

# Rights, Responsibilities and Pragmatic Practice: Family Participation in Case Reviews

This article considers the experiences of families and professionals in case reviews where a child has died/suffered serious injury as a result of abuse or neglect. There is an expectation in the four UK nations that families will be included in such case reviews. The article draws on a study of policies and practices, and family accounts of involvement. An overview of UK policies and practices is described, and the broader questions that emerge for participatory practices identified. Family experiences in this complex area of practice are considered, and recommendations made for practice. The uneven picture of family involvement is argued to reflect uncertainty about the purpose, value and role of family involvement. Concerns are raised about the unresolved dilemmas arising from family involvement and the potential for practice to be unhelpful if not carefully examined. Copyright © 2013 John Wiley & Sons, Ltd.

## KEY PRACTITIONER MESSAGES:

- Family involvement in reviews is an expectation across the UK nations, but with limited practice guidance.
- Family perspectives add invaluable insights and support learning for future protective services.
- Professionals have common drivers for family involvement in reviews, but few policies articulate the purpose of participation.
- Family involvement raises difficult questions for participatory practices.
- Without further clarity and adoption of principles for practice, dilemmas will remain whatever review models are adopted.

KEY WORDS: case reviews; child death/injury; family participation

**T**he examination of family involvement in child protection processes and practices has resulted in growing acknowledgement of the value and challenges of participation (Buckley *et al.*, 2011; Darlington *et al.*, 2010; Featherstone *et al.*, 2011; Kemp *et al.*, 2004; Thoburn *et al.*, 1995). The extent to which families proactively inform the plans for their children has been a focus for both empirical consideration and innovative practice. This article draws on a study (Morris *et al.*, 2012) commissioned by BASPCAN exploring family involvement in reviews where a child has died or suffered serious injury

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as a result of abuse or neglect. Whilst family involvement in case reviews is a policy expectation across the four UK nations, remarkably little is known about practice, and about family experiences. The reality of participation in this complex area is under-researched, and, as the study revealed, there are tensions concerned with purpose and practice. These tensions reflect the contested nature of rights and responsibilities in this area (Harris and Gosnell, 2012; Seim and Slettebø, 2011). Although focused upon family experiences in particularly profound and traumatic circumstances, the study provides broader messages for practitioners and for the review processes that seek to identify learning for service and professional development.

In the UK, and elsewhere, case reviews have been the triggers for repeated flurries of policy activity, often resulting in changes in the national or state guidance and in the climate for child protection practice (HM Government, 2010; Munro, 2011). Recent debates have questioned the value of existing review processes, and their capacity to support sustained change (Fish *et al.*, 2008; Munro, 2011). As this research reveals, family perspectives of the review processes are similarly concerned with change and with learning, albeit from a different point of engagement with professional processes.

### **The Study**

The study examined existing published policy guidance in each area of the four nations in the UK, to arrive at a picture of common approaches by localities to family involvement in the reviews of cases where a child had died or suffered serious injury as a result of abuse and/or neglect. Through a series of expert focus groups and interviews, a detailed understanding of the processes and practices for family participation was developed, using ‘snowball sampling’. Although the limits to this approach are acknowledged (Browne, 2005), the design enabled the study to identify and reach the relevant communities of interest. This iterative process built upon the expert contributions to arrive at comprehensive understandings of localised activity. A total of 190 professionals contributed to the research during the different stages, all with particular knowledge or responsibilities in relation to family involvement in case reviews. The study held a series of consultation events as the early findings emerged to ensure relevance and some internal verification.

Alongside the examination of professional activity, the study also sought to hear from families about their experiences (no other comparable study with accounts directly from families could be identified; hence, this strand of the research was exploratory, using unstructured qualitative interviews to capture family narratives). Representatives from seven families who had participated in case reviews contributed to the study; advocates for families also provided insights into the experiences of family participation. Families were accessed via safeguarding boards and link professionals, and some families contacted the research team directly having heard about the project from user-led family advocacy services. The sample included young people, parents, grandparents, adult siblings and step-parents. Accessing the families was extremely challenging. There was considerable professional anxiety about facilitating access, with concerns about the impact of contact on any existing work plans, and questions about the ownership of the information that the family would share. Inevitably, the family perspectives are just that – they give an insight into

how individual families experienced involvement in the review process; they do not offer an objective account of the processes and practices or provide a representative account. Likewise, the professional reflections also offer a partial picture of participation, the localised nature of activity meant that, in part, the value of the research lay in its ability to provide an overview of common themes and strategies. The high-profile nature of the events leading to the case reviews meant that very careful measures were put in place to avoid accidental identification when the data from families were shared or used, and the study was the subject of the necessary research governance processes and ethical scrutiny. The research design, safeguarding and consent arrangements were agreed by the commissioners and the relevant local safeguarding children boards (LSCBs) and local authorities and were approved by the appropriate university research ethics procedures.

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### **The Legal and Policy Frameworks for Each Country**

Human rights legislation puts an obligation on the state to carry out a review where a child has died with abuse as a factor, and also enshrines families’ rights to be involved in the process (Human Rights Act 1998). A number of studies of reviews have found that although most professionals agree that family members have a significant contribution to make to the review that enhances the learning, engaging families is full of tension and anxiety and that some families may not be given the opportunity to participate (Brandon *et al.*, 2012; Devaney *et al.*, 2011; Ofsted, 2008; Rose and Barnes, 2008; Sidebotham *et al.*, 2010). Rose and Barnes (2008) identified the difficult balance to be struck between individual rights (to be heard and to privacy) and the public interest – which presents a particular challenge in the move to publication of reviews.

Each of the four UK nations has its own way of reviewing child death or serious injury through abuse or neglect and there are subtle differences in the way each nation approaches the issue of family involvement. The principles behind the law and policy that guide the family’s participation are very similar however, and in all four nations, policies for the review process require (at least) that consideration be given to involving families. Serious case reviews in England and Wales have an expectation of family involvement and LSCBs are required to consider how this will be handled. Northern Ireland’s case management review process and Scotland’s significant case review systems allow the (area) child protection committees some discretion about whether or not to involve families.

**‘There are subtle differences in the way each nation approaches the issue of family involvement’**

In England, the guidance which informs the serious case review process is given in chapter 8 of *Working Together* 2010 (HM Government, 2010). This guidance presumes that family members will be involved throughout all stages of the review and that they will be informed of the review’s findings. A wider interpretation of ‘family’ is offered than in any earlier editions of *Working Together*. This includes, ‘the child (where the review does not include a death) surviving siblings, parents or other family members’ (HM Government, 2010, para 8.20).

Wales has had an expectation of family involvement in serious case reviews since the publication of *Working Together* 2004. As in England, Scotland and

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Northern Ireland, engagement with families is first planned at the review’s ‘scoping’ stage and chapter 10 of *Working Together* 2004 requires that consideration be given to how family members should contribute to the review and who should be responsible for facilitating this (p. 252). As in the other three nations, there is also a consideration of how any public, family and media interest should be handled before, during and after the review (p. 253).

In Northern Ireland, current national guidance for involving families in the case management review comes from chapter 10 of *Co-operating to Safeguard Children* (Department of Health, Social Services and Public Safety, 2003). Consideration should be given to whether or not to invite ‘family members or concerned individuals, who may have referred the case to social services’ (para 10.16) to contribute to the review. At the end of the review, arrangements should be made ‘to provide feedback and de-briefing to staff, family members of the child whose case has been reviewed and the media as appropriate’ (para 10.32).

Scotland has only had national guidance for carrying out significant case reviews since 2007 (in chapter 6 of *Protecting Children and Young People: Interim Guidance for Child Protection Committees for Conducting a Significant Case Review*). Although, as in Northern Ireland, local child protection committees have some discretion about whether or not to involve families, the benefits of ‘involving and taking the family with you’ have been emphasised. Scotland offers helpful detail about how to manage the involvement and support of families. The guidance suggests ways of engaging with the family, emphasising that care should be taken about where and when a child or their family/carers are interviewed (para 72) and states that reviewers should be experienced in communicating with children. It suggests that it may be useful to assign a member of staff as a liaison point throughout the review noting that the person carrying out this liaison role should be fully aware of the sensitivities and background of the case.

There are expectations in Scotland (and in England since 2010) that an anonymised version of the full report will normally be published and that the executive summary and recommendations will always be published. However, few reports have been published. Scotland’s guidance states that family/carers and/or other significant adults in the child’s life should receive a copy of any report in advance of publication (para 81).

The study identified that little additional local policy and guidance about family involvement was published in the localities of the four nations, and Northern Ireland and Scotland rely entirely on national guidance. Structured website searches revealed that most of the 150 LSCBs in England and the 22 LSCBs in Wales used basic, or only slightly elaborated, national guidance (from *Working Together*) in their local protocols. A minority of English and Welsh LSCBs provided more detail about how families should be supported at each stage of the review process, including seeking necessary consent and cooperation. Some local policies specified that families should be provided with the opportunity to contribute written or verbal views and that families should know what they would be asked in a meeting. Some policies directed panel members to consider how to handle any meeting with sensitivity including, for example, the possibility of making a visit to the family’s home.

A small group of LSCBs in England and Wales provided specimen letters or information leaflets for parents and families which were posted on LSCB websites. These tended to describe the process, the reasons and purposes for family involvement, and how the family would/could be involved and supported.

All four nations are in the midst of revising their guidance about the case review process including the role of family involvement. In England, *Working Together* is being re-written in the light of the Munro review and the recommendation that a systems methodology be used when carrying out a serious case review (Munro, 2011). The specific model suggested by Munro moves away from a prescriptive approach to focus on understanding the local context and reasons why professionals responded as they did (Fish *et al.*, 2008). Although family involvement is still likely to be part of England's new review process, the greater emphasis on professional learning and perspectives may diminish scope for hearing the family's story and views. However, it is argued, moving away from the family story means information about the family would be kept out of the public domain when the review report is published. Likewise, in Wales, a model of review has been developed and piloted that seeks to draw together the learning in a collaborative manner and moves away from prescriptive processes that can inhibit learning.

### **Professional Approaches to Family Involvement**

The content analysis of the professional responses suggested that the drivers for family involvement could be grouped within four broad perspectives:

1. *A rights-based approach*: Family involvement in a review about their child was set out as a fundamental right by review authors and lead professionals. However, for some professionals this right was conditional, with some localities indicating that the perpetrators of the crime(s) against the child would not be included. Others argued that perpetrators were key sources of information and that their information (if provided) could play a crucial role in ensuring the accuracy of the analysis that built the review recommendations.
2. *A child-centred perspective*: A view that family involvement helped keep the child central, and gave voice to the child through the family accounts of their life. Indeed, for report authors the contributions from family members were key to arriving at an understanding of the child's life, the risks that they had encountered and the daily reality of their existence. Innovative methods had been adopted to recount the child's experiences, including the use of drama students to represent the voice of the child and the inclusion of a 'day in the life' account of the child's reality.
3. *A primary source of knowledge and information*: Family accounts of service use and service efficacy were argued to be crucial in arriving at the necessary learning for future policy and practice. Report authors indicated that family members were the source of information about hitherto unknown aspects of the child's life, or revealed significant relationships within the kinship network that had been unacknowledged or unappreciated by professionals.
4. *Recognition of altruistic and cathartic motives*: Professionals acknowledged and understood that families participated to seek resolution and to prevent future tragedies, but the limits of the review in addressing these needs were also acknowledged. Professionals recognised the restricted ways in which the review (with its focus on learning) could adequately meet complex and enduring therapeutic family needs arising from the child's death or injury.

The absence in professional guidance and policy documents of an articulation of the purpose of family involvement inevitably led to variable practice with localities placing different emphasis on family participation.

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**'Identified hindrances and barriers to the participation of family members and significant others'**

The research also identified hindrances and barriers to the participation of family members and significant others, these included the professional cultures in which the review sat (whether participation was valued at a strategic level and the extent to which resources were put in place to facilitate involvement), defensive attitudes by professionals individually and/or collectively (with a reluctance to legitimise family perspectives by inclusion because of the historical nature of the relationship between the family and the agencies), the tensions between various care and criminal proceedings, and the reluctance by some families (despite considerable work by the professionals) to become involved in the review.

Review report authors reported different levels of personal experience in family involvement, and policies and practice guidance rarely addressed the more complex and contested outcomes of family participation for the review processes. Issues such as the arrangements for acknowledging any dissenting family views of report recommendations, the differing needs of children set against adults when participating in reviews and the agreements about family access to ongoing feedback about the implementation of change plans were rarely, if ever, addressed. The realities of participation in this complex context are discussed further within the concluding section of this article, but it is important to note that across the four nations practice and policies that addressed the challenging dilemmas presented by participation were largely underdeveloped, and thus became the subject of the individual decisions and pragmatic responses of report authors and/or individual board members.

**Family Experiences: Making Sense of Professional Processes**

**'Family accounts rarely, if ever, focused purely on the process of participating in the review'**

Family accounts rarely, if ever, focused purely on the process of participating in the review. Families wanted to describe, and reflect upon, the events leading up to the review and the services received prior to and immediately after the critical incident(s) involving the child. The legacy of this period of time informed and mediated the families' engagement with the review process. Services experienced as chaotic or inadequate prior to the death or serious injury of the child were often experienced as chaotic or inadequate after the incident(s). Families were floundering in the trauma and seriousness of the events, and saw professionals as also experiencing difficulties. Some practitioners were seen as inexperienced, unable to draw upon a maturity of practice to helpfully intervene and respond to the crisis:

'You know this was serious and they really didn't know how to handle it, it's as simple as that, they put a manager in who was inexperienced. . . I blame the people above that social care manager who put him there, he didn't put his hand up and say yeah I'll do that case, somebody put him there and he was not experienced enough. . . .' (Family member)

In some cases, professionals demonstrated thoughtful careful approaches despite the emotionally charged nature of the situation, and were able to build relationships that facilitated professional interventions. Whatever their experiences, for all the families, the activity surrounding the child's death or injury infused their later responses to the review and the opportunities to

participate. Families contextualised the review in these broader experiences of professional responses, and the nature and tone of their engagement with the review process were closely linked to their analysis of the professional responses to the child and the family during the acutely difficult earlier episodes.

‘...and so she knew none of the background, and the huge affect, whereas if she’d have maybe spoken to the XXX beforehand and maybe got the information, some background information, so that she knew what she was going into, that maybe would have given her some preparation of maybe what to discuss and not to discuss, and how sensitive things can be. So I think it’s very important for professionals to get the background information before they go into the family so that they know who they’re dealing with, and maybe what areas are sensitive, so that they can ask open questions and it can be more delicate and more sensitive. I think that’s hugely important...’ (Family member)

Families understood their needs could be overwhelming and provoke resistant professional responses; however, this did not negate their sense that they held valuable knowledge for the review. The families had experienced different but profoundly traumatic loss, often involving sudden violence but rarely without antecedents. (Whilst it was impossible to arrive at a representative sample, the family experiences mirrored broader analyses of trends in child death/serious injury, with family violence, unanticipated events, mental health and neglect being components of the risks faced by the child (Pritchard *et al.*, 2012).) The families all struggled to make sense of the multiple procedures that entered their lives after the critical incidents, and found it difficult to disentangle the different processes and their implications. The families often sought out an informal ‘navigator’ who might assist them by interpreting the professional responses. But for some families the absence of any support in mapping out and describing the various processes was a cause of confusion and anger:

‘... there should be somebody like I say there with (Y) and they should be there, even if (Y’s) ... might be a little bit better now, but that person should be still there in case (Y) needs that person back, you know what I mean, over the years, because this isn’t going to go away a year or two years, this is going to be there for, well it’s going to be there forever isn’t it...’ (Family member)

Hence, by the point that the case review begins, families are already bringing with them preconceived ideas about the nature and quality of support that they are likely to be offered, and the value and purpose of engagement.

Interesting parallels emerged when reading across the data from families and from report authors and policy leads. Professionals driving forward the reviews sought to do so to secure a better understanding of the child’s life and the critical episodes, and to arrive at learning that could support change. Family members also participated in the reviews to secure a fuller understanding about what happened to the child (with the exception of those young people who were themselves the focus of the review) and to achieve change:

‘... it’s incredibly likely to be an opportunity for you to learn more, from two ways, number one you just might find out information which will be disclosed to you, secondly you might learn more because in the process of disclosing you begin to develop your own thoughts and understanding... I believe that participating in a review may be one way in which you can feel as if you have done something, you have told authority, you have told the right people maybe, hopefully... you may be able to bring information to the review for which there are no official records...’ (Family member)

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**‘Families valued approaches to involvement that were flexible and responsive’**

These drivers for participation raise challenging questions about pre knowledge of risk, about perceived purposes of the review and the intentions behind participation. These are addressed in the later discussion, but the link for families into hearing about and witnessing change was a central and common reason for their decision to become involved in the review. The families also frequently sought to gain a fuller understanding of the child’s life and the episode(s) that had led to their injuries or death. The family narratives revealed that assumptions cannot be made about the extent to which the risks facing a child were shared and understood within the family, or the extent to which the child’s family network was engaged by the professionals prior to the critical episodes, reflecting experiences of highly vulnerable families more generally (Morris, 2012). For some family members, the review presented an opportunity to secure an account of the child’s life, but this carried with it difficult consequences in terms of provoking feelings of guilt or resurrecting feelings of inadequacy. For other family members, their unacknowledged presence prior to the death/injuries was simply further reinforced by the review process also failing to engage beyond the immediate carers, leading to frustration about exclusion and the potentially partial nature of the learning.

The family accounts of the process of participation revealed the essential nature of highly skilled practice in this context; families were able to articulate clearly the qualities and capabilities that professionals demonstrated that made a difference to their involvement. The demonstration of care in the most complex of circumstances was critical; thoughtful humane practice was recognised and appreciated. Likewise, hasty, careless practice that aimed to meet procedural requirements was resented and critically recalled. Engaging with the emotion of the situation and being able to recognise the trauma, whatever the antecedents, were valued but the degree of this emotional labour was also recognised by family members:

‘Yes, that sometimes it may not be the people, it may not be the fact that they’re inexperienced professionals, but the fact that the person’s not got any background skills and experience themselves in life, in life themselves, so therefore they’ve got no comprehension and they don’t build up that rapport with the person. . . it’s just the fact that they can’t comprehend it, they can’t do it. . . not walking into somebody and actually saying oh yeah I know, this, this, and this, you know, just actually you know taking a step back and you know, and not being judgemental, allowing that person to sort of speak for themselves. . .’ (Family member)

Families valued approaches to involvement that were flexible and responsive and that were based on a process of negotiation. The failure to be transparent about the gathering and use of information was important – families were sharing intimate accounts and some were unsure about how and why their information had been used:

‘They didn’t include what I’d told them, and there wasn’t enough about my life. . . in future people writing reports should listen to the person that’s talking to them, it’s rude not to listen to them.’

The decision about what a report eventually contains implies a set of messages for families about the relative worth and weight of their information, and such decisions required careful explanation. But, more importantly, for

families there was an enduring sense of frustration about the extent to which they had been able to access the full report. The executive summary was rarely adequate – families wanted to read the full report and to understand very clearly the action plans arising from the learning and recommendations. To be denied this access confirmed deep-rooted suspicions about professional motives and reinforced the marginality that they felt in the process.

The prospect of publication of review reports was resisted by family members; the families could not understand how their identities would not be revealed, an issue of particular concern for surviving siblings. But there was also a frustration that agencies were being reticent in their willingness to share the learning and to adopt the changes. There was an evident sense of confusion about rights and possibilities in these processes, and tensions arising from wanting to hold agencies to account but also wanting privacy maintained. This was played out in families' wishes to preserve their anonymity but also support publication where it was felt that agencies had not been honest, or learnt relevant lessons.

The analysis of professional and family data suggests that there is a set of useful principles that can guide the practice of family involvement. The individual nature of each case renders any prescriptive framework of policies and procedures of limited value. This move towards principles for participation, and away from prescription, reflects the broader national trends in safeguarding and as such will fit well within the current changes in the UK and internationally. In summary, the analysis suggests that the following principles could usefully be adopted when seeking to involve families in case reviews: *clarity of purpose* (which must be clearly articulated for each case); *negotiation* (that includes family input in determining the terms of reference for the review); *transparency in limits and opportunities* (agreement is needed about the level and reach of participation); *inclusivity* (the phrase 'family and significant others' is a useful guide); *sensitivity* (boards and review leads need to exercise considerable professional judgment in the methods and approaches adopted to facilitate participation); and *evaluation* (seeking feedback from family members on the process of any review will enable learning to be developed about family involvement).

### **Conclusion: The Dilemmas for Practice**

Family participation in child protection has historically been the subject of scrutiny and debate (Corby *et al.*, 1996; Featherstone *et al.*, 2011; Ferguson, 2011), and the study indicated that directly comparable debates about the processes and practices of participation were being raised when considering the inclusion of families in case reviews. Research has suggested that practitioners operationalise three principles for participation in protective practices: respect, appropriateness and transparency (Healy and Darlington, 2009). When set in the context of child death and serious injury, these principles for practice raise particular dilemmas. If focused upon service delivery, these principles can be directly related to the construction of safeguarding interventions. In the circumstances of case reviews, where death or severe injury has already occurred, complex debates about rights and responsibilities emerge that diffuse the translation of policy intent into practice.

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**'This move towards principles for participation, and away from prescription, reflects the broader national trends'**

**'In the context of child death and serious injury, these principles for practice raise particular dilemmas'**

**‘policy guidance has steadfastly avoided engagement with these dilemmas’**

**‘The complex emotional landscape that surrounded the policy intentions for participation’**

**‘Discussions are needed about the ‘rules of engagement’ in this process’**

**‘What are legitimate reasons for withholding the final report from those who provided the critical information?’**

Family participation in this context raises uncomfortable questions for practice, and, as the study indicated, policy guidance has steadfastly avoided engagement with these dilemmas. Notions of respect, appropriateness and transparency take on a different hue where family members or significant others are the subject of public, and at times professional, vilification. At the heart of these dilemmas are professional judgments about the legitimate role of families in supporting professional learning and system change.

Case reviews take place where profound failings have already occurred within family systems and within professional systems. In seeking to involve families in reviews, professional consideration has to be given to the value and weight attached to their involvement, whatever the roles played by family members in the child’s life or death. This is difficult territory, as evidenced by the response of a safeguarding board manager who explicitly rejected the invitation for families to become involved in the research, arguing this to be an appropriate response given the family’s failure to safeguard their child (ren). This reaction, suggesting that family failings prior to the critical incident negated their right to involvement in the research, revealed the complex emotional landscape that surrounded the policy intentions for participation. The decision by some boards to exclude perpetrators from their review process further illustrated the reality that professional judgments are being exercised about the ‘deserved’ nature of participation. Whilst the evidence is clear that the involvement of family/significant others offers unique knowledge (irrespective of their role in the child’s life or death), this recognition alone will not necessarily address the ethical dilemmas posed. The difficulties of supporting involvement are often compounded by the concurrent nature of contradictory professional interventions. Families may be the subject of scrutiny and have their parental rights curtailed (in respect of surviving siblings), whilst also being invited to play a role in supporting the learning of those same agencies mandated to formal compromise their rights. As Mayer (2009) suggests, for professionals to navigate these contradictory sets of activities requires a level of finesse in practice that systems may struggle to accommodate.

Consequently, discussions are needed about the ‘rules of engagement’ in this process. Questions arise in examining family involvement. Whilst family information and knowledge may be critical in understanding what happened and what should change, does this bring with it rights for the family in endorsing or dissenting from the review recommendations? Likewise, if promoting learning is a shared endeavour amongst family members and professionals, to what extent should family members be able to hold to account agencies for the implementation of changes? Finally, if family information is central to the analysis, what are legitimate reasons for withholding the final report from those who provided the critical information? (The need to address new requirements for publication then produces further tensions about the extent and nature of family information included in the report.)

These questions, concerned as they are with the realities of participation and the negotiation of rights and responsibilities, reveal the need for the principles informing participation to be articulated. A pattern of intent and expectation of participation is being built across the UK, but this research indicates that without the drivers for involvement being clearly set out, difficult and unintended practice dilemmas will arise. As a result, families will encounter

variable practices that may either further damage working relationships or facilitate and support learning partnerships.

As new models for reviewing emerge, so new debates about family participation also emerge. In the renewed focus on learning that seeks to pull away from culpability and censure and instead focuses upon systems analysis that can inform change (Fish *et al.*, 2008), there is an argument that the family narrative requires less prominence. If this is the anticipated outcome, this must be set against the findings that indicate family contributions are central to the comprehensive understandings necessary to support the learning. This study suggests that there are incremental and to some extent pragmatic changes that can be made to secure effective participation, including guidance for families and suggested principles for policies. However, broader questions are raised about the nature of the learning partnership that can and should be built between families and professionals in this contentious area of practice. The positive outcomes of family involvement in child protection services have an established evidence base, both nationally and internationally (Morris, 2011). But the evidence also indicates that inclusion remains a challenging aspect of protective practice. The experiences of families participating in reviews reflected these tensions, and, at times, gave a stark reality to the ethical and practical dilemmas that active family participation generates.

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**‘Inclusion remains a challenging aspect of protective practice’**

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