead to information being incorrectly shared in order to try and help that parent or make the parent happier.
The potentially corrosive effect of having a trusting relationship with parents is summarised in the lengthy response by a social worker in the USA who felt that:

"Taking things for granted means that there is a trust already there, so you are not using any of your normal observation powers, you are not using any, I don’t want to say, the cynical aspects of the job. I’ve done it myself. I’ve gotten to know foster parents so well and watched them do really well with one kid and then, I’ll have another kid there and I just continued that feeling that I had about them and I have not asked some of the right questions and I walked away from that home visit realising that I did a lousy job at finding anything out about what is going on in that kid’s life. I think the word is familiarity. That familiarity takes the edge off and when you start working without that edge then you don’t start asking those type of questions, the safety kind of questions that you suppose to ask. You know you ask the first question and you don’t ask the follow up question” (FP15A).

For social and healthcare professionals, the hard task of building and maintaining good relationships is followed by operational practice whereby behaviour of the cooperative parents is encouraged and rewarded, which promotes the culture of disguised compliance.

6.4.3 Facilitating ‘disguised compliance’ and deception

It is felt by all child safeguarding professionals (N=23) that they are more likely to disbelieve people who are aggressive and hostile to them, do not cooperate, refuse to answer questions, or just generally exhibit negative traits. Thus if somebody is quite openly inviting professionals to the house to look around, apparently co-operating
in investigations, thus exhibiting quite a positive relationship, this could lull practitioners into finding it very difficult to believe that they could do the ‘unthinkable.’ In other words, there is a temptation to think ‘nice people don’t harm their children’ which of course is untrue because even nice people get angry and lose their temper.

This notion is supported by a social care team manager who states:

“9 times out of 10 most parents come across as resistant, difficult, making it very difficult for you to do your job. So when you do come across a parent who is nice, social workers tend to relax and let their guard down. So when it turns out that the parents have lied to them, they feel totally gutted because they’ve invested so much in building a relationship. Because having achieved the relationship makes them proud” (FP07).

When asked to elaborate on the personal interest of a social worker in trying to make a relationship a success, a social care practitioner infers that it is driven by professional pride:

“Probably subconsciously most people might think they are the only person who could get through to this mum” (FP03).

Furthermore, the same social worker shares her personal example of being deceived by the parent who she thought she had a good relationship with. Her lengthy account is reproduced below:

“The worst case of deception I had was with a young mum with a child, a heroin user. I managed to secure a resource for her and her baby in a unit for rehabilitation. She said she wanted to go, that she was no longer using heroin, she was no longer with the father and she lied, totally, she lied. That was
probably the worst kind of deception. And again, she’d done what I’ve said before when I worked with her I used to say, ‘I really like her’. She was very pleasant, she engaged well, everyone had a respect for her, you believed what she was saying. And she lied all the way through. She was using heroin, she managed to fool the drugs tests, and it was a complete lie. That one left me with a bad feeling. We are not perfect, that parent had deceived us and no one spotted it. She was so friendly, did all her tasks in the unit, she engaged well, we were getting glowing reports, the drug tests were coming back clear. We had nothing to say that she was deceiving us. She did all that a relationship with a parent speaks for...And that was our Achilles heel. That is the very thing about forming relationship and asking of parents to engage, and she did it all. She had done everything in this unit, she was a model resident, she did with the course, she was very good with the child. But all the time she was lying about not seeing the so called father. But then again, other parents, who can be very aggressive and hostile, and they get a harder time if you like and everyone is against them because they are hostile. And actually we need to understand how it feels so I’ve got to work with that. Yes, perfect clients, ..they can get away with it. It is easy to believe a nice person” (FP03).

Apart from the relationship dynamics, the response above demonstrates that social workers viewed themselves as a ‘helping’ profession.

It is recognised in research that social workers can become too preoccupied with anti-oppressive practice. According to Thompson's (2006) PCS model, anti-oppressive practice occurs on three levels: personal, cultural and societal. As a social worker’s job is also to
facilitate change (on an individual level and in the surrounding environment), they tend to let oppressive factors dominate their involvement in the case. Hence if a mother is suffering from mental illness and/or is a victim of domestic violence or drug abuse, she becomes a 'priority' for any social workers involved rather than the child who is meant to be at the centre of thinking. As social workers feel they cannot ignore the mother; they feel they must help her first. As far as they access the situation, she is the victim of oppressive practice (which she is) who is in need of help. This may be a benign phenomenon if the mother in question is an honest person who genuinely wishes to engage in a constructive way with professionals. If however, her intentions are to deceive, this presents a situation where professionals develop their unquestionable trust in her interpretation of events and facts and ultimately facilitate her lies.

As demonstrated in one of the serious case overview reports SRC C (2012) in discussions with the Case Group it became evident that “staff were anxious to maintain a good working relationship with mother, were hopeful that she should do well and be “rewarded“ for her efforts on coming off illicit drugs.” The Case Group described how this positive approach “lowered the perception that challenge was necessary,” partly because professionals wanted to continue to have the good relationship with the mother that they saw as important to her success (SCR C, 2012).

Hence a number of professionals also struggle to accept that they are being lied to.
6.4.4 Refusing to recognise deceit

One of the detrimental effects of having to invest so much into a relationship is the professionals’ state of denial when there is a suspicion that the relationship is a façade. It was witnessed by a social work manager that when it was discovered that one of the mums in a case turned out to be lying, the social worker working with that parent instantly replied, "I cannot believe it." The manager elaborates by saying:

"The social worker did not want to believe it and she was trying to find a way to want to believe mum. She was not justifying it but she did not want to accept that mum had lied. Because they put so much effort into building relationships and when they felt that they built these, and later it is found that parents lied to them, it feels to them as a personal failure. One of the challenging aspects of this job is to have a balance in building relationship to promote positive change, and not take it personally when it does not work” (FP07).

Health professionals also express reluctance to accept that that they are lied to and admit the refusal to accept facts for what they stand for is a barrier to effective child safeguarding practice. The lengthy explanatory response of a child safeguarding clinician sheds light on some of the tensions associated with recognising deceit:

"We don’t want people to think of us of as ogres. So, that’s one side of it. The other side of it, I think is probably a tendency to try and make the world black and white when it is not. We like bad people to be bad people and we like good people to be good people. And I don’t think we feel comfortable with the fact that most abusers are not ogres, they are not
paedophiles or people who are setting up to hurt their children. They are genuinely, ordinary people like you and I where things have gone wrong. And that does not sit comfortably. It certainly does not sit comfortably with the general public, I think it also does not sit comfortably with a lot of professionals and you would much rather fit people into a box. I think the whole decision-making process and this feeling that we have to deal with certainties, so if you can prove that this was a non-accidental injury, then you are in a good position. If you can prove that this child has this particular position, things work well. When you are dealing with things on a balance of probabilities but we are not entirely sure and there could be these other explanations, and I think in those situations, our tendency is to default to ‘Well, if I cannot prove it is child abuse, actually I’ll go with a less threatening diagnosis’. If there is some other explanation, I’ll go with that because it is less threatening to me and less threatening to them. I think it is not comfortable to say to somebody, ‘Actually, I don’t accept what you are saying” (KP04).

However, the impact of this viewpoint is such that police have to rely on the doctors’ judgement in determining the cause of child death, and if there are surviving siblings any failure or reluctance to be robust in a diagnosis can have serious consequences for them. More specifically, a senior investigating officer dealing with child casualties expresses his frustration about a doctor’s refusal to recognise deception in parents for what it is, and he notes:

“A paediatrician makes their judgement on the fact they think there is ‘appropriate parental grieving’ and therefore no maltreatment, the police are making their decision based on paediatrician’s decisions” (FP12).
However, even when the professionals do accept that they are being deceived by parents, they often adhere to a non-confrontational strategy of dealing with it.

### 6.4.5 Not challenging suspected deceit

It is already mentioned in this chapter that in order to maintain a relationship with parents, social work and healthcare professionals choose to resort to non-confrontational approaches. This means that effectively they do not feel that they can challenge parents when deception is suspected. It is felt by police professionals interviewed that paediatricians and paediatric nurses do not wish to get into conflict with parents in order to preserve their relationship.

This is confirmed by a paediatrician interviewed for the current research who states:

"When we work with parents, we take everything they say at face value, we try to work in partnership. And so, in a majority of case that is what we are doing. So when we are then confronted with something, ‘Actually, we are not getting their partnership’, it is very difficult for us to handle it. And I think a lot of people really do struggle with that. A) To acknowledge, 'Okay, they might not be telling the truth or acting in their child’s best interest; B) Trying to understand their reasons for that. We seek to find a way of working with them in spite of that. This all comes to that whole thing of understanding of ‘why it is that they might not be telling the truth’ (KP04).

Additionally, it is argued by a police participant that social workers also face inherent difficulties with their interactions with parents:
“I think because they have to deal with families in the longer term they are probably less challenging in terms of their confrontation or maybe they do not confront as much as we do” (KP03).

This is supported by a social work educator who feels that:

“What you cannot do is to be somebody that challenges and alienates the service user” (KP01).

Instead they prevaricate by trying to get some leverage by gaining support of other professionals. If the parents are suspected of being deceitful, and this is brought up in their conversations with professionals, professionals are likely to be challenged on their judgements by their senior managers. Although the full effect of organisational context will be explored in detail in the next chapter, it is important to note that these decisions leave the frontline practitioners demoralised and feeling less confident over their judgement as to their ability to spot the signs of deceit and make appropriate decisions. This was particularly true when a professional was moved from her role by the management due to upsetting the parent:

“It is devastating when they ring up and say they want to change you for whatever reason. It’s obviously something that they did not like they’ve got to do. The parents are then allowed to change health visitors. They call and say, ‘I don’t want to see this person anymore’, and they are just given to someone else” (FP06).

This seems to be another example of subservience on the part of professionals (in this case managers, rather than practitioners). It
could be considered quite worrying that if an abusing parent feels they have been ‘rumbled’ they need just ring up and complain that they no longer want to see the social worker or health visitor, and the worker who has ‘rumbled’ them will thereafter be removed from the case. Apart from the obvious danger to the child, the detrimental effect on staff morale is incalculable. If the above practitioner is representative of colleagues when she says it is ‘devastating’ to be taken off a case, the effect must surely be to avoid that happening if at all possible. A fear of upsetting parents to avoid being taken off a case is not conducive to the robust detection and challenging of deceit.

To further illustrate that this phenomenon seems to be caused by the concept of ‘relationship’ taking on a disproportionate importance in child safeguarding work, when asked about their approach in relation to deception, police practitioners (who feel less need to maintain any sort of relationship) claimed that they felt ‘no qualms’ about challenging a parent.

Another reason why the professionals feel they could not challenge parents is open hostility that terrifies the worker. The effect the hostility has on social and health care practitioners, as supported by Littlechild (2012), is explained by a former police practitioner currently involved in joint police-social worker training:

"There are people that you would meet that would scare the living daylights out of you. And most professionals are lone workers. I am lucky, I come from a point of view of being in the police, I had support and back up and weapons to carry. I had some form of protection. Those professionals do not have that protection. And if you are dealing with somebody who is openly hostile with you all the time that is incredibly difficult
to deal with. I think it is a really scary situation to be in. But more worrying and more often you will see the families that will go so far, so just keep professionals on the side enough, not openly hostile so the professionals say, ‘I cannot work with you, that’s why we are going to do something else,’ but just keep them on side enough that they professionals don’t feel that they can challenge because that hostility is there. But not so overt that they would have to take action. So there is that hostility element which is very difficult I think” (KP05).

Consequently, the need to preserve the relationship with parents pushes social and healthcare professionals into various practices none of which provide appropriate responses to suspected or confirmed deception in parents. Whilst it can be argued that:

“it is human nature and that humans will go down the path of least resistance and will try to avoid confrontations. It is more likely that the whole relationship is built on smoke and mirrors and it’s the professionals’ version of disguised compliance” (KP08).

The relevance of this becomes clear when professionals make decisions relating to a child’s safety, because decisions to avoid intervention are often based on the perceived necessity to maintain a relationship, sometimes against the users’ wishes.

To conclude this chapter, all child safeguarding professionals in this research subscribe to relationship-based practice with parents. For police practitioners, due to the nature of their involvement, this relationship is short termed, whereas for health and social care providers it is medium and long-termed. It is acknowledged amongst child safeguarding professionals that having a relationship with a
parent affects how they are able to deal with their potential deception. The chapter brings out a number of common themes as well as contradictions.

For social and healthcare professionals, trying to build a ‘good’ relationship with parents is seen as essential for information exchange purposes, access to the child and in order to encourage parents to become receptive to agency interventions in relation to the index child. These relationships are preserved; even when professionals suspect they are being deceived by a parent they do not challenge this for the fear of severing these ties.

Managers expect that a relationship will be created and sometimes the worker may be removed from a case if the parent feels it has broken down. Hence for social and healthcare professionals the dogma of the importance of a relationship that is based on positive regard is instrumental in their practice, with social workers in particular reluctant to go against the ‘norm.’ Yet they nevertheless question the authenticity of the relationship that according to them should be based on mutual trust and respect. Many feel that parents do not want to build a relationship with professionals because they do not view them as being genuine. All child safeguarding professionals argue that having a relationship with parents affects their professional judgement where they find themselves colluding with parents, excusing their deceptive behaviour, and in some instances facilitating deception or blatantly refusing to accept that they are being lied to.

Key points summarising this chapter relation to child safeguarding professionals are presented in Table 6 below.
Table 7. Child safeguarding professionals and a relationship with parents

<table>
<thead>
<tr>
<th>Professionals</th>
<th>Nature of a relationship</th>
<th>Perception of a relationship</th>
<th>Purpose of a relationship</th>
<th>Effect of a relationship</th>
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<tbody>
<tr>
<td>Police, UK</td>
<td>Short-term</td>
<td>Open Empathetic</td>
<td>Obtain information</td>
<td>Colluding with professionals and parents</td>
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<td></td>
<td></td>
<td>Not really a relationship at all</td>
<td>Provide initial support</td>
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<td>Often one-sided</td>
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<tr>
<td>Social care, UK</td>
<td>Short-, medium and long-term</td>
<td>Meant not to cause intrusion</td>
<td>Get access to the child</td>
<td>Validating deception</td>
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<td>More parent focused</td>
<td>Get access to information</td>
<td>Colluding with professionals and parents</td>
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<td>Open Empathetic</td>
<td>Provide support</td>
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<td>Honest</td>
<td>To get parental cooperation and engagement</td>
<td>Refusing to recognise deceit</td>
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<td>Often one-sided</td>
<td>A good one</td>
<td>Lack of challenge</td>
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<td>Health, UK</td>
<td>Short-, medium and long-term</td>
<td>Meant not to cause intrusion</td>
<td>Get access to the child</td>
<td>Validating deception</td>
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*Child abuse investigator/former police professional
Seven    Rendering deceit impotent

7.1    Introduction

Having explored in previous chapters the ability of child safeguarding professionals to recognise deceit, as well as a number of difficulties practitioners face when trying to deal with parental deception in the context of relationship-based practice, this final analytical chapter explores other areas of practice that affect professional decision-making. The chapter begins by examining the context of family-centred practice whilst commenting on the professionals’ ability to achieve the right balance between being caring and sceptical with parents. Following this, the discussion will explore the concept of ‘misvocabularisation’ and the impact it has on how parental deceit is reported within organisations. Finally, the chapter looks at some of the strategies proposed by interviewed professionals on how to overcome difficult challenges inherent in child safeguarding practice in relation to deception.

It has been recognised in Chapter Six that the practice of having to foster a working relationship with parents has often had a debilitating effect on the child safeguarding professionals’ capability to assess the truthfulness of parental engagement, as well as their ability to respond to the suspected deceit effectively.

This element of the discussion now needs to be situated within the discourse that has shaped child safeguarding and the role of parents within it, together with the role of the organisational and occupational culture affecting respective professionals.
7.2 Organisational culture: ‘Working with families’

Schein’s (1985, p.14) model views organisational culture as “a pattern of basic assumptions that a group has invented, discovered or developed in learning to cope with its problems of external adaptation and internal integration which have worked well enough to be considered valid.” The role of an occupational culture is important as it is, “taught to new members as the correct way to perceive, think and feel in relation to problems...” (Schein, 1985, p.14) whilst shaping the behavioural responses of those who carry out work on a daily basis (Maksymyk and Caslor, 2014). Furthermore, the individual and group behaviour of the professionals is affected by visible manifestations of the culture, such as policies and procedures, as well as language utilised within the organisation and intangible aspects such as an organisation’s shared values (Huczynski & Buchanan, 2007).

It is revealed by this research that social work culture is characterised by rigidity as described by Glisson et al. (2012) and adherence to “casework by concession” (Barber, 1991). Within this cultural norm professionals follow process-oriented conventional rules and procedures imposed by management, with little to no innovation taking place on an individual level, and confrontation and conflict with parents being avoided. Working with families whilst attempting to exhaust every opportunity to get them to change, and “trying to get parents to understand the obvious’ (OB) formed the day to day practice of the majority of those respondents delivering frontline safeguarding services.

This routine engagement with having to work with a family and the ultimate goal of being able to promote the desired changes often reflect the internal “feelings of discomfort and being apologetic about
their authority”, as mirrored by Ferguson (2011, p.172). Indeed, it is explained by a research participant that:

“Many people want to come to social work for example, or healthcare, not to start fighting. They would be doing something different if they wanted to fight. These are not people who want to go into an organisation where there is confrontation all the time” (KP05).

This view is shared by a healthcare professional who claims:

“I think people that come in into these roles that we are doing, social workers, teacher, support, you come into it because you want to help the child and you want to work with the parent” (KP06).

The child safeguarding culture is not monolithic. Child safeguarding professionals and indeed practitioners from health (Wilson & James, 2007) and the police (Cockcroft, 2013) are not a homogenous group, but rather they are individuals adhering to differing professional values, cultures, and interpretations of how to exercise power and authority.

All police professionals in this research (N=7) feel that they enjoy a great level of discretion when it comes to risk assessment and decision making, as supported by Westmarland’s (2008) research. They share the view of Silvestri (2003, p.15) by identifying themselves as being “forceful and quick thinking.” As demonstrated by the response of a police professional below:

“I always get to pause and think, ‘This parent is giving the explanation about the child. We are not happy with the
explanation.’ It might be perfectly legitimate but it’s a good starting point to be curious about that things do not add up here. It’s a good opportunity to ask some questions to trying to work things out” (FP09).

Additionally police participants feel that they project an aura of authority when dealing with parents which was seen to be crucial in establishing evidence:

“Whether they see you as more authoritative or they had a lot of dealings with children services and they are not necessarily happy, but the view is, I am generalising, that they tend to speak to you as a police officer, but they won’t if you are a social worker” (FP11).

It is the consensus of all respondents however that in being part of public sector organisations their practice is shaped by political and legal considerations, as indicated by Cockcroft (2013). Furthermore it is claimed by Parton (2014) that these considerations were, in the 2008 post Baby Peter Connolly climate, based on “the politics of outrage”. Parton claims that this resulted in current child protection policy and practice in England taking on a form of coercive intervention by professionals, and constituting a departure from “helping parents and children in a supportive way” (Parton, 2014, p.4).

Yet the current research contradicts Parton, and in fact finds that far from “policing” (Parton, 2014 p.4) families, child safeguarding professionals, particularly from social work and healthcare are still adhering to the principles of involvement, partnership and family support enshrined in the highly influential document Child Protection: Messages from Research (DH, 1995), which as discussed
in an earlier chapter was issued by the Government to "inform the planning and delivery of services” (DH, 1995, p.8). This document in essence advocated that there should be a rebalanced approach from coercive child protection intervention towards family support and partnership with parents (DH, 1995, p.55), often referred to at the time as “a lighter touch”. Crucially in the context of the current research, Child Protection: Messages from Research (DH, 1995) also suggested that the “balance of power” (DH, 1995, p.47) within a professional relationship should be shifted more in favour of parents.

Contrary to the findings of Parton (2014) and based upon the findings within the current research it can be inferred that these ‘lighter touch’ principles are still an integral part of social work occupational culture. This is exemplified by a senior social worker participant:

“Undoubtedly, there is a pressure on social workers to work with families, to exhaust every possible avenue. I think some people are put in that position and it is imperative to act within the law for the children to remain with families wherever possible. We have families coming through to me in other situations who’ve been open and known to the Authority for many, many years. And then there is a decision eventually that enough is enough and we are going to have to go through care proceedings. But there is an expectation on the Local Authority to show other evidence of how they have got to that position, what they’ve offered, how they’ve offered” (FP01).

As underpinned by The Munro review of child protection: Final report (Munro, 2011) that most parents are reasonable and have strong protective feelings towards their children, child safeguarding professionals in this research felt that they are being indoctrinated
throughout their career to accept that generally families are doing the best they can with the resources they have available, that the values and beliefs of the families receiving services must be respected, and that their role as professionals is to empower families to meet the needs of their children. Thus, family oriented practice is still based on the premise that the best outcome for children occurs usually when cared for within their own families, and that a safe and permanent home and family is the best place for the children (DH, 1995, p19).

The rhetoric expressed by Eileen Munro (2011, p.16) that “children are neither the property of their parents nor are they helpless objects of charity” is counteracted by the view that “the family is the best place for bringing up children and young people wherever possible and that the family is the prime source of protection” and that “successful engagement with the parents is a key contributor to effective helping” (Munro, 2011, pp.34-35).

The relevance of this becomes paramount when it comes to professionals responding to suspected or known parental deceit and making decisions relating to a child’s safety and wellbeing in the safeguarding context. Removal of a child from their carers is looked upon by the system as a ‘last resort’ and even when deemed essential, reunification is often attempted through successful demonstration by the carers of apparent co-operation, as well as the desired change in their attitudes and behaviour towards their children through the medium of a “working relationship,” discussed in the previous chapter.

More so, this culture puts an impossible burden on child safeguarding professionals to achieve a good partnership with parents and creates a climate whereby it is difficult to challenge implausible statements
by non-compliant carers. This climate is unlikely to foster ‘professional curiosity,’ so often called for in the literature (e.g. Munro, 2011) and serious case review reports, because arguably the culture of working with parents in partnership is expectantly seen as a non-judgemental approach that emphasises positive regard. It is hard to argue for a dose of “healthy scepticism” (Laming, 2003) in the circumstances where this concept is seen almost as an artificial one. When this is examined amidst the emotional considerations toward parents, as demonstrated by the responses by the police in the previous chapter, determining what exactly constitutes ‘healthy’ is particularly problematic.

In particular social and healthcare participants in this study find it challenging to achieve the appropriate balance between the rights of children and the rights of parents as they struggle to achieve successful engagement with parents and make an appropriate assessment of the safety and wellbeing of the child. Indeed it is felt by some professionals that the current child protection system favours parents’ rights over children’s rights, as demonstrated by the detailed and chilling explanation of a former social worker and a nurse, and a current social work trainer:

“For example, the child that has been malnourished, whose teeth are rotting. And yet still that is not necessarily seen as sufficient evidence. What they [managers] will say is, ‘We need to work with the family. We need to help them understand the importance of dental hygiene. Have we provided toothbrushes and toothpaste?’ So we’ll get this family support workers to go in. They will go in to deal with this, and the parents, may agree with them, they’ll just pay lip service. ‘Yeah, yeah, we brush her teeth, as another tooth turns black. Yeah, yeah.’ Or ‘We’ve lost the toothbrush or the toothpaste or whatever else it is.
And because they [professionals] have not got any leverage they are constantly having to play the game, woo them, trying to convince them because without having this relationship with the parent they cannot access the girl. And that’s why the system is very much bordering by adult human rights, parent’s rights rather that children’s, children’s right to have dental care or whatever else it is, proper food, sound sleep at night. We allow children to be treated in a way that we will never allow prisoners to be treated. So, an adult prisoner in the criminal justice system would not be allowed to be put in a cell with dog faeces all over the floor, with a urine soaked mattress, with no access to a toothbrush, or a toilet that does not flush. It would not ever happen and they would have legal redress. But some children are expected to live like that all the time” (KP08).

As the example above summarises, the professionals are aware that they are being lied to but feel that the only possible intervention is to continue to adhere to the dogmatic practice of working in partnership with parents. To this extent the response of child safeguarding professionals to deception is shaped by an organisational dogma or ideology of ‘working with families’ at all costs.

Furthermore, it is felt by the current social work trainer that:

"The whole thing about working with the family assumes that the needs and the interests of the family are congruent with each other. And they are not. The needs and interests of the parents are rather different from the needs and interests of the children in my view. When we are talking about particularly maltreatment and neglect. So they have got different needs
and different expectations of the service. And yet we are saying that we are working with the whole family and expect one to be able to balance all of these different interests” (KP08).

Another social worker practitioner relates how she has to address parental needs:

“It can be disproportionate as well. I recently had to tell the parents, ‘I am here to see the child and I want to see the child only. Any discussions that you may have, you could have a separate appointment’. Sometimes the parents feel that you are their social worker. And you have to remind them” (FP02).

When reminded that the client is in fact the child however it is the perception of the interviewed social worker that the parents are “shocked” that this should be the case, which consequently leads to tensions in the relationship and difficulties with information gathering.

Another senior social worker feels that working with families involves having a:

“critical conversation with somebody, and you are assuring them that you are there to support them but actually the priority is the child and you want to hear their view. I am trying to find that kind of medium where they feel secure, but you need to still challenge them as well” (FP08).

A police professional relates that working with parents in partnership involves:
“...keeping an open mind. Because if you don’t, you don’t want to convict somebody who hasn’t done it” (FP09).

Because as argued by a police respondent:

“the law enforcement part it is relatively straightforward. But if you are working with a family and you are trying to make changes and trying to achieve change then I can see that there really is a thought in people’s minds, ‘Actually, if we can keep these people on side, if we just give it a thought’ You start giving a little, then they will take more and more. And what you’ll get is that those hidden problems which do not get exposed because you are not prepared to open their doors” (KP05).

One of the reasonable considerations in response to the view above is the lack of clarity around the exact time that is required for a change to occur amidst the clear evidence of abuse, especially if it is suspected that a parent is lying about the change process. Hence it questions the importance of working with parents as the right approach in child safeguarding for the benefit of the child.

In particular, as illustrated by the view of another police participant, the role of social workers is very different to that of police professionals, and working with a family oriented agenda has a bigger impact on the way they are dealing with parents:

"I think they are looking at things in a different way...They are looking at it from the point of view whether it is best for the child to be there. So they are thinking about steps they are going to put in place” (FP10).
It is evident however that social workers tend to focus entirely on parents’ strengths and rationalise evidence to the contrary. This can also explain why parental deception is often rationalised by social care professionals as benign or ‘unintentional.’

Additionally, it is the overoptimistic approach employed by social workers when working with families which at times affects police practice:

"Where social workers may inadvertently be doing things because they are looking for the positive all the time, but actually by doing that they are not necessary keeping it open for us to be able to see what is really going on. Because with the police, we will tend to do that one visit, respond and step out. Whereas, a social worker will do a number of visits. Then what happens is that we are steered slightly by the social workers and obviously, we are being guided by what the social workers are giving us. So I think sometimes, if something is not been picked up by the social workers then it won’t necessarily be picked up by the police” (KP07).

This is supported below by another police practitioner who feels that despite the MASH arrangements that facilitated sharing of information, practitioners essentially rely on their colleagues’ professional judgements as to the quality of such information:

"We have still got little influence over each other’s agency in terms of their practitioners on the ground. For example, in relation to the core assessment, our consequent actions depended on how social workers completed that core assessment. If they were lied to by the parents and they believed it, or if they were not curious and they didn’t check
the bedrooms and they didn’t cross check what parents are telling them, that influenced their judgement in relation to the safety of that child” (FP13).

In other words, if the social workers’ assessment lacks a robust approach, the MASH team are not able to obtain a true picture of the family situation and therefore could not make an appropriate decision in relation to the child’s safety.

Hence the decision-making about the safety of the child is largely dependent on the quality of information collated and provided by individual child safeguarding agencies.

With regard to health care professionals and as argued by the police senior investigating officer involved in child abuse inquiries, the idea that it is imperative to work with families:

“It stems right from the top. The healthcare professionals know that trying to move the child from a family is quite a difficult thing to do. If you do remove the child, where are they going to go? We will place the child under police protection and then it is after that social care need to place that child anywhere at all. If they had a perception that child’s best in the family home, they let the child stay in the family home rather than do something positive about it. It is a subjective perception and does not appear to be based on any objective assessment” (FP12).

Another social worker participant states that working with families leads to collusion and has a detrimental effect on the professional’s ability to detect deceit. She feels that self-reflection is necessary in order to get an objective perspective:
"You get to know the family at the time and they become quite friendly and actually essentially what you needed to do is to step back because if you don’t, it becomes more familiar in a sense then they think you are going to believe what they are saying. So if they are talking about the relationship they can say, 'Oh, yes, that’s fine, we don’t have any problems. They will use the relationship in a sense to get you to believe what they are saying’” (FP03).

It is also argued by a former police professional and current multi-agency child safeguarding trainer that the culture of working with families affects some professionals’ desire to challenge statements. As observed by one of the participants:

"Social and health workers often demonstrate this genuine willingness and wanting to work with people, maybe seeing the best in people, maybe too often. A lot of serious case reviews talk about the rule of optimism. They want to see things that aren’t there or they see a little bit that is there. But there is more of nothing there than there is and that lack of challenge can be very difficult if you feel that somebody won’t work with you if you start challenge them” (KP05).

For some professionals the effect of the working within a family oriented culture results in their unwillingness to accept, rather than inability to know, when they were being hoodwinked by parents. It is argued by a social worker that:

"We are making an effort to understand them. We try not to hassle them [parents]- and in the process, we are getting groomed” (OB)
The unreserved view above, expressed by a social worker during the training event, highlights the high sense of frustration and lack of support for partnership-like relationship with parents when the safety of the child is concerned, and paints a depressing picture of the state of morale of these professionals.

Thus it can be inferred that the organisational dogma of having to work with families in order to achieve the best outcomes puts a stress on child safeguarding professionals whilst inhibiting their ability to assess the truthfulness of parental accounts as well as the situation around the child. This also leads to something which can be conceptualised as ‘apologetic practice’, aimed at minimising intrusion into family life. As demonstrated by a health visitor:

“Some parents are clever, for want of a better word, and they would know what happens on each visit and what they could kind of get away with. Because I suppose in our role, every time we visit, say, we are talking about bruises, we would not be seeing the child without any clothes on at every visit unless we ask. And if we didn’t have a reason to ask that I think we wouldn’t. It would be like a conversation, the child will be fully clothed for the whole time, unless there was something before that and we would ask, ‘Can I, say, weigh your child today?’ and when we weigh children they have to be naked, so that would be a good way to do that” (FP06).

The widely held perception that the child safeguarding professional should not be seen as encroaching on family life without overwhelming evidence of abuse or neglect is unlikely to promote healthy scepticism, as illustrated by a response of a social work participant:
“I’ve seen very often in multi-agency child protection settings. They settle initial concerns for a child’s well-being and you’ve worked with the family and you’ve ameliorated, you reduced, you addressed all of those concerns. But one of the professional comes and says ‘Oh by the way, I am concerned about this’ and introduces this new element. Well, that’s not fair. Unless it’s something that’s major that would cause a child protection conference in the first place, then deal with that separately” (KP01).

Additionally, it is claimed by a health care professional that when working with families:

“...some doctors in acute hospital settings particularly were really hesitant to go down that line of trying to confirm or refute something and express their views. Others, who have more experience in child protection, who actually will be a lot more systematic and say, ‘Ok, we need to investigate these, we need to try to get some confirmation so that we could share it in the multi-agency arena so other people can cross check’ So it does vary from an individual to an individual I think” (KP04).

With the family at the heart of decision-making as to the children’s wellbeing, and with blurred lines between what constitutes their roles, social workers in this research feel that:

"We are apologetic. We constantly say, 'I am really sorry to bother you. It’s in the way we look, body language and confidence levels” (OB).
This attitude amongst certain professionals is unlikely to create a climate where they are able to probe and challenge parents. Furthermore, the ambiguity over their overall role in the culture of working with families and the organisational response leaves social workers and healthcare professionals feeling incompetent, and it certainly affects their confidence to do their job.

It is offered by a social work practitioner that:

"Newly appointed practitioners are really quite worried about sharing their analysis of the situation with parents. They really are quite worried. Because you are making your professional judgements on a situation. And they are worried about that, they are less secure" (FP01).

Another social practitioner shares this view about his colleagues:

"A lot are not that confident. I can confirm that because I used to specialise as a senior practitioner, I used to specialise with what I call resistant service users. I would take the ones that were threatening, the ones that were very loud and vocal and accusatory. At any one time, the complaints were going on all the time and that’s one of the consequences" (KP01).

The lack of confidence and a perceived lack of support they are likely to receive from their managers and organisations has a detrimental effect on health professionals’ willingness to report suspected abuse to multi-agency safeguarding hubs (MASH). A contrast is drawn in relation to the police organisational response. This is demonstrated by a comment by a police child abuse investigator below:

"What we often get are healthcare professionals, they will ring
us, they are at their wits ends feeling that they are disclosing information that they should not be disclosing, or are reluctant to be bothering the police, but they’ve got an issue over a child. It is almost a case of ‘I did not really want to call you, but I am going to have to call you because this has now happened’. Whereas they should have perhaps called us earlier after two things that had occurred or alarm bells went off. I think it is because they don’t necessarily know they can disclose information to us and if they do disclose information, are they going to be the one that is viewed as ‘Oh my God, this midwife A is completely overacting again over this and this.’ Whereas for our organisation, we prefer to raise a concern even if in the end it is completely unfounded” (FP12).

Interestingly police practitioners in this research are quick to portray themselves as the ‘agency of action’, whereas there is also evidence in this research that police practice is marked by inaction in a variety of matters when it comes to dealing with suspected deception in parents. Although the examination of the rationale behind this view is outside the scope of current research, it nevertheless points to the possible tensions that exist within multi-agency collaborations and the perception of professionals of each other’s’ roles within these.

The healthcare professionals themselves feel that the organisational response to parental complaints about their sceptical attitude and challenging practice often leave them feeling demoralised and undermined. The quote that was utilised in the previous chapter is being reproduced here in its entirety:

"When parents did not like the message they were being told by health visitor, they were allowed to change health visitors. I sometimes feel it would be better to have a restorative
Understanding and responding to deceptive practices by parents and carers in the child safeguarding context

approach - trying to work it through - but they’ve got every right to call and say, ‘I do not want to see this person anymore,” and they are just given to someone else.” Which makes me feel rubbish. I don’t particularly like the family. But it is an insult to you - it’s like saying you are not very good at your job” (FP06).

This again points out to the fact that in practice, and as supported by organisations, working together with parents put the parent at the heart of the intervention, not the child.

Another health visitor, when not being able to work with the family, finds it particularly:

“..upsetting. I would think, Oh, what have I done?’ Actually, no, I did all the right things for that child. I cannot help the way they feel about me. I’ve had some colleagues whose parents had asked for a different health visitor which again, affects people different ways. Some people feel it’s really offensive, ‘I did not do anything wrong.’ But other think they probably should not be allowed to have another health visitor because they will try to do the same with them anyway” (FP05).

Highly publicised cases of child abuse and the way organisations have dealt with that also result in low morale and lack of confidence in an ability to recognise and respond to deception, specifically in relation to social and healthcare professionals. This is exemplified by the response of a safeguarding nurse:

"In [our local authority], we have 300,000 children. We never talk about our high achievement, all the other children that are
doing very well. We are looking only at those who were missed. And that can be detrimental for frontline staff. So hence, we now are looking at appreciative learning to re-boost the confidence of our frontline staff. Because all they get is bash, bash, bash” (KP06).

Arguably it is too simplistic to assume that ‘high achievement’ of all these children is in fact attributable to the success of professional intervention as it overlooks the roles of parents, family, and teachers in their lives. However, by the same token it is reasonable to question the intervention approaches of child safeguarding professionals in cases where things do not go so smoothly.

Additionally, a social work participant feels that although:

“Serious case reviews are about learning, but certainly going through some of the responses to these they tend to be over punitive and critical - unnecessarily so sometimes, and very punitive and blaming towards the professionals” (FP08).

This she feels affects the workers’ ability to deal with parents appropriately and be courageous enough to reassert their assessment of the situation.

Family-centred practice is also found to be prevalent in the USA as supported by research (Miller, 2012; Huebner et al., 2012). It is demonstrated by the child protection investigator that:

“...the orientation of the agencies is to keep the families together and to improve the family. They are trying to keep the family together and address whatever the deficiencies that prevent taking care of the child is” (FP14A).
It is also stated by another US participant, a social worker that:

“a family [oriented] approach only works with the people that are subservient, really want help, and those totally understand what is going on. There really is not anything that works with people that are going to be totally adversarial with you, the whole system, they hate the system, they hate the judge, they hate you, they are not going to do anything. They are going to stand in front of the courtroom with a megaphone and they are going to complain about how we stole their kids from them. So I don’t have any answers to you about how to work with those kind of people” (FP15A).

The latter point of distinguishing one group of parents from another is an important one and is particularly relevant to child safeguarding practice in England. One of major factors that affects professionals’ decisions in their interaction with parents is the labelling of certain types who attempt to conceal their abuse by a range of tactics, variously described in child safeguarding literature as hostile, manipulative, non-compliant, displaying disguised compliance, resistant and dangerous (Brandon, et al. 2009; Ferguson, 2010; Laming, 2009; Littlechild, 2005; Dale et al, 1986). This inadvertently puts these types in the category of deviant parents who fail to adhere to the realms of “normal” (DH, 1995) behaviour demonstrated by all other reasonable parents. It is in fact, noted by Parton (2011) that the child protection system from the 1990s stressed the importance of professionals working with children to identify “the small minority” (Parton, 2011) of “high risk” families in order to set them apart from the rest.
These findings from research inevitably reinforce the view amongst certain professionals that generally most parents genuinely want the best for their children, and therefore trying to work with them effectively and help them overcome their problems is bound to assure the child’s safety and wellbeing in the long run. Consequently, deception in its various forms, including manipulation and disguised compliance, is perceived by certain professionals as an attribute of bad parenting that is ascribed just to certain parents rather than potentially all, contrary to the research on prevalence of deception (Vrij, 2008 etc.). Furthermore, if the parents are suspected to be lying this is often justified by reasons that were not associated with potential child abuse. This can perhaps explain why certain professionals continue to fall prey to parents whose behaviours are perceived as “normal” and with whom they enjoy “good working relationships.”

As illustrated above these views are nurtured by the organisational dogma of ‘working together with parents’. The effect of it is profound in a sense that it not only inhibits scepticism and professional curiosity; it discourages objective outlook in assessment of parents. Consequently, the perceptions and the views of the parents by professionals are interpreted by practitioners as worthless or redundant as the latter are urged to continue to make the often-unmanageable situations work amidst suspected deception.

Rendering deceit impotent requires professionals to be able to acknowledge within their organisations that some families are impossible to work with; it requires a professional environment which is supportive of practitioners who are attempting to tackle resistance; and certainly it requires that they do not feel constantly under threat that if the relationship breaks down, they the professional will be removed from the case. Professionals also need
to be encouraged – indeed required - to write up their reports and make verbal statements to their supervisors in clear unambiguous language which cannot be misunderstood. This leads to the next section which explores the difficulty of clarity in communication.

7.3 Misvocabularisation

This results in a phenomenon, conceptualised in this research as ‘misvocabularisation’, whereby facts are not stated clearly in verbal or written reports, but rather are tempered with softened words and phrases and conveyed in language felt to be more palatable to parents. Additionally, the culture of working with families perpetuates the situations where case notes are written in over-positive terms to avoid complaints or criticism by managers, thus presenting an overly optimistic picture of the family.

There is evidence that in some cases, where a strict organisational culture prevails, professionals are forbidden from using language that might be considered harsh, too direct, or too descriptive, in their case notes. This phenomenon is supported by the Sapir-Whorf hypothesis of linguistic determinism that examines the relationship between language, culture and thought, and maintains that one’s spoken language determines their interpretation of the surrounding events and circumstances (Koerner & Konrad, 1992). Consequently, what constitutes a ‘reality’ is often shaped by the language used to interpret it. Therefore, as underpinned by Sapir (1929) it is the professionals’ culture that determines the spoken and written language used within that environment, which in turn determines the way that these professionals compartmentalise their thoughts about the situations they are faced with as well as their experiences of them.
Social care participants in this study are particularly hesitant to refer to parents in their verbal and written communications as deceptive, and they never would use the term “liar” when describing a parent. Neither do they refer to parents as deceitful in case conferences. As demonstrated by a social worker respondent who not only confirms that she is likely to practise misvocabularisation, but also justifies dishonesty by parents:

"That’s not a nice word, is it? That you are a liar. We would use something like, ‘Have not been completely honest with the social worker about this’. Because I don’t think the parents intently want to lie but it’s the high-stake stuff, it’s their children. And I think they are not always honest when speaking because they are scared. They perhaps think ‘If I am honest, what is going to happen?’ Oh, I am not going to talk about that bit’. And a lot of our parents have gone through some really awful childhood themselves” (FP02).

Given that the professionals are not able to separate the intentional liars from not so honest parents, and are often guided by their truth biases and/or adherence to maintain a relationship with them, the ambiguity surrounding language does not allow for an objective assessment of the situation.

It is noted by a social work educator in this research that:

"Some of it is that we are fearful of the repercussions as practitioners that the department that you work with will not like that, that they will, ‘You cannot call people liars’ - ‘Well, where is the evidence?’ I think we are fearful of repercussions on our own careers as well” (KP01)."
When asked about other reasons that contributed to social workers’ reluctance to identify parents as deceitful, the above quoted professional explains:

“Parents lie. Within child protection systems parents lie. Let’s get off the fence and say that parents lie. We all know it, we just don’t like using that language. We prefer people being mad not bad. It’s the human condition that we don’t actually like the thought the badness. We try to contextualise it. ‘Well, it’s a half-truth’. No, no it’s a lie. But we dress it up. We are fearful as practitioners to actually say to parents, ‘You are lying to me’” (KP01).

This is corroborated by another senior social worker who feels that, “people are actually reticent to actually label parents as deceitful in black and white” (FP08).

Another social work participant reports that when challenged by the parent’s advocate in court about the truthfulness of their account whilst having compelling evidence to the contrary:

"Rather than saying, ‘Actually, your client is lying’ I would use my statement which contains evidence that says ‘what your client is saying is contradicted very clearly by the evidence that we see.’ And there is a certain degree of recognition that we all have different perceptions on things, particularly when you had a difficult childhood and I alluded to that life lens which is distorted. Parents can generally say X and Y and generally believe that to be the truth. And that again is something we need to be cautious of when are starting to label people as
misleading or untruthful because actually for them, that might be the general truth based on their perception” (FP08).

As demonstrated in the utterance above, deception is seen as a subjective, rather than a factual event.

It is also related by a senior social work professional that “it has happened” (FP01) that there were cases when the notes on families did not reflect the true nature of parents’ veracity, and only in cases when evidence was overwhelming was a reference made to parents as being deceitful. Considering the limitations of the evidence-based practice that was discussed in Chapter Five, as well as the uncertainly of child safeguarding work in social care and health care, it is not difficult to envisage how this distorted picture of reality leads to the ‘start again syndrome’ discussed in several serious case reviews (Munro, 2010).

In fact, the majority of social work practitioners in this research (N=6) confirm they would never in their notes refer to parents as ‘deceptive’ or ‘lying’. If deception is suspected but not substantiated it does not find its way into a workers’ written assessment but is replaced with terminology which is softened, ambiguous, and a non-factual reflection of reality.

This phenomenon is also evident in serious case reviews. For example, in SCR E (2014), bedrooms soiled with faeces were described by social and family workers as "cold, dirty and cluttered home condition." In SCR D (2011), the variation in health visitors’, nurse’s and social workers’ recording of home conditions in a case of severe child neglect ranged from being “messy” to “untidy” and “very dirty”, whereas the police officers in their statements described being “concerned about the state of the home with baby sick on a
pillow and faeces on a bed” and the state of the flat as “incredibly disgusting….You could hardly move inside the flat for the dirt”.

Their police colleague in the USA also feels that for many US social workers:

“lying was too a strong word to use and you are going to be called on a carpet [by the management] for talking to a client like that” (FP15A),

although he adds that in the US at least the notes would describe the situation for what it was:

“filthy and disgusting, sheets not being washed for weeks and stained with urine” (FP15A).

A police practitioner shares his experiences of dealing with healthcare professionals and relates that in their notes the healthcare professionals often fail to include the exact number of times parents refused or avoided to be seen by them. For example, instead of accurately reporting that they could not see the family on four occasions, the notes made a reference to just “not being able to see the family this time” (FP12) or “could not see the child on couple of occasions” (FP12). It is this police professional’s view that healthcare professionals:

“Do not want any conflict. I don’t think they record accurately, and if they do record, they will record in positive language” (FP12).

Yet it is argued by a paediatrician respondent that confronting someone as being deceptive is not always appropriate as it may put them in a defensive mode thereby making it harder to gather
evidence. However, this professional also warned about the dangers of prevarication over confronting parents and labelling them as deceitful to other professionals:

“We try to approach things in terms of, ‘We don’t understand what is going on, we are going to investigate this further. We need to work with other professionals including social workers and police’. Yes, it raises concerns, but you are not immediately saying to the parents, ‘You are a liar’ and therefore, putting them into this much more defensive, aggressive position. I think depending on how it is handled, it can be appropriate. I do have concerns about it if health professionals are using that as an excuse not even to do any confrontation. And I think you do sometimes get that, particularly in case conferences where parents are in attendance, colleagues will try to present a glossy picture that is less hurting to the parents. Being upfront is hard for professionals. I am sure I’ve done it myself” (KP04).

In contrast however two health workers (N=2) interviewed for this research feel that they could, and they would, state in their notes if the parents are lying to them.

In relation to police professionals (N=7), those who are interviewed in this research share the view that:

“When we summarise our investigation we would be clear that what people are telling us is not true. We are not shy in saying what we can disprove. Call somebody a liar? - we are quite happy to do that if that’s indeed what they’ve done” (KP03).
As stated in the Introduction to this thesis, it is a fact that in everyday life many people (probably including police officers) feel uncomfortable using words such as ‘liar’ when describing an individual. There is no point in making professionals feel uncomfortable, and in fact there is no need for professionals to use that particular word to describe someone who deceives. The important thing is that clarity and honesty is encouraged and expected in written and verbal reports. If professionals accurately and robustly report the evidence, the facts, their beliefs, and their suspicions, it will be self-evident whether it is known or suspected that a parent is not telling the truth; hence clarity in vocabularisation can help to render deceit impotent.

The evidence emerging from the current research reveals there is clearly a need for professionals to have the ‘healthy scepticism’ that has been emphasised in the literature and serious case reviews (Brandon, et al., 2008). Despite Munro’s (2011) recommendation to move to a method that encourages the exercise of professional judgment, the culture of "working with families" makes it challenging for professionals to allude to deception in factual terms and confront parents about inconsistencies.

However, despite remaining sceptical about being able to free themselves from the shackles of their organisational culture that for over 20 years has pushed the agenda of working with families, a number of areas for improvement have been identified to enable professionals to become more alive to parental deceit.

### 7.4 Promoting scepticism

To further render parental deceit impotent, organisations must create a culture whereby professionals are expected to genuinely
practice healthy scepticism. This ideal should not be seen as merely rhetoric included in inquiry reports or serious case review reports, but must become a part of good everyday practice which is nurtured and encouraged.

It is acknowledged by research participants that child safeguarding professionals:

"...continually work in a very murky area of risk. And we do everything we can to minimise that risk but we cannot always remove it. There will always be occasions where things will go wrong. That is not to say we should not do everything we can to stop them go wrong” (FP08).

Yet it is also recognised that the messages of serious case reviews are not communicated to professionals in an appropriate way as the practitioners often feel somewhat exasperated about how they:

"bang on and bang on about us being able to do things better” (FP08),

and it is shared across another set of professionals during the observational phase of this research that:

“We don’t need to learn lessons - we know them” (OB).

The initiatives suggested below by professionals participating in this research tend to address this concern and propose to do ‘better things,’ or at least to do things differently.

Specifically, professionals in this research feel that they need to be challenged by their colleagues and supervisors in order to recognise
the signs of deception. As provided by a social worker practitioner:

“Having an objective viewpoint regarding what work you are doing and that questioning, inquisitive attitude towards your decision making is really, really important... We all need challenging on occasions, we all sometimes get drawn into situations where we cannot see the perspective of what needs to happen. And that is when regular supervision is very important” (FP08).

Although this may sound like a reasonable suggestion for practice, this research demonstrates that guided by the principles of organisational culture of working with family, the supervisors are likely to have different priorities and are unlikely to provide an objective sounding board.

Yet social care professionals argue that in order to be confident in their approach with parents they have to have full support of their managers and operate within a culture that promotes learning rather than blame. It is related by a social work participant that:

“When you work with resistant service users you must be prepared to get a complaint. And what you need is a good manager that will support you within the context of that, understanding that if you are working with non-compliant people they will, as a tactic, complain against the member of staff. And have a transparent process to deal with that but put it in the context of, ‘This is a difficult person to work’. And they will use a range of approaches to try and cause you as an agency to disengage” (KP01).
Many professionals in child safeguarding with social and health care practitioners are unclear and burdened by their role of being a helper to both the parent and the child. In some instances these roles are mutually exclusive; in many others they are extremely difficult to fulfil.

Amidst the presence of the organisational culture of working with families, and considering the difficulties experienced by practitioners of being both supportive and sceptical with parents, and the parental needs dominating the interventions, it may be worth envisaging a system where a child and the parent are supported by different social workers, each advocating for the interests of their clients.

An alternative to this arrangement is for a child safeguarding professional to be accountable for each decision made prior to engaging with a parent.

In order to not cross the line between caring and scepticism it is felt by a social worker in the USA that professionals ought to:

“...prepare for every contact that you have with a client. You have to have a goal in mind. If you are going to see your client, if you are going to talk to your client, if you are going to do a home visit, you should have a goal in mind, this is what I want to accomplish today. These are the things I want to find out, these are the things I want to talk about” (FP15A).

However, it is also argued by the same respondent that as part of being authoritative (Ferguson, 2011) it is important to act based on the assumption that a problem exists. For example, it is seen as more effective to ask parents what they are doing to help a child in
school as opposed to how the child is doing in school. As explained by the participant:

“When you are asking the question like that, where you are already supposing there is a problem, you are more likely to get an answer that is going to reveal something and then you can go from there. And that goes into your prep work before you go. Sort of you know, you never ask a client if they do drugs, you always ask people when was the last time they did drugs” (FP15A).

In other situations it means asking a drug using parent when they last used an illegal substance rather than if they use it at all. As related by the respondent above, this sends a signal to a parent that their potential lies will not be tolerated, and in many cases it is likely that the professional will gain a certain amount of respect from the parent by adopting a pragmatic, realistic and straightforward approach. However, the type of approach as discussed by a US-based social worker is likely to create tensions in a relationship with parents for his colleagues in England. Equally what is seen as authoritative practice in the USA may be perceived in England as judgmental assessment.

A police respondent feels that professionals should be able to report on every factual event of their encounter in order for multi-agency professionals to have a full picture of the situation and detect any incongruence.

It is felt by a social work professional in the USA that it is imperative for professionals to become comfortable with exercising their authority with parents by citing his example of practice:
"I talk to people about the fact that after reunification we are going to be coming to the home for at least six months, which we call post-placement supervision. And I want you know that we look at this as the most critical time in the case and one of the most dangerous times in the case. So we are going to have your case manager come and see you once a week. Now, you can look at this as big brother looking over your shoulder and I will tell you, ‘You are absolutely correct. It is Big brother looking over your shoulder. We want to make sure that everything is going okay and we want to make sure that this child is safe. That is our main job’” (FP15A).

This view is echoed in the research by Ferguson (2011) and is supported by a research participant in England who states that professionals should be able to say to parents:

“‘We want to make things safer for your children’. These are our rules. This is how we are going to check out if that’s working or not. I am going to work with you but we have to be honest with each other and I am going to be checking things out, I am not going to take things at face value. If you say your child is at your mom’s I am going to phone your mom and ask if he is there. I am not going to accept that that child is going to be somewhere inappropriately. It is about having those ground rules also” (KP07).

Yet for some professionals it is perhaps utopian thinking, as they feel that in order to change things for the better it is important to have a culture change whereby professionals in social and healthcare work could learn to be sceptical whilst getting full organisational support and encouragement. This is illustrated in the lengthy comment from a former police detective and current child safeguarding trainer:
"I was working in child abuse and I remember thinking at the time, I actually think we are doing so much, we are doing lots of good things. Trying to do good things for families, putting plans, lots of stuff that did not exist before the 1990s and post 1989 Children Act. So, lots of things had changed and I was under the impression that actually lots of people’s attitude have changed. So when there is an inquiry and everything was sort of exposed as being very weak, I, like lots of people thought, this is going to be a sea of changes, we are really going to start nailing this down. Now is the time! Huge changes, Working together, Children Act, lots and lots of change. Actually fundamentally, did that change people’s minds and attitudes about working with families? Sadly, I don’t think it has completely. You still hear from Head Teachers for example, they will very often say, ‘I cannot challenge because that will affect our working relationship. I don’t feel that I can.’ And this is somebody who is in a position of responsibility, intelligent, articulate, and probably knows the pitfalls of not challenging. But it is having that mindset also, it has got to be deeply rooted. Because all the evidence says that those changes are not happening. And that is very worrying. Changing culture, changing mindset is very difficult...It is very difficult to get people to think differently about things. I think there are some things you can say, ‘Actually, that’s going to have a long-lasting effect. For others, you just know people are paying lip service and they are not really going to change no matter how much you train them. If I can train them on almost a daily basis and they will still go ahead and do what they want. There is no magic solution. But it is absolutely about having an investigative mindset. And often people do not feel it is their job to do that but it clearly is. If you are
doing an assessment you have to have the mindset that you are going to be presented with some evidence. You have to challenge that evidence, you have to test that evidence, and you have to make sure that evidence is sound. If you don’t have that mindset, your starting point is you are just going to accept everything that you are told. And that is hopeless, completely hopeless. So it is about changing that mindset for all professionals. And you can borrow that from the police if you like where you believe no one, you trust no one, but it is true. Also, my view is your gut instinct is a good risk assessment. If you think there is something wrong there probably is. Let’s just trying to find out what that is because if you are uncertain about something you may not be able to articulate this very clearly. But actually you need to dig and try to find out what that genuinely is. But there normally is, is it not?” (KP05).

The idea that a new approach is needed is recognised by a social work professional who felt that it is crucial for all child safeguarding professionals to:

"Recognise that parents wish to hide things which are very nasty and very painful for people to exist. This social work conditioning means that our aim is that we always have a strong belief in people, people can change. We use a few current global sayings, ‘we should always show conditional positive regard to people’- It’s rubbish!” (KP01)

An approach which could alter this ‘social work conditioning’ would require that certain professionals have to accept that all and not just some parents could be deceptive in communications with
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professionals, and that it is imperative for the organisations to support and empower their professionals in their scepticism and their decision-making. This is not to suggest that all parents will be deceptive, but it should not be organisational heresy for a child safeguarding professional to be able to consider and express the possibility that they can be.

A number of professionals discuss the importance of having a joint multiagency or interagency visit to a family, and call for this to become formally integrated into existing child safeguarding practice. This could be jointly with a social worker and health visitor, but more often than not the phrase ‘joint visit’ means a social worker going along with a police officer. It is felt that it could provide practitioners with much needed support, alleviate stress levels when dealing with hostility and, by having a second opinion on the matter, minimise the chance of getting hoodwinked, as illustrated below:

“If there is a worker that is having real difficulties with a family then a joint visit would be a far more effective way of conducting this visit, getting more that you need out of that visit. But I don’t think there are enough resources and I don’t think there is enough willingness for people to do joint visits. Even if it is multiagency joint visits, one of the things I talk about in my working together course, why not? It does not have to be a formal meeting. But if two organisations are involved, go together. There is a huge amount of support that could be gained and you can get that mutual goal in place. Say health visitors and social worker, do it as a joint visit rather than separately, so it could be done effectively” (KP07).

A social work trainer advocates for multi-agency training where instead of being told what to do, the delegates have an opportunity
to reflect on their practice.

“And if they can protect their professional integrity they are less likely to give in to a system that might be trying to change them. Even if we cannot change the system we need to try to stop the system from changing us in terms of letting go of that desire to be child centred. Because we have to keep expressing it, otherwise, we just become immersed in this, I call it, 'Newspeak’ which was a term from 1984, the Orwell book, where you say the words but you don’t mean it. They are all the right words but the meaning is not there” (KP08).

As stated previously, Newspeak referred to in the above excerpt has been evidenced by this research to be prevalent phenomena in contemporary safeguarding work and as stated has been conceptualised as misvocabularisation.

Interestingly, perhaps the slavish following of organisational culture and a lack of confidence in independent action and decision-making, goes against time honoured conceptions of being a professional. It is felt among many that their individual discretion and judgement are discounted, whereas the accountability that is placed on them in cases of serious abuse or death of children is increased. They crave to be recognised for success stories.

Returning to the opening lines of the thesis, it would appear that many child safeguarding professionals see themselves as victims rather than standard-bearers of their organisational cultures. Yet there is room for practitioners to scrutinise their own assumptions and actions amidst findings of unacceptable practices (Stevenson, 2007). Their role is to draw on information and evidence from all different sources and make informed decisions whilst being
professionally aware of their biases. Their role is also to challenge their own attitudes as well as the rationale of their managers. It is to be confident with their colleagues, managers and parents. As professionals their role is to be appropriately skilled and trained in order to work with parents effectively, which includes being able to identify potential deception and respond to it.

The findings of this research suggest that many child safeguarding professionals in this research are struggling with their identity as professionals and what is required of them, which has an adverse effect on their understanding and handling of deceit in parents as an embedded factor.
Eight Conclusions and recommendations informed by this research

To conclude this thesis, the researcher re-examines the aims and objectives of the current research in order to identify the contribution it intends to make to the existing debate. To facilitate this the research questions are revisited and the research informing each question is identified. This chapter also discusses any policy implications for child safeguarding professionals, and some suggestions for further research are provided. The key research findings provided in the analytical chapters are revisited and the conclusions and recommendations arising from them are offered.

8.1 Revisiting the rationale, aims and objectives

As illustrated by the serious case reviews findings, child safeguarding professionals do not always meet the public’s expectations to protect children from significant harm. Putting aside the statistical syllogism that not all children unfortunately can be saved by professionals, it is incomprehensible to imagine that practitioners can be so incompetent as to forfeit their core function to identify and address risks to the child. It is also inconceivable to suggest that these trained professionals could be gullible enough not to spot ‘the obvious’ signs of being hoodwinked by parents and unreservedly believe the very people whose actions towards their children necessitated the professionals’ involvement in the first place. This is particularly relevant in relation to cases where often many risks posed by parents are identified but consequently tolerated rather than confronted and tackled by practitioners. Despite there being no public consensus on what to do with parents who put their children at risk, the professionals’ judgements are nevertheless likely to
prompt a sense of incredulity in a lay person. For the researcher however, privy to the complexities of child safeguarding practice, the decision-making of frontline practitioners is often underpinned by their organisational practice, culture, and ethos, and therefore is not restricted to individuals.

Hence what inspires the current research is the urge by the researcher to explain the unexplainable by evaluating the current child safeguarding practices adhered to by practitioners amidst suspected or known deceit by parents. One aspect of this evaluation is to reflect on the professionals’ ability to detect deception. However, a particular consideration is afforded to the professionals’ judgements when such deception is suspected or confirmed as translated into their consequent response. In trying to understand the decision-making by professionals in relation to parental deceit, the current research aims to establish whether any developments in professional practice could contribute to the reduction of child homicide and serious abuse.

In order to meet these aims the researcher sought to ‘go straight to the source’ by obtaining the practitioners’ perspectives on parental deception and understanding their experiences in trying to uncover and respond to it. Although it is felt strongly by the researcher that these professionals are best placed to provide first-person accounts of the intricacies of the child safeguarding practice when it comes to working with parents, the research is also informed by the analysis of serious case reviews and an observational study in order to promote a balanced argument.

The findings of the current research are guided by the research questions below. These are reproduced for convenience.
1. Do child safeguarding professionals feel able to detect deception in parents and carers?

2. What is the response of child safeguarding professionals to suspected or identified deception in parents and carers?

3. Does training properly equip child safeguarding professionals to identify deception and disguised compliance, and challenge and rebut lies told by parents?

4. Are there strategies already established within the criminal justice investigative arena in relation to deception detection which might be useful, and if so, are they transferrable to child safeguarding work?

5. Is there within child safeguarding a dogmatic culture of "working with families", and if so, what effect, if any does it have on child safeguarding professionals’ ability to challenge non-compliant parents and carers?

6. What role, if any does the family centred practice play in the way child safeguarding professionals deal with potentially deceptive parents and carers to ensure that the best interests of the child are met?

8.2 The ability of child safeguarding professionals to detect deception in parents and carers

The new knowledge elicited from the current research is that child safeguarding professionals are suspicious of deceit, aware of the common deception tactics and, if they allow themselves to
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Contemplate it, they are largely aware of when they are being lied to by parents.

This research confirms previous research findings that the occurrence of deceit in the arena of child safeguarding in England as well as in the United States is common and considered to be a part of the job. It is also anticipated by practitioners that parents are likely to resort to deceit at any point of engagement by using disguised compliance, evasiveness, aggression, hostility or other forms of resistance to deceive professionals and cover the circumstances of abuse. This research finds that parents are prepared to go to great lengths, and to use considerable ingenuity, to cover their abuse of children who were seriously injured or died, which resonates with prior research findings (e.g. Tuck, 2013; Laming, 2003; Laming, 2009).

Additionally, this research confirms that some parents who are exposed to agency intervention over an extended period of time can become exceptionally skilled at lying. This supports the literature findings that lying is learned and the longer it goes unchallenged, the bolder and more elaborate the lies become (Garrett et al., 2016).

Furthermore, current research adds to the literature and finds that there are significant variations in the perception of parental deception amongst the police, social care and healthcare professionals engaged with parents in a child safeguarding context.

This research’s original contribution is that the professionals’ rationalisation of suspected or confirmed parental deceit influences their understanding of it. Furthermore the perception of what constitutes deception influences the professionals’ attitude towards it as well as the consequent response.
When trying to make sense of suspected deceit, social and health care professionals in particular draw a line between *malicious* and *benign* deception by parents. No such taxonomy is employed by police professionals.

It is believed by these professionals that *malicious* deception is attributed to certain categories of wicked parents who wish to cause harm to their children, although relatively rare in occurrence.

Yet if deception is rationalised as *benign*, it is felt by these practitioners that parents lie not to conceal abuse of their children but because of their distrust of professionals and their reluctance to be intruded upon in their private lives. It is accepted as almost permissible and not motivated by the *intent* of parents to cause harm to children, and is looked upon in an empathetic way. Largely ignoring the possibility of these parents seeking privacy in order to cover abuse, this view is underpinned by a shared conviction that the vast majority of parents do not wish to hurt their children. This research finds that that even when professionals recognise the signs of deceit they attribute them to the signs of *benign deception* where the risk to the child is minimised.

In either scenario the professionals’ objectivity is compromised whereby they are unable to view deception dispassionately and accept it for what it is - a deliberate act by parents to hide the truth about the harm they are inflicting on their children.

This research finds that a practitioner’s rationalisation of a lie creates a basis for professionals’ risk assessment of the child and the family and consequent interventions.
For practitioners in social and health care, deception is contextualised and consequently accompanied by an emotional reaction (either negative or empathetic). The new knowledge from this research is that it results in a debilitating effect on their ability to recognise parental deception.

This research finds that social and healthcare professionals’ view of parents is that they mainly lie not to conceal their abuse of their children, but rather because of their distrust of professionals and their reluctance to be intruded upon in their private lives, or perhaps because they are coerced to lie by an abusive partner. In fact, they are reluctant to acknowledge that a parent can lie maliciously. This supports previous literature findings in relation to a truth bias and ‘relationship truth bias heuristics’.

This research finds that in addition to exhibiting lie bias, as supported by previous research, police professionals appear to remain detached in their view on parental deception and view it rather objectively.

This research finds that practitioners in the police, social work and healthcare are familiar with numerous tactics cited in previous research and utilised by parents to deceive the professionals, commonly known as ‘deception tactics’. The signs of disguised compliance were known to all child safeguarding professionals. Although it is feasible to argue that these are known with the benefit of hindsight only, this research finds that the awareness of deception tactics by parents is nevertheless an integral part of the professionals’ assessment of risk to children.
This research adds to previous studies by arguing that these tactics are not the same for all child safeguarding professionals although there are some overlaps.

It is related by all groups of professionals that some parents try to appear nice, play professionals off against each other, and attempt to control and manipulate facts. In order to deceive, parents are sometimes also seen to exploit cultural differences and religious affiliations with practitioners.

On an organisational level, for police, the parents ‘sticking together’ and avoiding a deviation from each other’s accounts warrants that they are likely being deceptive.

For social workers, avoidance, intimidation and refusal to engage serve as indicators of possible lies. Yet, intimidation tactics are largely absent in police visits and it is reasonable to suggest that unlike with health and social care professionals, parents are reluctant to use threats and pressure in their police encounters because they do not consider these to be effective in covering abuse. In other words, and as illustrated earlier, it would appear that parents would adapt their deception tactics to suit their intended audience whilst making a rational determination as to what they would be able to get away with.

For health professionals, lies are associated with aggression, parents exaggerating symptoms and having no explanation for children’s injuries.

The intimidation and aggression with health and social care professionals is likely to result in the withdrawal of these
practitioners from the scene, whereas with the police it is likely to lead to the arousal of suspicions.

However, despite professionals being acutely aware of the predominant tactics used by parents to deceive, all professionals are not entirely confident in their ability to recognise and accept them as such. One of the main challenges associated with professionals recognising deception using particular tactics is that the tactics rarely stay the same and are subject to continuous changes as dictated by ever evolving circumstances, a finding that supports previous research by Brandon et al. (2009).

A combination of approaches including intuition, verbal and non-verbal signs of deception, found in psychology research to be ineffective, as well as practice wisdom are employed by these professionals to help them recognise the signs of deception.

And finally, in the child safeguarding context, despite the awareness by practitioners of the common deception tactics used by parents to cover the circumstances of abuse, the ability of professionals to detect deception in parents is linked to their perceptions and views of deception itself. In other words benign deception is not viewed by professionals as deceit as such because it is harmless.

This research finds that professionals in fact are consciously aware of the presence of deception, but after having an internal argument as to whether or not it is intended to cause harm to a child, often conclude that a lie is justifiable and thus to be tolerated. Equally, this decision may be unconscious, when professionals suspect they are being lied to, but refuse to believe that the lie exists.
Therefore, to claim that the ability to detect deception in parents is shaped by truth or lie biases as related in previous research would be too simplistic.

In fact, professionals across all agencies are found to be empathetic toward parents and applying their own sense of morality in trying to make sense of the alleged abuse of a child and deceit utilised by parents to cover it. The combination of these factors has a debilitating effect on their capability to remain sceptical and be confident in their ability to see deceit for what it is.

In relation to the importance of promoting ‘healthy scepticism’ in child safeguarding, this research also finds that there is a sense of ambiguity amongst professionals about how much scepticism is ‘healthy’. On one hand they are tasked to seek cooperation and build a relationship which is based on trust and respect for privacy. On the other, in doing so, they fall prey to deceptive parents.

This could perhaps explain why many professionals do not feel confident despite being able to detect parental deception. It is reasonable to suggest that to some extent this represents the professional’ refusal to accept that they knowingly facilitate lies by parents.

8.3 The professionals’ response to suspected or identified deception in parents.

With child safeguarding professionals being alive to the signs of deception, there is however a differentiated response within the professional groups in England as to how they respond to it, as this research originally establishes.
Arguably adherence to the *benign-malicious deception* taxonomy discussed in the previous section represents one such response. The assessment of what constitutes parental deception is then translated into consequent action.

When deception in parents is identified or suspected, the professionals’ response to deceit is actioned through the paradigm of relationship-based practice, a new but compelling finding of this research. The discussion of what it represents is outlined below.

Whether short termed, as it is for police practitioners, or medium and long-termed, as it is for social and healthcare professionals, it is acknowledged amongst child safeguarding professionals that the requirement to have a relationship with a parent affects how they are able to deal with suspected or confirmed deception.

For social and healthcare professionals, building a ‘good’ relationship with parents that is characterised by mutual honesty, openness and a lack of confrontation and challenge is seen as essential, and in fact is perceived as being required by their organisation. They see the relationship as necessary for information-exchange purposes, for gaining access to the child, ensuring a child’s safety, and in order to encourage parents to become receptive to agency interventions in relation to the index child. This is particularly important for healthcare professionals whose service provision is not mandatory and who would require to have parental consent in order to work with the child.

The significance of seeking to establish a relationship is important as practitioners strive to be compassionate with parents and create minimum intrusion in their lives, which includes parental practices
with children. Both in England and the USA these relationships are preserved; even when professionals suspect they are being deceived by the parent they do not challenge this for the fear of severing these ties. Furthermore this is underpinned by two important factors. When attempting to foster the empathetic relationship with parents, this influences the professionals’ perception of deception as being a flaw rather than a potential manipulation to hide the abuse. Additionally, it makes the professionals uncomfortable about being authoritative in their child safeguarding practice as they feel that they ought to allow the family their privacy, leading to ‘apologetic professional practice.’

Interestingly child safeguarding professionals are themselves troubled, and they question the authenticity of a relationship that according to them should be based on mutual trust and respect. Many professionals feel that parents do not want to build a relationship with professionals because they do not view them as being genuine. The inevitable one-sidedness of the relationship, with parents inadvertently pursuing their own interests, is frustrating and demoralising for professionals in social work and healthcare, who unlike their colleagues from the police are there for the long run.

Paradoxically a professional who buries their pragmatism and realism so as to avoid confronting the possibility that they are being lied to is, in fact, not being genuine in their dealings with the parent, so by adopting such an approach they may lose the respect of those they are attempting to work with. There is evidence that a no-nonsense, savvy professional could achieve a better, more respectful long term relationship with a parent, and such a professional will certainly be less emotionally damaged by being ‘let down’ by the carer.
What this points to is the prevalence of deep rooted dogma in child safeguarding practice whereby the presence of a relationship with parents that is based on positive regard is instrumental and influential when it comes to responding to deception, with social workers in particular reluctant to go against the cultural ‘norm’ by confronting parents when deception is suspected. This consequently facilitates a scenario where professionals are taking parents’ accounts at face value. This is another new finding of this research.

Therefore having a relationship with parents affects the professionals’ judgement when it came to dealing with suspected deceit. Because of their fear of jeopardising this all important relationship, child safeguarding professionals find themselves colluding with parents or making excuses for their deceptive behaviour. In some instances, child safeguarding professionals, in particular social and health care professionals, facilitate disguised compliance. In other instances, child safeguarding professionals, including the police, blatantly refuse to accept that they are being lied to by simply hoping for a change to occur. By trying to be empathetic, the professionals become emotionally involved, which motivates them to interpret parental deception as lacking any malice. Consequently deception is endorsed and excused and the professional’s objective assessment of the circumstances is absent.

Thus carrying the framework of ‘relationship’, professionals are forced to play a balancing act between being empathetic and supportive towards parents whilst trying to promote the needs of the child. With parents being the most vocal party in the relationship, it is how professionals often lose sight of their role and purpose in relation to the child, this research finds.
8.4 The debilitating effect of organisational dogma

The current research has revealed an organisational dogma of needing to work successfully with families at all costs within child safeguarding. This new finding divulges that this organisational dogma has a stifling effect on the child safeguarding professionals’ ability to assess parental deception, as well as on their capability to respond to deceit effectively and in the best interest of the child. It inhibits good and pragmatic child safeguarding practice, and is therefore dangerous for vulnerable children.

The effect of this culture is debilitating on the morale and practice of practitioners whereby some feel they are the victims, and are ambiguous about their roles as professionals tasked with promoting the safety and wellbeing of children, confirming previous research findings.

To add to previous research, more prevalent with social and healthcare professionals, there is a belief that they are unable to challenge the parents even when the lies are suspected. Instead they feel constrained by the framework of the ‘working with families’ culture. Consequently, the professionals in this research adhere to the organisations’ blanket policy of "family is the best environment for the children to be in". The shared view of the professionals in this research is that this policy inadvertently shifts the focus away from the child and brings the parent to the centre of interventions.

Arguably the professionals represented in this research would have a differentiated response to parental deception that is underpinned by their respective organisational ethos and values. This explains why police practitioners, unlike their colleagues in social work and healthcare, feel empowered to exercise power and authority and a
great deal of discretion when it comes to risk assessment and decision making. For social and healthcare professionals, the decision making in response to deception however is framed by the principles of partnership with parents and family support.

The new knowledge derived from this research is that all child safeguarding professionals are indoctrinated throughout their career to accept that most parents are reasonable and protective towards their children and that the best outcome for children occurs usually when cared for within their own families. This is probably in fact true in most cases, but it could be argued that by maintaining a dogmatic approach which discourages or forbids practitioners from being robust and authoritative, there is a danger that it renders the children of the few dangerous, deceitful, abusing families, as collateral damage in the quest to maintain a working together at all costs.

The relevance of this family oriented safeguarding practice, discussed in previous research is that removal of a child from their parents is considered by the system as a very last resort, where all other considerations are exhausted first, normally through a means of relationship. To add to previous research findings, this culture that favours a non-judgemental approach and inhibits scepticism puts an impossible burden on child safeguarding professionals to achieve a good partnership with parents and creates a climate where it is difficult to challenge parents when deception is suspected or even confirmed. This is also evident in the US based practice. The effect of the ‘working with parents’ culture is also evident in the way parental deception is understood and viewed within child safeguarding. There is a reluctance to refer to parents as deceitful, as evidenced by the SCR findings as well as by the practitioners contributing to this research. Deception is viewed in negative and
judgemental rather than objective terms, which goes against the principles of professionals engaged in the partnership-based practice.

Consequently, the original contribution of this research is that there is a tendency within case records and reports to soften language in relation to deceit because professionals and their organisations are uncomfortable with using firm and unambiguous terminology. This alone can disguise or mask the extent of the deceit being practiced. This also applies to verbal communications by professionals who refer to and about parents in overly optimistic terms, or misguided terms. Thus, the family-friendly language makes it challenging for professionals to allude to deception in factual terms and confront parents about their inconsistencies.

Hence this research finds that the rhetoric found in countless reports into the harm caused to children must finally be turned into practice reality. In other words, for professionals to exercise ‘healthy scepticism’ and ‘professional curiosity’ when dealing with deceit, the organisational culture within Local Authorities and Health Authorities needs to undergo a radical change to shift from the dogma of ‘working with parents at all costs’ towards a more pragmatic and dispassionate approach that is centred on the needs of the child. It is the view of the researcher that professionals are unable to balance the needs of the parents against the needs of children objectively, as many times these are mutually exclusive. In relation to children’s social work, it is worth examining the feasibility of a scenario where each of the child and the parents have a separate designated professional advocating for their respective interests.
8.5 The role of training and deception detection strategies

Amidst a lack of previous research in this area, this research’s contribution is that few child safeguarding professionals working with parents benefit from training in the ‘detection of parental deception’.

To add to previous research findings, in relation to the police, professionals who get involved in investigating allegations of child abuse are expected to undertake the Professionalising Investigative Programme (PIP) accredited by the College of Policing, and a Special Child Abuse Investigator Development Programme (SCAIDP), as well as multi-agency training provided by the Local Safeguarding Children Boards (LSCB) and training with children’s social care professionals in investigating cases that necessitate a joint response. Included in this programme is interview training for those who engage in all aspects of interviewing involving, victims, witnesses and suspects.

This explains why police professionals do not feel the need for specific deception detection training as they feel that the current training equips them to identify deception, a finding of this current research.

This research finds that although undertaken by all detectives involved in child safeguarding, this level of training is not extended to an average first on the scene police officer or perhaps a uniformed response officer who would be conducting a joint visit or a ‘safe and well check’ visit with a social care professional, which adds to previous research findings.

This research establishes that despite undertaking a number of training programmes and practical exercises, healthcare
professionals are not trained to detect deceit in parents. Arguably against the backdrop of the organisational culture of ‘working with parents’ such training is unlikely to promote the desired effect as most healthcare professionals do not wish to challenge and therefore ‘lose’ the parent. In fact, the majority of training programmes aim at working with adults and maintain a strong emphasis on the value of care and compassion by the professionals towards parents.

As for social care professionals, despite there being a number of programmes aimed at addressing communication with parents and conducting an effective risk assessment, this research finds that these practitioners are not trained to detect deceit in parents, thus providing new knowledge in this area. There is however a training course that addresses the issue of all child safeguarding practitioners (including healthcare and the police) having to work with resistant parents. It is primarily reflective in nature as it allows practitioners to reflect on their practice, and only limited tools are offered to assist professionals in their deception detection.

Additionally, training in interviewing parents for social and healthcare professionals is limited primarily to motivational interviewing, the role of which is limited and as this research establishes inappropriate when it comes to challenging accounts and testing evidence.

No practical advice is offered to social and healthcare professionals as to how to interview resistant parents, which largely confirms previous research findings (e.g. Littlechild, 2005).

This research confirms previous findings that professionals use assessment to gather evidence, with information being elicited through the means of an interview with parents. However, this
research finds that an assessment implies parental cooperation and compliance, echoing previous research findings. Therefore, an assessment can only be effective if the professionals are prepared to probe and challenge for inconsistencies, an approach that is not facilitated by the current organisational dogma, this research finds.

It is believed within social work that the cognitive interviewing style utilised by the police can be employed in the social work context as useful. However as this research finds, unless the professionals feel empowered to challenge parents, the effectiveness of this training is disputed. In the absence of an appetite by organisations to challenge the long-ingrained culture that sees parents as partners rather than potential abusers, it is likely that additional training would serve little more than a tick in the box, and the decision-making and the interventions will follow the organisational ethos.

This research finds that changing an organisational culture and the mindset of its practitioners is undoubtedly difficult as it involves getting people to think differently about things, which confirms previous findings.

The key new overall finding revealed by this research is that in many respects, safeguarding professionals are paralysed in their ability to protect vulnerable children effectively. It is clear that child safeguarding practitioners in England are generally competent and knowledgeable. They go to work each day wanting to do their job well and as a result many, many children are protected from harm. However, some children are let down by the inability of professionals to operate effectively within the constraints of their professional culture and environment.
The language used in this section of the thesis may be seen as forceful and hard-hitting, yet it is entirely accepted that many parents do want to try their best and can be assisted. However for a ‘child centred approach’ to actually mean more than just words in a serious case review report there needs to be a shift in balance from a focus on the needs of parents and the need for a relationship with the parent, towards the needs of the child, and indeed, a relationship with that child. This does not mean a huge lurch in policy from one extreme to the other, but simply an acceptance of the realities revealed by this research and a gentle re-positioning of the safeguarding paradigm.

8.6 Recommendations

There needs to be an organisational preparedness to accept that all parents may potentially be deceitful in order to cover abuse. Organisation management structure must accept and anticipate that all parents are more likely than not to attempt to conceal information, and therefore resist agency involvement, due to the fear of ‘losing’ their child. Hence parental deception should be presumed until evidence to support the contrary is obtained. The culture of the social and health care organisations to promote a dogmatic partnership-based practice with parents is inconsistent with this approach; it should undergo a radical change.

Because of some inherent incompatibilities that exist within social work, it challenges the capability of social care professionals working in the child safeguarding context to be empathetic to and helping with parents, as well as suspicious of abusive behaviour at the same time, in order to evaluate the risk to the child. It is feasible that
many social workers go into the profession because they want to help those who are disadvantaged and empower them to change. However, working in child safeguarding must require much more, including self-reflection of one’s own empathetic approach to working with parents if it is being exercised at the expense of the child’s welfare. Although it is likely to present a challenging and difficult task to measure the level of curiosity in people during the recruitment process, the limitations or willingness of some professionals to want to drill further needs to be tackled, either through better selection or training or a mixture of both. A genuine ability to demonstrate a degree of healthy scepticism and probe for evidence as to the veracity of information, should be seen as a core competency for effective children’s social work.

However, to emphasise an earlier point, without an organisation change, messages delivered in training and/or recruitment promoting scepticism and authoritative practice are likely to invite a sense of frustration and disillusionment with the professionals as they would feel unable to practise ‘what is being preached’ due to the limitations of their organisational practice.

A non-confrontational motivational interviewing approach that encourages transparency and openness, is aimed at creating the desired changes in parents and utilised in social and health care, needs to supplemented by cognitive and/or strategic interviewing techniques aimed at detection of inconsistencies and promotion of challenging response. For assessment purposes, it should be used a first point of reference. All social and health care safeguarding professionals need to be trained in cognitive interviewing techniques which includes the preparation of an interviewing strategy plan.
Additionally, in respect of paediatricians there is a good level of awareness of child development and identifying signs of child abuse and this is obtained through training for doctors at national and local levels. Some training covers authoritative practice in child protection with a focus on being able to balance support and challenge whilst remaining empathetic to the views of the child and the family in the so-called partnership working. However, in their training more emphasis should be placed on risk formulation and consequent decision making.

All child safeguarding professionals should look for evidence outside the parental engagement to corroborate their accounts; if practitioners do not have cause to do so, having been satisfied previously by parental explanations, it is unlikely that the professionals’ curiosity is triggered. In other words, to be curious requires some amount of scepticism in the first place.

Police professionals must be able to challenge health care professionals accounts when it comes to their assessment of parents.

In the event of a long-lasting relationship between a professional and a parent there is a need for professional practice to be peer reviewed, the so called fresh pair of eyes, in order to not allow professionals to become nose blind to parental deceit.

Professionals must be challenged by their colleagues and supervisors in order to recognise the signs of deception. In order to be confident in their approach with parents they must have the full support of their managers, with alike priorities and who therefore are likely to provide an objective sounding board, and operate within a culture that promotes learning rather than blame.
Many professionals in child safeguarding with social and health care practitioners are unclear and burdened by their role of being a helper to both the parent and the child. In some instances, these roles are mutually exclusive; in many others, they are extremely difficult to fulfil. Amidst the presence of the organisational culture of working with families, and considering the difficulties experienced by practitioners of being both supportive and sceptical with parents, and the parental needs dominating the interventions, it may be worth envisaging a system where a child and the parent are supported by different social workers, each advocating for the interests of their clients. An alternative to this arrangement is for a child safeguarding professional to be accountable for each decision made prior to engaging with a parent.

Rendering deceit impotent requires professionals to be able to acknowledge within their organisations that some families are impossible to work with; it requires a professional environment which is supportive of practitioners who are attempting to tackle resistance; and certainly it requires that they do not feel constantly under threat that if the relationship breaks down, they the professional will be removed from the case. To avoid misvocabularisation, professionals also need to be encouraged, indeed required, to write up their reports and make verbal statements to their supervisors in clear unambiguous language which cannot be misunderstood.
References


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Horwath, J. (2010). 'See the Practitioner, See the Child: The Framework for the Assessment of Children in Need and their Families


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https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendmarch2015/chapter2homicide


RCPCH (Royal College of Paediatrics and Child Health) (2014). Safeguarding children and young people: roles and competences for health care staff INTERCOLLEGIATE DOCUMENT. Retrieved from https://www.rcpch.ac.uk/sites/default/files/page/Safeguarding Children - Roles and Competences for Healthcare Staff 02 0 (3)0.pdf


SCR M (2004). *PUBLIC REPORT REPORT TO CUMBRIA CHILD PROTECTION COMMITTEE SERIOUS CASE REVIEW (CONducted UNDER THE GUIDANCE OF PART 8 WORKING TOGETHER) of events*
leading to the death of Michael who was the victim of fabricated or induced illness (FII) (formerly known as Munchausen syndrome by proxy. Cumbria: Cumbria Child Protection Services


Sturges, J. & Hanrahan, K. (2004). Comparing telephone and face-
to-face qualitative interviewing: a research note, Qualitative Research, 4(1), pp. 107–118.


Appendices
Appendix A

Ethics application forms and approval

Form 1: Ethics Self-Assessment Form

Introduction

All research involving human participants, animals and/or sensitive data undertaken by students and staff must receive a favourable ethical opinion before it can be undertaken and, if appropriate, subsequently used for publication.

The completion of this ICJS Ethics Self-Assessment Form is the start point for applying for favourable ethical opinion and as such it is a record of the ethical considerations that have been addressed in planning the research proposal.

The ICJS Ethics Self-Assessment Form has 4 sections, all of which must be completed.

Section 1: Student details and proposed research topic

Section 2: Preparation; and details of ethical issues identified in the proposed research

Section 3: Ethical Narrative

Section 4: Ethical Opinion Outcome Record

A copy of this completed Self-Assessment Form should be supplied with your research proposal. It will then be passed on to your dissertation supervisor.

You may not proceed to data collection until you have received a favourable ethical opinion.
Understanding and responding to deceptive practices by parents and carers in the child safeguarding context

Please see the document: ‘How to Apply for Ethical Review’ for the process that you will need to follow in order to receive a favourable ethical opinion.

**Section 1: Student details and proposed research topic**

Student name:  *Leah Fox*

Student number:  *UP757520*

Proposed research topic (original topic):  *A contribution to the reduction of child homicide and serious abuse: seeing through deception and tackling resistance of parents and careers in a child safeguarding context - A UK and US comparative study*

**Section 2: Preparation and details of ethical issues identified in the proposed research**

1. Student has read the *British Society of Criminology* ethical guidelines.
   *http://www.britsoccrim.org/docs/CodeofEthics.pdf*
   [X] Yes [ ] No

2. Student has participated in research ethics sessions (lecture/seminar/workshop/other on-line or face to face activity) provided by their programme of study.
   [X] Yes [ ] No
   
   01/12/2014- GSDP111 – *Taking your research design forward* workshop
   
   02/12/2014- GSDP 114- *Designing ethical research and preparing for ethical review* workshop
3. Will the research involve the collection and analysis of primary or secondary data?

   Primary data Yes [X] No [ ]

   (The interview method, possibly an observation)

   Secondary data Yes [X] No [ ]

   (Review of Ten Serious case review overview reports and examination of Two case studies)

   Note: Secondary data is data that has already been collected by other researchers or an organisation for another purpose. Data may be in the public domain or available under the Freedom of Information Act (2000).

   If ‘No’ to both parts of Q3, go to Q16.

   If ‘Yes’ to both or either parts of Q3, go on to answer ALL of the questions on the following pages.

   Does proposed research involve face-to-face contact with members of the community (including professionals and those held or ‘looked after’)?

   Yes [x] No [ ]

   (Research will involve face-to-face contact with current and former professionals in child safeguarding)

4. Is access to personal or confidential data sought? Yes [ ] No [x]

   Note 1: This question applies to both primary and secondary data.

   Note 2: You should be aware that privileged access to contact details or information as a result of a professional role, links to a host organization or personal association is considered to be ethically problematic and arrangements should be made for third party anonymised access.
No personal or confidential data will be sought in primary data collection. With regards to secondary data, i.e. Serious Case Review (SCR) reports and Case studies, this research will seek to examine the SCR reports published by local safeguarding boards and widely available to general public with information already appropriately redacted and anonymised to protect the privacy and welfare of vulnerable children and their families. Any and all court documents relating to the Daniel Pelka and Jamie Knightley case studies will be sought by this research under the Freedom of Information Act.

5. Are you aware of the need to ensure anonymity and confidentiality of research participants?

Yes [ x ]  No [ ]

All research participants will be honoured rights to confidentiality and anonymity, unless there are clear and overriding reasons to do otherwise, for example in relation to the abuse of children.

6. Are there potential risks (to you and/or research subjects) in the research?
(If ‘Yes’, then specify these risks in the spaces provided.)

Physical risks – to participants  Yes [ ]  No [ x ]

There are no foreseeable physical risks to the participants in this research ........

Physical risks – to yourself  Yes [ ]  No [ x ]

There are no foreseeable physical risks to the researcher ........

Psychological risks – to participants  Yes [ x ]  No [ ]

It is recognised that due to the sensitive nature of the child safeguarding practice and the responsibilities it entails, some research participants may be apprehensive and/or distressed prior, during or after the interview. To safeguard against this potential psychological harm, the researcher will ensure that all participants are fully informed about their right to refuse permission or withdraw from involvement in research whenever and for whatever reason they wish, and without any repercussions. Additionally, it will be the
Understanding and responding to deceptive practices by parents and carers in the child safeguarding context

It is acknowledged that due to the sensitive nature of the child safeguarding practice and the responsibilities it entails, some research participants may be apprehensive and/or distressed prior, during or after the interview. To safeguard against this unlikely but recognised psychological harm, the researcher will ensure that all participants are fully informed about their right to refuse permission or withdraw from involvement in research whenever and for whatever reason they wish, and without any repercussions. Additionally, it will be the responsibility of the researcher that the participants' consent is informed, voluntary and continuing.
9. Is participation in the research entirely voluntary? Yes [x] No []

The research will ensure that the participants’ consent is informed, voluntary and continuing.

10. Have you considered how you are going to obtain informed consent from research participants?

   Yes [x]  
   No []

All research participants will be informed about the purpose, methods and intended possible uses of the research as well as the nature of the participants’ involvement and any potential risks it may pose. Voluntary informed consent will be obtained from participants by having them sign a written statement. Any decision by the participant will be respected by the researcher without any adverse effects on the participant.

11. Is there any potential role conflict for you in the research?

   Yes [x]  
   No []

Note: Role conflict is defined as any contact with a participant who knows you (the researcher) in another capacity. Commonly this is a professional capacity. There is no potential role conflict with regards to any but one key participant in the research whereas the relationship between the participant and the researcher is a spousal one.

12. If you are using secondary data, is the data available in the public domain?

   Yes [x]  
   No []  
   Not using secondary data []

(Yes. Please refer to Q5)

If “No”, please explain:

- how you have access to the data
- the arrangements you have made with the host organisation/holder of the information to receive the data in an anonymised state which conforms to the Data Protection Act (1998)
13. If access to data outside of the public domain is proposed, have you consulted with your data protection officer?  
Yes [   ]  No [   ]  
Not applicable

14. Are there any other data protection issues?  
Yes [   ]  No [ x ]

16. Are there any other potential sources of ethical issues or conflict in the proposed research (e.g. political considerations, sensitivity of the topic, reputational issues for researcher, participants and/or host organisation)?  
Yes [ X ]  No [   ]

If ‘Yes’, then specify these risks

Potential risks include 1) sensitivity of the topic of detecting and dealing with deception in parents/carers for child safeguarding professionals; 2) access to and recruitment of some of the key participants in the research; 3) reputational issues for participants and/or host organisations in relation to dealing with disclosures around practice that may not conform to organisational standards/guidelines.

I confirm that:

- the information provided is a complete and accurate record of my plans at present;
- I have read and understood the process for obtaining a favourable ethical opinion as contained in the document: ‘How to Apply for Ethical Review’; and
- I shall resubmit an amended version of this form should my research alter significantly such that there is any significant variation of ethical risk.

Signed: …Mrs Leah Fox.........................Student

Signed: …Prof Mike Nash......................... Research supervisor

Date: …24/03/2015
Form 2: Section3 - Ethical Narrative

In your ethical narrative, you should address and fully develop your responses to any ethical issues that you have identified from your Self-Assessment Form as requiring further consideration.

In addition, your ethical narrative should address the following issues:

- Sensitivity of research topic
- Permission from host organisation/s. You will require written authority from the host organisation/s agreeing to allow your research to be conducted. This means you must write to the host organisation/s (using UOP logo and contact details) and set out the risks and costs (use of office time, professional time, reputational issues, access to staff, internet, etc.) associated with your research activity.
- Reputational issues – for the university/researcher/host organisation/s
- Anonymity and confidentiality
- Data protection and storage
- Role conflict
- Access to privileged data and privileged resources – and action to mitigate risks and concerns arising from accessing this type of data
- Risks posed by research - to participants and researcher
- Ownership of research data
Section 4: Ethical Opinion Outcome Record

This section will be completed by the ICJS Ethics Committee for: Undergraduate, Masters and DCRMJ (Professional Doctorate) [Stage 2,1, ART] research proposals and therefore this document must be included in the Ethical Bundle when it is sent for ethical review to Jane Winstone (icjsethics@port.ac.uk)

A copy of the outcome of ethical opinion will be sent to the student who is responsible for providing this to the dissertation/research supervisor. A copy will also be kept on record by the ICJS Ethics Committee.

Please note: PhD candidates will be notified of a favourable ethical opinion in a letter from the Faculty Ethics Committee (FEthC) which will include a REC number. (For further details of this see the document: ‘How to Apply for Ethical Opinion’ – Stage 2: The process for applying for ethical opinion.)

<table>
<thead>
<tr>
<th>ICJS EC Ethical Opinion Outcome Record*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favourable ethical opinion</td>
</tr>
<tr>
<td>You can commence data collection with the agreement of your supervisor.</td>
</tr>
</tbody>
</table>

| Provisional favourable ethical opinion subject to requirements. |
| See ‘Comments’ on following page. |
| Once your supervisor is satisfied that you have met these requirements, you may commence data collection. |

| RISKS ASSESSED AS SIGNIFICANT and a favourable ethical opinion cannot be provided for the proposal in its present form. |
| See ‘Comments’ on following page. |
| You must revise your proposal in consultation with your supervisor. Once your supervisor is satisfied that you have addressed all of the Comments below, you may resubmit for ethical opinion|
| You may not commence data collection. |
*The ICJS EC default position is to reserve the right to refer any research proposal to the Faculty Ethics Committee where the proposal poses ethical issues beyond its remit to form an opinion upon.

Date complete ethical bundle received fit for review: ............................................................

Date reviewed: ............................................................

Signed: .................................................................................. (Member of ICJS Ethics Committee)

**Section 5: Ethical Narrative**

Student name:  **Leah Fox**

Student number:  **UP757520**

Proposed research topic (original topic):  *A contribution to the reduction of child homicide and serious abuse: seeing through deception and tackling resistance of parents and careers in a child safeguarding context- A UK and US comparative study.*

The purpose of this Ethical Narrative is to fully examine any and all ethical issues identified by the researcher in Section 2 of the Self-Assessment form.

The identification of such issues, how they relate to this research and the researcher’s action plan to mitigate the potential risks are summarised in the table below (Table 1. Ethical Narrative).

<table>
<thead>
<tr>
<th>Ethical issues/Risks/Considerations</th>
<th>Brief description in relation to research</th>
<th>Researcher’s actions to mitigate risks</th>
</tr>
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<tbody>
<tr>
<td>Sensitivity of the topic/ Psychological harm to participants</td>
<td>Child homicide and serious abuse is undoubtedly an emotional and/or sensitive topic even for the most</td>
<td>The researcher is an established professional who has worked in the child safeguarding arena in the UK and United</td>
</tr>
</tbody>
</table>
Understanding and responding to deceptive practices by parents and carers in the child safeguarding context

'Seasoned' child welfare professionals. Discussing the topic can generate an emotional response which may be psychologically harmful for the participant.

Additionally, given the increasing public attention to child safeguarding professionals who reportedly fail to protect children from harm in high profile media cases, it is possible that a number of participants in this research may feel that they are once again, being scrutinised for their decision making. In response, some may take on defensive roles before/during or after the interview; others may experience a sense of incompetence and failure. The revisiting of the topic may have an immediate and/or delayed impact on the emotions of the participants.

States for approximately 7 years. During her career she had to interview various stakeholders, members of the public and professionals, and often, in stressful situations. Given her background and professional experience, the researcher is able to recognise the signs of stress and manage it effectively.

The researcher will ask for signed, informed consent from all the participants. Information about the proposed research and its parameters will be provided to the potential participants through information sheet. It will be communicated to the participants prior to and during the interview that their participant in research is voluntary. The participants will be informed that they have a right to withdraw prior to and during the interview without any adverse consequences. The participants will be assured of their rights to confidentiality and anonymity.

The researcher will make every step to avoid undue intrusion by creating an undue burden on participants either by...
| Recruitment of participants | This research will aim to utilise the following research participants: frontline child care workers and key policy informants/consultants. It is imperative that ethical standards are adhered to in relation to identification of eligible participants, explanation of the study to the potential participants and obtaining their informed consent, recruitment of an additional participant. | The researcher will ensure that all respondents participate in the research freely and willingly and know and understand what they are agreeing to when they take part. (This will be provided via information sheets and informed consent) No undue influence will be exerted in order to persuade the participants to take part in the research. |
There is a risk of biased findings as the researcher might be tempted to identify and recruit participants who think similarly.

### Key participants/informants

Approximately 14 ‘experts’ in child safeguarding practice were identified by the researcher as potential participants in the study. The proposed sample included academics, policy makers, strategy leaders, SCR authors and child welfare specialist who were selected because of their recognised unique roles and positions in the field. A number of proposed participants were selected for the study using the researcher’s personal contacts and knowledge; others-as a result of snowball effect (provisionally agreed participants suggesting other participants).

In addition to providing ‘in depth expert information’ on the subject being researched (Werner & Schoepfle, 1987) the use of such participants is particularly important in exploration of less well-researched topic of interest (Johnson, 1990). Additionally, the researcher felt that utilising the proposed ‘key’ participants, would enable the former to
fulfil the research aims.

The recruitment of the key informants will be conducted using targeted, direct approach with appropriate correspondence to the host organisation to obtain their permission.

The researcher will be mindful that the key participants, particularly policy makers, could have a vested interest in giving biased information especially if speaking about policy they have created. To safeguard against this potentially skewing the analysis and findings, the researcher will aim to corroborate their information with other sources, specifically from frontline child care participants.

**Frontline participants**

The recruitment of frontline participants will be conducted by the researcher sending the invitation letter (along with appropriate information sheet and informed consent form) to Local Authorities to invite social workers to participate in research. It is likely that a ‘gatekeeper’ will be utilised to identify and help
> Understanding and responding to deceptive practices by parents and carers in the child safeguarding context

| Access to privileged data/resources | There is a potential risk that some key participants might feel coerced into participation as a result of direct or indirect knowledge of the researcher and/or as a result of 'doing a favour' to the participant who suggested their name in the snowball identification of key participants. One participant to whom the researcher owes duties beyond those associated with research might feel coerced into participation. | The researcher will ensure that the informed consent is obtained before attempting to access resources and that the permission of data custodians is obtained before attempting to access data. The researcher will ensure the participants that any and all research will be undertaken in the name of the University of Portsmouth and that it will be sponsored by the University which provides indemnity. No research will be undertaken until the permission is sought from the host organisation. A letter the UoP logo and departmental address will be sent to the host organisation to
communicate the research needs. Therefore any potential conflicts of interest can be resolved by the researcher making her researcher role clear.

Mr Fox who has been identified as a potential key participant because of his unique role of the lead Police agent for the Victoria Climbie inquiry is the researcher’s husband. It would be a significant loss of an important input if Mr Fox was not a participant. Mr Fox, just like any other research participant for the research in question will have the right to refuse permission or withdraw from involvement in research whenever and for whatever reason he wishes. Mr Fox’s participation will have to be informed, voluntary and continuing.

<table>
<thead>
<tr>
<th>Permission from host organisations</th>
<th>In relation to access to key participant recruitment and to privileged data and the associated potential threat to the integrity of the research.</th>
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<tr>
<td></td>
<td>The researcher will write to the host organisation/s (using UOP logo and contact details) and set out the risks and costs (use of office time, professional time, reputational issues, access to staff, internet, etc.) associated with the research activity.</td>
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<tr>
<td></td>
<td>It is only after the</td>
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</table>
| Reputational issues for participants and host organisations | In relation to dealing with disclosures around practice that may not conform to organisational standards and/or guidelines. | Reputation is a major risk issue for all organisations and the research will ensure that the risks are mitigated against.

The identities and research records of those participating in the research will be kept confidential whether or not an explicit pledge of confidentiality has been given or requested.

All research data will be stored in a secure manner (password protected) under the Data Protection Act.

Where requested, appropriate methods for preserving anonymity will be used including the removal of identifiers, the use of pseudonyms and other technical means for breaking the link between data, identifiable individuals and identifiable host organisations.

The researcher will ensure and inform the participants that great care will be taken to prevent data being published or released in a form |
that would permit the actual or potential identification of research participants without prior written consent of the participants.

Any potential participants, especially those possessing a combination of attributes that make them readily identifiable, will be informed that it may be difficult to disguise their identity without introducing an unacceptably large measure of distortion into the data.

Anonymity and confidentiality

Risks of participants being identified in the research

The researcher has a duty of confidentiality to the research participants. Anonymity and confidentiality will be honoured to all key participants unless there are clear and overriding reasons to do otherwise, such as in the event of disclosure of child abuse allegations. Exemptions will exist in the event of a legal compulsion or a result of police investigation and/or court proceeding, or where the disclosure of the information by the participants is to be made 'in the public interest', as defined by the courts. This will be communicated to the participants in the information sheet concerning the research.
<table>
<thead>
<tr>
<th>Role conflict</th>
<th>One participant to whom the researcher owes duties beyond those associated with research might feel coerced into participation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The researcher will ensure that the informed consent is obtained before attempting to access resources and that the permission of data custodians is obtained before attempting to access data. The researcher will ensure the participants that any and all research will be undertaken in the name of the University of Portsmouth and that it will be sponsored by the University which provides indemnity. No research will be undertaken until the permission is sought from the host organisation. A letter the UoP logo and departmental address will be sent to the host organisation to communicate the research needs. Therefore any potential conflicts of interest can be resolved by the researcher making</td>
</tr>
</tbody>
</table>
**Data protection and storage**

<p>| Primary data: Interviews with participants will be either digitally recorded or by taking notes. Secondary data: SCR reports /Case studies will be retrieved electronically. Any court transcripts under the FOI request may be utilised as a hard copy or electronically. Signed consent forms will be collected as hard copies. | Digital data of the recordings will be stored on the external password protected drive. Electronic files with recordings and transcript of the interviews will be password protected and stored on the password protected drive. Electronically retrieved secondary data (SCR reports and cases studies) will be stored on the external password protected drive. Back up files will be stored on the researcher’s hard drive and could be accessed by password. Any and all hard copies, including consent forms, notes of the interviews and court transcripts will be stored in a locked cabinet in the researcher’s office study at home. The research participants will be informed that raw data (such as recording of interviews) will be stored until the degree has been awarded. Once the degree has been awarded all raw data will be safely destroyed. Raw data will typically include named persons and locations thus posing... |</p>
<table>
<thead>
<tr>
<th>Ownership of research data</th>
<th>Potential dispute over ownership of research data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>It will be communicated to the participants through information sheets that the University of Portsmouth has an ownership of research data.</td>
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<tr>
<th>Doing research in USA</th>
<th>Addressing specific requirements of doing research in the USA</th>
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<tr>
<td>In addition to adhering to British Society of Criminology ethical guidelines, the researcher will ensure that the research in the USA is conducted within the guidelines of the American Psychological Association’s (APA) Ethical Principles of Psychologists and Code of Conduct as well as the Code of Ethics of the</td>
<td></td>
</tr>
</tbody>
</table>
Table 1. Ethical Narrative

References


Form 3: Invitation letter for frontline professionals

Study Title: A contribution to the reduction of child homicide and serious abuse: seeing through deception and tackling resistance of parents and careers in a child safeguarding context- A UK and US comparative study.

Dear Potential Participant,

I would like to invite you to participate in a research study dealing with the culture, current practice and supervisory support for child safeguarding professionals and how it enables and equips them to assess the veracity the parents/carers during assessment interviews and professional conversations.

This letter has been forwarded to you by your senior colleague because they have identified that you might be a suitable participant in the research however, they have not provided me with your name, address or personal details.

As a part of this research study, I will be conducting interviews to increase overall understanding of how deception is perceived, experienced and dealt with by frontline child safeguarding professionals. As a practicing social worker you are in an ideal position to provide me with valuable first hand information from your perspective.
There are no right or wrong answers– we are keen to gain a wide variety of opinions. Additionally, this research study is not aimed to criticise any specific individual or agency practice.

Your participation in the research is entirely voluntary and the interview will take approximately 30 minutes. You do not have to answer any questions that you do not wish to, and you may withdraw at any point during the interview up to the point of data analysis.

Each interviewee will be assigned a number code to help ensure that personal details are not revealed during the analysis and final report.

Please take time to read the enclosed information sheet carefully and take time to think about whether or not you would like to take part.

If you agree to take part in the research, please sign the enclosed consent form and email it back to leah.fox@port.ac.uk. The researcher will contact you for the suitable date, time and location to arrange an interview.

In the absence of a response within 15 days, the researcher will send the organisation a reminder with a follow up letter.

Whether you decided to participate in the study or not, thank you for taking the time to read the invitation letter and the information sheet.

I look forward to hearing from you. If you have any queries please do not hesitate to contact me or my research supervisor.

Yours sincerely,

Leah Fox
PhD Candidate
ICJS
University of Portsmouth

Form 4: Invitation letter to host organisations

Request for participation in PhD level research project.

The researcher is an established full time PhD candidate who has worked in the child safeguarding arena in the UK and United States for approximately 7 years. The proposed research is aimed at improving safeguarding arrangements for children and the early identification of serious child abuse. It is intended to specifically to examine whether the culture, current practice and supervisory support for child safeguarding professionals enable and equip them to recognise deceit and assess the veracity the parents/carers.
Approximately 35 child safeguarding professionals will be approached to take part in the research, including frontline workers in both the UK and USA.

A favourable ethical opinion provided by the University Ethics Committee confirms that the proposed research is ethically compliant and I can start data collection provided the host organisation is in agreement. It is my responsibility to gain relevant permission from all the participants and to ensure that their consent is fully informed. The following outlines the key risks/issues for consideration in relation to your organisation:

- All participation will be voluntary; informed consent will be obtained from the participants. The respondents will have a right to withdraw prior and during the interview.

- Respondents and their employers will be completely anonymised in the final report.

- This research topic is exploratory in nature and further information about this area is likely to enhance practice and is not likely to pose any reputational threat to the organisation.

- There will be some small hidden costs to the organisation such as the employee time to participate in the interview. The interview is likely to take 30 to 45 minutes.

The research is sponsored by the University of Portsmouth, which provides indemnity, and the raw data belongs to the University and the Student. All electronic data will be encrypted and stored as per the Data Protection Act behind secure firewalls. Paper documentation will be kept in a locked cabinet and will be fully anonymised. The raw data cannot be used for Human Resources or performance-related issues. However, I would be very happy to provide your organisation with a report of my findings.

Please refer to the enclosed participant information sheet and the consent form and contact the researcher and/or the researcher’s supervisor using the contact information above.

I would like to take this opportunity to thank you for supporting my continued educational and professional development and I look forward to hearing from you. If you have any queries please do not hesitate to contact me or my research supervisor.

Yours sincerely,

Leah Fox
PhD Candidate
ICJS
University of Portsmouth
Understanding and responding to deceptive practices by parents and carers in the child safeguarding context

**Form 5: Participant Information Sheet**

**Study Title:** A contribution to the reduction of child homicide and serious abuse: seeing through deception and tackling resistance of parents and careers in a child safeguarding context - A UK and US comparative study.

*We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Talk to others about the study if you wish. Ask us if there is anything that is not clear.*

**What is the purpose of the study?**

The proposed research is aimed to examine whether the culture, current practice and supervisory support for child safeguarding professionals enable and equip them to assess the veracity the parents/carers during assessment interviews and professional contact. The study will therefore be designed to gain primary and secondary data which reveals the perceptions, training, and interviewing skills of safeguarding professionals. The ultimate purpose of the study is to examine practice and policy which may have a bearing on the prevention of murder or serious harm to children, and to add new learning to the field.

The research will also be used to form the basis of a PhD thesis which will be available in the Library at the University of Portsmouth.

**Why have I been invited?**

The research will primarily utilise semi-structured interviews in order to understand the nature of the problem within the context of the current policy. Approximately 35 child safeguarding professionals will be approached to be interviewed, including frontline workers in both the UK and USA and several key informants/consultants such as academics, policy makers and strategic leaders. The recruitment of frontline workers will be undertaken through a third party (e.g., a gatekeeper in a Local Authority) to ensure the impartiality and transparency of the process.

You have been invited to participate because of your role in the area of child safeguarding where it is felt that you are able to provide an in-depth insight into current practices.

**Do I have to take part?**
Your participation in the research is entirely voluntary. It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form.

What will happen to me if I take part?

If agreed to take part, you will be interviewed for approximately 30 minutes. The interview will take place in a mutually agreed upon location but we will fit in with your wishes as much as possible. You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher. With your permission, the interview will be audio-recorded to facilitate collection of information, and later transcribed for analysis. It is very difficult to have a meaningful conversation and write notes as well, hence the preference for recording however in the end you can decide that you do not wish the conversation to be recorded in which case notes can be taken. Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. All information you provide is considered completely confidential. Your name will not appear in any thesis or report resulting from this study, however, your quotations may be used but they will be completely anonymised. Data collected during this study will be retained until the conclusion of this study and will be password protected and stored on the researcher’s computer. Any hard copies will be locked in the researcher’s office. Only researchers associated with this project will have access.

Expenses and payments

Unfortunately, no compensation or expenses are being provided for your participation in this study although it is anticipated that in the end the study will help inform policy makers in the field of safeguarding and therefore serve to protect children in the future.

What will I have to do?

Once you have read the information sheet and agreed to participate in the research, please contact the researcher on the email address above to provide your availability for the interview. The researcher will schedule the appointment at the agreed date, time and location.

What are the possible disadvantages and risks of taking part?

Child abuse is undoubtedly an emotional and/or sensitive topic even for the most 'seasoned' child welfare professionals. Discussing the topic can generate an emotional response which may be upsetting for the participant.

You will be able to decline to answer any questions or withdraw at any time during the interview. The researcher will take every step to avoid undue intrusion or burden on participants either by conducting longer than necessary interviews or discussing issues outside the areas specified on the previously provided information sheet.

It is possible that you may wish to discuss practice or a working environment that does not conform to your organisational standards and/or guidelines. The researcher will ensure that the identities and research records of those participating in the research will be kept confidential whether or not an explicit pledge of confidentiality has been given or requested. Where requested, appropriate methods for preserving anonymity will be used including the removal of identifiers, the use of pseudonyms and other technical means for breaking the link between data, identifiable individuals and identifiable host organisations.

Great care will be taken to prevent data being published or released in a form that would permit the actual or potential identification of research participants without prior written consent of the participants.
What are the possible benefits of taking part?

It is felt that the proposed research, including a thorough examination of current practice, will bring new learning to the field of family involvement with child welfare professionals (e.g. police, social workers, third sector practitioners) leading to a contribution to improvements in training, practice guidance and policy construction.

Will my taking part in the study be kept confidential?

The researcher has a duty of confidentiality to the research participants. Anonymity and confidentiality will be honoured to all key participants unless there are clear and overriding reasons to do otherwise, such as in the event of disclosure of child abuse allegations. Exemptions will exist in the event of a legal compulsion or a result of police investigation and/or court proceeding, or where the disclosure of the information by the participants is to be made ‘in the public interest’, as defined by the courts.

The research will not breach the ‘duty of confidentiality’ by passing identifiable data to third parties without participants’ consent. However, it will be communicated to the participants that research data given in confidence do not enjoy legal privilege and may be liable to subpoena by a court.

Digital data of the recordings will be stored on the external password protected drive. Electronic files with recordings and transcript of the interviews will be password protected and stored on the password protected drive. Electronically retrieved secondary data (SCR reports and cases studies) will be stored on the external password protected drive.

Back up files will be stored on the researcher’s hard drive and could be accessed by password. Any and all hard copies, including consent forms, notes of the interviews and court transcripts will be stored in a locked cabinet in the researcher’s office study at home.

The research participants will be informed that raw data (such as recording of interviews) will be stored until the degree has been awarded. Once the degree has been awarded, all raw data will be safely destroyed. Raw data will typically include named persons and locations thus posing a risk to promised confidentiality.

Access to raw data would be restricted to the researcher and her supervisor; although it is believed that very occasionally examiners may require access and, though rarely, auditors with a responsibility to ensure the quality of research in the University might request access. Specific consent will be sought from participants to have the anonymised transcripts of interviews retained for future, unspecified research but will only be retained if such permission is granted.

What will happen if I don’t want to carry on with the study?

You could withdraw in the course an interview, however, once the interview data have been analysed it may not be possible to withdraw any individual’s personal contribution. Your data will be retained until the completion of the study, upon which it will be safely destroyed.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher or their supervisor, who will do their best to answer your questions (Leah Fox- leah.fox@port.ac.uk or Prof Mike Nash on Telephone 02392 843062 or email mike.nash@port.ac.uk). If you remain unhappy and wish to complain formally, you can do so by contacting the Head of Department Dr Phil Clements, phil.clements@port.ac.uk)
What will happen to the results of the research study?

It is intended that the results of the study will be published. You will not be identified in any report/publication unless you have given your consent.

Who is organising and funding the research?

This research is undertaken in the name of the University of Portsmouth and that it is sponsored by the University which provides indemnity.

Who has reviewed the study?

Research in the University of Portsmouth is looked at by independent group of people, called an Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by the ICJS Ethics Committee.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me by e-mail at leah.fox@port.ac.uk. You can also contact my supervisor Professor Mike Nash at 02392 843062 or e-mail mike.nash@port.ac.uk

Whether you decided to participate in the study or not, thank you for taking the time to read the information sheet. If you decide to participate you will be provided with a copy of the information sheet to keep and your consent will be sought.

Sincerely,

Leah Fox
PhD Candidate
ICJS
University of Portsmouth
Leah.fox@port.ac.uk
Understanding and responding to deceptive practices by parents and carers in the child safeguarding context

**Study Title:** A contribution to the reduction of child homicide and serious abuse: seeing through deception and tackling resistance of parents and careers in a child safeguarding context - A UK and US comparative study.

**Name of Researcher:** Leah Fox

Please initial box

1. I confirm that I have read and understand the information sheet dated 12th of March, for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time up to the point when the data are analysed without giving any reason. I agree to take part in the above study.

3. I understand that data collected during the study, may be looked at by

---

Form 6: Consent Form

**Researcher:** Leah Fox
PhD Candidate,
Institute of Criminal Justice Studies,
ICJS
Leah.fox@port.ac.uk

**Supervisor:** Professor Mike Nash
Institute of Criminal Justice Studies
University of Portsmouth
St George’s Building
Room 5.14 (floor 5)
141 High Street
Portsmouth, PO1 2HY
mike.nash@port.ac.uk

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individuals from University of Portsmouth, or from regulatory authorities.
I give permission for these individuals to have access to my data.

4. I agree to my interview being audio recorded.

5. I agree to being quoted verbatim.

6. I agree to the data I contribute being retained for future, REC approved, research.

7. I agree to being a named participant and quoted by name.

8. Knowing all the facts, I agree to take part in the above study.

Name of Participant: Date:
Signature:

Name of Person taking consent: Date:
Signature:

(When completed: 1 for participant; 1 for researcher's file)
Form 7: Favourable opinion by ethics committee

Leah Fox
PHD Candidate
Institute of Criminal Justice Studies
University of Portsmouth

REC reference number: 14/15:38
Please quote this number on all correspondence.

13th April 2015

Dear Leah,

Full Title of Study: A contribution to the reduction of child homicide and serious abuse: seeing through deception and tackling resistance of parents and carers in a child safeguarding context: A UK and US comparative study.

Documents reviewed:
Consent Form
Ethical Narrative
Ethics Self-assessment
Invitation Letter
Participant Information Sheets
Protocol
Questionnaire

Further to our recent correspondence, this proposal was reviewed by The Research Ethics Committee of The Faculty of Humanities and Social Sciences.

I am pleased to tell you that the proposal was awarded a favourable ethical opinion by the committee.

Kind regards,

FHSS FREC Chair
Dr Jane Winstone

Members participating in the review:

- David Carpenter
- Richard Hitchcock
- Geoff Wade
- Jane Winstone
Form 8: Research Ethics Review Checklist FORM UPR16

FORM UPR16
Research Ethics Review Checklist

Please include this completed form as an appendix to your thesis (see the Postgraduate Research Student Handbook for more information)

Postgraduate Research Student (PGRS) Information

<table>
<thead>
<tr>
<th>Student ID: 757520</th>
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</table>

PGRS Name: Leah Fox

Department: Institute of Criminal Justice Studies

First Supervisor: Professor Mike Nash

Start Date: October 2014

Study Mode and Route: Part-time [x] MPhil [ ] PhD [ ] MD [ ] Professional Doctorate [ ]

Title of Thesis: The paralysis of practice in child safeguarding: understanding and responding to deceptive practices by parents and carers in the child safeguarding context

Thesis Word Count: 70,630 (excluding ancillary data)

If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University’s Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study.

Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

UKRIO Finished Research Checklist:
(If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: http://www.ukr.io/what-we-do/code-of-practice-for-research)

- a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame? YES [x] NO [ ]
- b) Have all contributions to knowledge been acknowledged? YES [x] NO [ ]
- c) Have you complied with all agreements relating to intellectual property, publication and authorship? YES [x] NO [ ]
- d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration? YES [x] NO [ ]
- e) Does your research comply with all legal, ethical, and contractual requirements? YES [x] NO [ ]

Candidate Statement:
I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)

Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC): 14/15/38

If you have not submitted your work for ethical review, and/or you have answered ‘No’ to one or more of questions a) to e), please explain below why this is so:

N/A

UPR16 – August 2015

Signed (PGRS): [Signature]

Date: 18/12/2017

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Appendix B

Interview schedule 1a: Key participants (initial)

1. What is your organisation and your role in relation to child safeguarding?

2. Are child safeguarding professionals equipped with the interviewing skills to identify deceit?
   - possible collusion between family members?

3. What training do child safeguarding professions receive to help them identify deception in parents/carers?

4. Does training properly equip child safeguarding professionals to challenge and rebut lies told by carers?
   - identify disguised non-compliance?

5. What model of interviewing is being used, if any?
1. What is your organisation and your role in relation to child safeguarding?

2. What training do child safeguarding professions receive to help them identify deception in parents/carers?

3. Does training properly equip child safeguarding professionals to challenge and rebut lies told by carers and/or identify disguised non-compliance?

4. Please discuss the role of relationship-based practice for child safeguarding professionals

5. What is the role of organisational culture on child safeguarding professionals’ practice in relation to deception detection and subsequent action?

6. What are the deception detection techniques /methods used by frontline professionals in child safeguarding and can they be transferable?
Appendix D

Interview schedule 2a: Frontline Participants (initial)

1. What is your role and number of years in service?

2. Did you receive any training? If so, what?

3. Is interviewing parents/career a part of your risk assessment/job? What type of an interview is it?

4. Please elaborate on your skill/ability to assess a parent (including interviewing them)

5. Are you able to detect when parents/careers are lying? Please explain

6. What are your subsequent actions?

7. Do you experience any stress/fear/intimidation when dealing with parents?

8. What impact does it have on your decision making if any?
Appendix E

Interview schedule 2b: Frontline Participants (during analytical stage)

1. What is your role and number of years in service?

2. Did you receive any training? If so, what?

3. Discuss your understanding of motivational and investigative types of interviewing and elaborate on their values in child safeguarding.

4. What is the nature of your relationship with parents and what role does it play in your interactions with parents?

5. Are you able to detect when parents/careers are lying? Please explain

6. What are your subsequent actions?

7. Discuss whether having a relationship with parents plays any role in your ability to detect deceit in parents? What about your subsequent actions?

8. Please explain the role management and the organisation as a whole in relation to your job of dealing with parents?

9. What impact does it have on your decision making, if any?
Appendix F

Cycles of coding and analytical process

1. Phase 2: Open coding (Selected text from Interview transcript FP04 is coded as Assessment process/Interviewing/Information gathering)

2. Open codes: 60
3. Example: Code ‘Response of professionals to deception in parents’ in 3 sets data

4. Phase 3: Categories
5. Phase 4: An example of focused coding

6. An example of an analytical memo