Institute for Systemic Leadership

# What Baby Peter Connelly teaches us about leadership

In his tragically short life Baby P (Peter Connelly) learnt how cruel a place the world can be. But he taught us a great deal about systemic failure and leadership, and how it was denied him. Here we recount his story and offer the key lessons and messages about the new discipline of systemic leadership.

The extracts below are taken from the book The Search for Leadership: An Organisational Perspective (Author William Tate, published by Triarchy Press on 21 May 2009).

## The earlier case of Victoria Climbié

'Another high-profile case occurred in local government: the murder of eight years-old Victoria Climbié in the London Borough of Haringey in 2000. In June 2005 Lisa Arthurworrey, the disgraced social worker at the heart of the series of mistakes that failed to prevent Climbié's murder, launched a legal attempt to win back her good name. She argued that she had been made a scapegoat to protect senior officers in Haringey Council. Her appeal was successful. Reported systems deficiencies in Haringey included the following:-

- an unreasonably high caseload
- lengthy investigation of cases lasting months and even years
- a culture that was hostile to cooperating with the police (there was a sign pinned on the wall 'No Police')
- flawed local procedures at odds with national guidance
- an absence of supervision
- a lack of people for social workers to share case worries with
- an unclear structure of accountability.

## Baby Peter

Just two years later, in 2007, something similar happened again in the London Borough of Haringey, only a few streets away from Climbié's murder. This time Baby Peter was killed by his mother Tracey Connelly and her accomplices Jason Owen and Steven Barker. His injuries included a broken back, gashes to his head, a fractured shinbone, a ripped ear, blackened fingers and toes, a missing fingernail, skin torn from his nose and mouth, cuts on his neck and a tooth knocked out.

Instinctively, we look for an individual in authority to blame: if not a social worker, then the pediatrician who examined Baby Peter and failed to notice the child's back had been broken. In a tragic case like this, we assume that it's a matter of someone's professional incompetence, carelessness or neglect. There may well be an element of that, but systemic issues always begin to surface after a few days, such as professional agencies who didn't share information. Even the pediatrician is able to describe her environment as problematic: she was not handed appropriate background file notes.

In this tragic case, systemic failures that were reported included:

- insufficient strategic leadership and management across the board

- failure to comply with recommendations about written records
- failure by the local safeguarding children board to question the agencies that reported to it
- lack of independence in its approach
- lack of communication and collaboration between agencies
- failure to identify and address the needs of children at immediate risk of harm
- inconsistent quality of frontline practice among all those involved in child protection.

## How the service operates

Looking at how the service operates we find 'the government has now centralised the system and, crucially, split it between a front-end referral and assessment function that filters incoming cases, and a back end that handles demand for ongoing care'. Baby Peter was seen on 60 occasions by Haringey officials, the police and hospitals, yet very few professionals saw him more than once. The new working system replaced the local teams that had had responsibility for handling cases from start to finish. At its heart is the Integrated Children's System (ICS), a computerised recording, performance management and data-sharing system, which relentlessly chivvies officials to complete their on-screen documents.

## The effect of the computer system

Workers report being more worried about missed deadlines than missed visits … The computer system regularly takes up 80% of their day. … use of tick boxes was criticised because of a lack of precision that could lead to inaccuracy. … If you go into a social work office today there is no chatter, it is just people tapping at computers.

Work by Sue White from Lancaster University highlights the role of the ICS in her explanation:
*'ICS's onerous workflows and forms compound difficulties in meeting government-imposed timescales and targets. Social workers are acutely concerned with performance targets, such as moving the cases flashing in red on their screens into the next phase of the workflow within the timescale. ... social workers report spending between 60% and 80% of their time at the computer screen.'*

## Discontinuity

John Seddon of Vanguard Consulting explains why children get seen by lots of different people. Every time a child is referred, it is treated by the IT system as a 'new' case. Those who visit will be predisposed to avoid taking the child on. Why? If you take a child on, the computer system will allocate 'workflow' activity targets, hard-wired to a status that gets managers hovering if anything is 'going red'. It is better to discount relatives' or neighbours' reports and/or find any reason not to take the child on.

Some systemic questions about leadership arise:

- Who has clear responsibility for social workers' environment (for what surrounds them, separately from their competence and daily performance; i.e. for the fishtank rather than the fish)?
- Who has responsibility for the design, functioning, monitoring and improvement of the system within which social workers are required to perform their jobs, and for how this responsibility is divided between the local authority and the government's Department for Children, Schools and Families?
- How is the accountability for these aspects of officials' performance managed in the ordinary course of events; i.e. before things go wrong (including the roles of elected councilors, since they were deemed to have failed too and were removed)?
- When serious cases are reviewed (as they are regularly), how do they guard against unconsciously

noticing only evidence that supports their earlier decision? Do they, for example, use a Devil's Advocate? Do they use different chairpersons to avoid defensive behaviour?

The danger is that, in place of clear answers to such tough questions, the public will yet again be offered the balm of 'lessons will be learned'.

## Playing politics

Almost as shocking as Baby Peter's death is the naivety shown by Ed Balls, the UK government's Secretary of State for Children, Schools and Families, who insists that 'there is nothing wrong with the system and Haringey was a special case'. Has he not read Ofsted's report? Instead Balls has ordered council children's services chiefs to undergo intensive training programmes. Without wishing to discount training, it should be recognised that it has less leverage in situations like this than other systemic interventions.

He went on: 'We must do more to value good leadership across the whole of children's services'. He makes the common mistake of equating training with improved leadership. If ever evidence was needed of the importance of understanding and taking a systemic leadership perspective and the uphill battle of awakening influential figures to it, the minister's woeful response provides it.

## Sharon Shoesmith

Sharon Shoesmith, the dismissed Director of Children and Young Persons Services in the London Borough of Haringey, was criticised for providing insufficient strategic oversight to her department. As with Lisa Arthurworrey in the Climbié case, Shoesmith became a scapegoat, conveniently protecting the minister Ed Balls, Ofsted and others who had a share in the responsibility for the design and running of the failed [national] child protection system.

## Senior executives' role options

This raises the question of how clearly Shoesmith saw her role and involvement in Systems 1, 2 and 3. [NB: This structure of three 'role systems' which every senior executive has available to call upon is explained fully in the book on pages 215-218.] How did she allocate her time – between delivering today under the present system ('System 1') and improving the system to secure tomorrow ('System 2'), and between a hands-on role leading change ('System 2') and an overseeing one where others seek and propose solutions and make the change ('System 3')?

For senior executives there is a risk of becoming reactive to the needs and demands of others … of confusing the three role systems, of ending up responding to the urgent and tactical short term ahead of the important and strategic longer term, and of addressing the people rather than the system. This is a difficult enough balancing act if undertaken consciously. It is almost impossible without the help of a mental model like that above, a coach to prompt reflection, and a superior to ensure accountability.

## Shoesmith's supervision

This raises another important question in the Baby Peter case: what role in this scenario was being played by the person to whom Shoesmith had to account for her performance? Was it clear to her? Was it clear to them?

In seeking improvement the starting point is to change senior executives' perceptions of their various roles

and involvement in these three systems. Such a discussion should be part of a performance review.

## Risks if there is no System 2 or System 3

Without a mental model of the kind described above, there is a risk that incidents will be 'solved' by finding someone to blame, an explanation ('staff member sick'), by someone being asked to make a procedural fix, and then by offering customers, the public and media a reassurance that 'lessons have been learnt'. What is usually missing is a process of developing and culturally embedding the permanent systemic leadership capability that the organisation needs.

## Accountability for child protection

An increasingly common problem for organisations is that the everyday operational system crosses many boundaries. In the case of child protection services, there are several major parties who collectively deliver that system. These include the local authority, police, schools and hospitals. Added to this list are several other bodies and agencies: the government's Department for Children, Schools and Families, Ofsted, the Healthcare Commission and the Audit Commission. There is also the cross-party Commons Select Committee for Children, Schools and Families, which can summon officials to appear before it and ask them to account for their action, yet which has no formal authority to hold them accountable.

In Baby Peter's case, Haringey Council's Director of Children and Young Persons Services seemed to be expected to hold the ring and shoulder the blame for the system's failings. But she didn't design the overall system, or the national IT system that supports it.
In complex systems like this the government needs to be more clear about where accountably lies and how a fair accountability process should operate.

## Single-point or multiple accountability

Popular advice seems to be to make an individual alone clearly responsible for an activity. Conventional wisdom says this assists that person's motivation. It is also claimed to be easier to hold them to account when things go wrong; if several people are collectively involved it is more difficult to pinpoint where responsibility for failure rests. … but the advice in favour of having a single person who is responsible and who alone can be held to account may simply not accord with the modern-day realities of complex organisations. As we saw with the Baby Peter case, this is particularly so where partnership working is built into the structure, where responsibilities may need to be held jointly. In such instances, a system for holding numbers of managers jointly to account would be appropriate and should be used, but this is rarely practised.

## A duty to cooperate

In connection with the Victoria Climbié case the Audit Commission report identified that Children's Trusts were failing to ensure that the various parties were fulfilling their duty to cooperate. So what did the Government do? It announced that it would hold each of the parties individually to account. At first glance this sounds fine, but it is actually the opposite of what the government should be doing. Individual accountability reinforces each party's perception from their own silo's perspective and encourages them to point the finger elsewhere. If you want the parties to see themselves as a joint service and to be managed as a team, they need to be held to account collectively. In practical terms that means two things:
First, they must be brought together and collectively charged with proposing upwards (to government – effectively the Secretary of State for Health) for how they will themselves collectively manage their duty to cooperate. Secondly, they must be brought together to account to government for how they have cooperated

collectively.

## A question of competence – but whose?

Was the failure in Haringey's child protection service caused by individuals' incompetence? The book critically examines the contribution made by competency frameworks to any corporation's leadership development and improvement. After major failure, the gut response of most people including the media and government ministers is to find out whose performance showed a lack of competence. The Ofsted inspector's focus *'is on corporate and collective competence and delivered system performance, because that is what the public ultimately requires from child protection services'*. A particular social worker's (or even departmental director's competence – whether assessed as a capability or as actually performed) is a subset of that, although it is what most people, including the media and government ministers, choose to concentrate on in cases like this.

## Measure for Measure

The case provides a graphic reminder of how measures of competence (both individual and collective) in a Council's Department of Children and Young Persons Services serve as a simple and simplistic proxy for the complexity of real performance. There are several reasons why these measures can never constitute actual performance:

- The measures comprise a limited range of metrics deemed by certain planners to be sufficiently indicative of overall performance.
- The metrics are chosen because they are measurable (e.g. completion of records), while important but immeasurable ones are omitted (e.g. quality of relationships).
- The measures represent just one party's contribution (i.e. the Council's) in a complex web of interactions within a wider system that includes police, schools and hospitals.
- The measures require an inspection, which is a subjective process that calls for interpretation.
- The managers who are the target of the inspection selectively provide the data to an Ofsted inspector.

## Where were the hidden incentives in the system?

Ofsted's routine inspection of Haringey's Children and Young Persons Services beginning in November 2006 and published in November 2007 (shortly after Baby Peter's death in August) had ticked all the right boxes and awarded the department '3 Star' status of 'Good'.

Yet a year later when Ofsted, the Healthcare Commission and Police conducted an enquiry into the department, it found gross systemic failure, at which point Ed Balls, the government's Secretary of State for Children, Schools and Families, removed Haringey's director from her post. How could Ofsted effectively overturn its judgement? An inquiry into the inquiry showed that Ofsted had originally allowed itself to be hoodwinked. The assessment method was open to manipulation. 'Officials in the Council were able to "hide behind" false data to earn themselves a good rating'. The motives are clear: successfully jumping through the government's hoops brings resources, money and political advantage.

## It's the wrong question

The problem lies with the inspector's question. That question forms a crucial part of managers' environment. Inspectors are interested in the question: 'Is the service up to standard?'. A high rating lets everyone relax, and a low one damns them. This is the wrong question to be asking. They should be asking: 'What are you

doing to improve?'. A culture of learning and continual improvement would then replace a culture of cheating. Volition in an improvement mindset is very different from that engendered by a compliance one.

## Keeping leadership in mind

When taking up their job, most managers who see themselves as having a clear leadership role gradually lose sight of their high hopes and aspirations for change and improvement. They fall victim to the pressures that come upon them. They find themselves reacting to demands, requests and circumstances. The managers become bureaucratised; their jobs are eroded by entropy. They forget why they were put there.

The challenge to overcome this trap is mental. All managers should produce and then keep alive in their mind a plan for how to structure, prioritise and use time and resources for that part of the job that concerns their leadership role. They need to write answers to these questions on a piece of paper, keep it to hand, remind themselves, and reflect frequently on them:

- What am I trying to achieve with my leadership?
- What do I need to change around here?
- Who are my customers and what leadership do they need from me?
- What are my leadership priorities?
- How will I manage the time I need to allocate to my leadership role?
- How will I enable others to use their leadership?
- What is the system doing to me and what am I doing to the system?
- How will I successfully account for my leadership?

[Update: Following strong criticism of the Government-imposed Integrated Computer System (ICS), on 22 June 2009 the Government announced that it was rescinding the requirement for local authorities to use the ICS or lose funding. With immediate effect they would be free to use local discretion within a simplified national framework.]

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# ADVICE TO THE MUNRO REVIEW
# Leadership principles

*We can't solve problems by using the same kind of thinking we used when we created them. (Albert Einstein)*

1. Implementing the Munro recommendations successfully will require high levels of both management and leadership expertise. If they are to meet the future challenges, authorities, officials, members and partners are likely to see this challenge as significantly different in focus and capability from hitherto.

2. Managers have to satisfy the organisation's needs of both today and tomorrow. On the one hand, they provide day-to-day stable and consistent management of child protection services, while also exercising leadership to challenge and bring about change and improvement focused on securing a better future. They also need to balance improving service efficiency and effectiveness, sometimes under tight budget pressures. At a senior level, leadership activity itself divides between an official's hands-on change-leading role and the supervision or oversight of other managers who are engaged in direct leadership action and programmes. These multiple roles call for awareness, discipline and good time management.

3. Among the many challenges of the change process, three stand out:

1. Putting in place particular Munro changes by agreed dates.
2. Over a longer timeframe, developing the working culture in the direction pointed out by Munro.
3. Moving from old to new child protection working arrangements in a way that maintains high standards and minimises transition risks.

The various leadership challenges are explained in greater detail here.

4. Getting leadership right cannot be achieved by concentrating on a small number of senior appointments, by selecting the best strong leaders who will push harder for commitment and compliance. Nor can leadership be assumed to happen by virtue of having good leaders, because leaders are not independent of the system, its capability and relationships. Leadership is much more than authority, and leadership behaviour should be valued and encouraged at all organisation levels.

5. Senior officials should put in place processes to ensure that:

- managers have clearly demarcated accountable roles and are formally held to account for delivering leadership in them
- understand and perceive a leadership role for themselves as a key component of their job
- that this leadership role contributes improvements to the way the system learns and works
- and that this leadership role is reinforced through managerial processes and in formal learning experiences.

Distributed leadership is crucial to managerial empowerment and being part of change and not part of those needing to be convinced of others' planned change. It calls for care over organisation design and management structures and processes.

6. Leadership is best understood as a process, one that is manifested not just by many individual managers, but also in relationships, and in the spaces between partner agencies. Leadership is a property of the system as well as of individuals, and a resource to be husbanded. The aim is for that system to be demonstrably well led holistically and not simply be known for having good individual leaders.

7. Appropriate governance and performance management systems need to be in place for ensuring that leadership performance (in addition to meeting agreed child protection measures) is managed, delivered, improved, and requirements made clear, at all points where leadership is needed. The delivery of required outcomes should be actively managed though a process by which accountable senior officials and members (whether singly, and as colleague teams and partners where appropriate) are held to account by appearing before appropriate officials and bodies, both regularly and ad hoc in connection with specific change delivery requirements.

8. Leadership in a managerial hierarchy sometimes feels like a zero-sum game; but success for those leading does not need to be at the expense of those who are led. A system's capacity for leadership can always be expanded. Realising leadership capacity and using leadership opportunities takes time and effort to build. By contrast, leadership waste in organisations – particularly down gaps between managers, teams, functions and partners – is widespread and an act of managerial carelessness. Where child protection systems have failed catastrophically on occasions, the organisation's system of leadership has usually failed in one or more ways. For improvement to come about, leadership waste needs managing as much as leadership development.

9. Managers should use their leadership role to monitor (i) the way the system is continually learning and improving, (ii) what the system requires of front-line workers, and (iii) how healthy and free of toxicity is the system that surrounds workers. They will need a high level of awareness of how organisations perform as systems. (See Munro report 1)

10. The nature of modern leadership of complex adaptive systems was set out in Munro Report 1.

11. To achieve the above, councils should specifically review their leadership process and leadership culture, and develop a strategy for making improvements.

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# APPLYING SYSTEMIC LEADERSHIP
# A facilitation approach for improving leadership

The question of leadership always arises when a major programme is going to fundamentally change the way the organisation works. Deep systemic change has an impact *on* leadership, and change makes new demands *of* leadership. The process of leadership inevitably will, but also must, change.

Two things in particular stand out. First, the leadership that is required has to take account of how organisations are, and interact as, systems. Secondly, lots of leadership is needed, coming from all levels, not just a few top managers. This calls for a clear and new leadership agenda, one that addresses the required leadership strategy, learning and support needed to embed new ways of working, especially ways that see the organisation as a system. Systemic leadership is a process for understanding, expanding, releasing, promoting, improving and applying the organisation's leadership capability. The approach blends the understanding of how an organisation works that comes from *systems thinking*, with leadership interventions that draw on *organisation development*.

This is an applied method. It works on practical leadership issues that affect managers as they try to exercise new ways of leading. The practical issues concern what managers are trying to achieve, what gets in the way, and what is needed from the system to free up and make use of available leadership energy. This approach is different from teaching individuals leadership theory in a classroom and hoping that they will find useful things to apply their learning to. We are more concerned with what is happening outside the classroom than inside it. Classroom time is used mainly for practical workshops, with easy access to relevant systems leadership theory as required. The key point for the organisation is that the learning has to escape from the classroom and from individuals' heads and be applied and used to challenge, change and deliver.

The aim is to target benefit on the whole organisation. What matters is that the organisation should be well led as a whole. Having good individual leaders is not sufficient. Many managers will already be excellent leaders anyway. We do not formally attempt to teach leadership to managers. We work with the system wherever leadership is and where it needs to be, and wherever issues and opportunities arise, so that the system manifests leadership that is continually improving. The learning dynamic is live and experiential, not formal, predictable and controlled, mirroring the work environment in which leadership is increasingly situated.

This means working at the point where people and the organisation's daily practicalities come together. Sometimes the work and the learning is planned, as in workshops and in coaching, mentoring and guiding sessions, and sometimes more spontaneous with support to hand, including by phone and email. These practicalities include all those things that go on around and between people as they try to go about exercising personal leadership in a dynamic and political environment. Think of this like a fishtank. The leader needs to be able to see and give attention to what people, including managers, are expected to swim in as well as what they are personally good at doing. How healthy is the 'fishtank'? Who ensures that it's clean? Where does nourishment come from? And what about toxins? The 'system' that surrounds people is very powerful and explains much about how well they perform, either providing opportunities or blocking them. This system – including leadership-related policies, practices, procedures and structures – may itself need redesign; for example, performance management systems and how managers are held accountable specifically for their

leadership. Leadership is a frequent victim of waste, and this too needs to be discovered and stopped.

Our approach to leadership is not an intervention or an event or simply a series of workshops. It is a more like a way of living leadership. It means leading an organisation in a way that deeply affects and infects the culture. It becomes 'the way we do leadership round here'. It is concerned with more than implementing a change programme by some planned end date. It's more like a virus, changing the way managers see their role as leaders, how they make their choices, and how the system responds.

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# The fishtank metaphor

The fishtank metaphor appears frequently in *The Search for Leadership* and the *Systemic Leadership Toolkit*. The description below is an extract from the Toolkit.

We can liken an organisation to a fishtank, with the managers and other employees as the fish. The system elements listed above become social and environmental influences on the fish.

The fish (people) need to navigate, swim and survive in these waters. The waters contain essential nutrients, but they are rarely pure, clear and favourable. In fact, they are often toxic and opaque, the cause of much confusion, unclear vision and stress.

The waters contain unseen but strongly felt undercurrents in their shadows that are part of what surrounds everyone, including managers when they try to take a leadership role. The result is frequently a collapse of over-stressed individual fish, and in extreme circumstances the tank as a whole ('systemic failure').

In this murky environment managers are expected to exercise leadership. It is also their job to clean the tank. Unhelpfully, the toxins may come from above, though that's not the default management assumption. Not able to see the tank for what it is, and not knowing how to set about cleaning their environment, some flounder in the shallows and do what is easiest: they seek out the small fry. When not bearing down on them, they take them out, tell them to smarten up, make them look good with a little training, say if they're good they'll reward them with a bonus, and plop them back into the same murky water.

Some of the system elements have aspects that are as intended and designed; they comprise the legitimate or official system.

Other aspects are unintended, including 'unwritten rules', politics, grapevine, friendships, etc; they comprise the informal or shadow system.

Both the official/formal system and the unofficial/shadow system have positive and negative effects on the fish: both systems can be supportive, and both can make the 'water' toxic and inhibit the free exercise of honourable, transparent and energetic leadership.

The system's combined effect on permitting or frustrating leadership is more powerful than any individual manager's skills, behaviours or personality.

All of which leads to the moral of this story: (as one book reviewer put it) "stop polishing the fish and tackle the water they swim in".

You may also like to see 'How to improve the fishtank.