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A Systems Approach to Investigating Child Abuse Deaths

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Summary

A new systemic approach to investigating child abuse deaths is proposed, drawing on the lessons learned in engineering. Investigations have traditionally taken the approach of concluding once faults in professional practice are identified. Solutions take the form of trying to control erratic practitioners: psychological pressure to achieve higher standards, increasing formalization and guidelines to reduce the scope for individual fallibility, and stricter management surveillance. The inquiry into the death of Victoria Climbie fits this model. However, thirty years of such inquiries have not led to the expected improvement in professional practice. Indeed, the *Climbie* report describes several agencies operating at a very low level, and failing to implement the most basic elements of good practice. A similar history of failure in engineering has led to the development of a systems approach. Human error is taken as the starting point, not the conclusion, and the investigation tries to understand *why* the mistake was made, by studying interacting factors in the practitioners, the resources available and the organizational context. The way this approach could be adopted in child protection work is outlined.

Keywords: Child protection, errors, inquiries, systems

Introduction

> 'If at first you don't succeed, try, try again.'

This inspirational proverb has clearly been followed in UK attempts to improve child protection services. However, there comes a point when its wisdom needs to be questioned; perhaps it is time that another well known saying took precedence:

> 'Don't keep hitting your head against a brick wall.'

The publication of the report into the death of Victoria Climbie (Department of Health, 2003) is such a turning point. It bears a strong resemblance to its numerous predecessors, both in its analysis of what went wrong and its recommendations for preventing further tragedies. But, having read all inquiry reports published since 1973, I find it strikingly different in one respect: it describes a level of practice breathtakingly worse than any of its forerunners. The types of errors are similar but they are far more prevalent—in all professions and on numerous occasions—indicating a sharp and widespread fall in standards of practice. Moreover, there has been a steep drop in staff morale and an accompanying rise in problems in recruiting and keeping experienced workers (Audit Commission, 2002). The social work departments involved in Victoria's care were relying heavily on short-term agency staff not trained in the UK. Despite strenuous efforts to improve children's safety, services seem to be getting worse. The long series of public inquiries have been expensive and stressful. They have been intelligently conducted; their analyses of practice look accurate; and their recommendations seem very sensible. Yet, they are not leading to the desired improvements in outcomes for children and families.

It is time to stop, reflect and ask whether there is an alternative way of approaching the problem. Fortunately, there is. Engineering has a similar history: repeated inquiries into disasters, such as plane crashes or nuclear power plant accidents, produced well reasoned recommendations and were then followed by further disasters, revealing that the proposed solutions were either not fully implemented or failed to have the desired effect (Reason, 1990; Woods *et al.*, 1994). The lesson that has been drawn is that these traditional inquiries were too narrow. They tended to look, first, for a technical failing and then attention turned to human performance. If human error was found—a technician did not notice a warning light, say, or a pilot misinterpreted an instrument reading—then this was considered a satisfactory account of why things went wrong. If they had taken the 'right' action, then the disaster would not have happened. Solutions then focused on trying to reduce human lapses, using three strategies: psychological pressure to work more diligently, increased automation or formalization of the tasks to reduce or remove the scope for human (fallible) judgement, and, thirdly, closer monitoring of front line operators to ensure that instructions were followed.

This approach, though, did not eradicate the problems and, indeed, in some cases appeared to create new problems. In aviation, for example, engineers automated as many of the pilot's tasks as they could on the assumption that more automation is better: '... the parts that could be automated *were* automated, and the leftovers given to humans' (Norman, 1993, p. 47). Unfortunately, this meant that the elements left for the pilots became more difficult. It is typically when the instruments malfunction that pilots have to intervene, but they now had to do so with less information to guide them. In the early days of aviation, pilots would have been flying the plane with the assistance of a few pieces of equipment and with a constant awareness of what was going on. If something

went wrong, they would have an emerging picture of where and how the problem was arising, and this would help them to diagnose it and take steps to solve it. Once most of the processes had been automated, planes were basically flown by computers, with pilots having little knowledge of what was going on. If something went wrong and they had to intervene, they had limited knowledge of how the problem had arisen. When they then misinterpreted the situation and the plane crashed, it was attributed to 'human error'; the solution was then seen to be to increase the automation, but this in fact exacerbated the problem by making the tasks left over for the pilots even harder.

The traditional style of investigation is now being superseded by a systemic approach. Instead of stopping when human error is found, investigations take this as a starting point: Why are humans in those circumstances performing badly? What demands do the tasks make on the operators' knowledge and skills? Does this particular individual have the necessary capabilities, and are the demands, in fact, realistic, given what we know of human reasoning skills? How do these tasks interact with the other demands being made on the operator?

Disasters are rarely found to happen because of one major mistake by one grossly incompetent worker but to be the result of a system operating with a chronic pattern of small errors or omissions, most of which have no serious adverse effect but which, on one tragic occasion, come together to lead to a major accident. Solutions, then, do not take the form of rebuking the front line worker who happened to perform the final mistake in this long causal sequence. It is, instead, necessary to examine the system to see if a better match can be achieved between the tasks and the workforce's skills, knowledge and resources.

The parallels with child protection are clear. Inquiries have typically ended once professional mistakes have been found. Social workers failed to interview the child; the health visitor misinterpreted the evidence she had been given; the doctor did not share crucial information with other professionals. The cumulative results of thirty years of child abuse inquiries have created the traditional solutions: psychological pressure to avoid mistakes, increasingly detailed procedures and guidelines, strengthened managerial control to ensure compliance, and steady erosion of the scope for individual professional judgement through use of standardized protocols, assessment frameworks and decision-making aids (e.g. Department of Health, 1999). And the parallels also extend to discovering that the solutions are not working as expected but appear to be creating new problems.

This article outlines the framework of a system-centred inquiry. Using the case of Victoria Climbie as an illustration, it shows how it would add to the traditional inquiry by exploring new questions and offering novel types of solutions.

System-centred inquiries

The cornerstone of the paradigm shift for understanding error is to take human error as the starting point of an investigation, not as the ending (Rasmussen, 1986). The *Climbie* report has a conclusion:

> Victoria died because those responsible for her care adopted poor practice standards. These were allowed to persist in the absence of effective supervision and monitoring (Department of Health, 2003, para. 6.94).

But why did so many professionals adopt poor practice standards? Why did intelligent, motivated individuals who had chosen to enter a caring profession and work with distressed children function at such a low level? This is the key question if we are to find solutions that are effective.

A systems-centred approach looks for causal explanations of error in all parts of the system, not just within the individual. When a traditional investigation identifies human error as a cause, it is assumed that the person who erred 'could have acted differently'—that he or she can be held responsible for omitting a crucial step or misinterpreting a vital piece of information. The systems approach has a more complicated picture of causality. The human operator is only one factor; the final outcome is a product of the *interaction* of the individual with the rest of the system. It has been found that human errors are not usually random but can be understood and predicted by seeing them in this wider context.

If, for example, you ask people for their mobile phone numbers, they often struggle; they have to look them up or make mistakes as they quote the number. This can be classed as human error but it is not a mysterious result. It is quite predictable, given the design of the mobile phone system. The numbers are eleven digits long and human short-term memory can handle about seven items (plus or minus two) (Simon, 1990). It is therefore not surprising that people have difficulty dealing with eleven digits. The traditional phone number system gives the memory an easier task because although the numbers can be just as long, they are systematically grouped. So a number, for instance, has an area code, a local code and then only the last four digits are unique to a particular phone. This means that the task is to learn only six items: the two area codes are learned as single groups.

When someone misquotes a mobile phone number, they have made a human error but part of the cause lies in the design of a system not well tailored for use by human beings. If we want to reduce the error, rebuking people and telling them to try harder will have limited success. A more effective solution would be achieved by altering the design so that the cognitive task asked of humans fell more readily within human competence. This, in essence, is the type of solution sought by a systems investigation.

Human performance needs to be understood in its wider context. Woods *et al.* (1994, p. 21) provide the following diagram to illustrate the layers of analysis (see Fig. 1).

At the 'sharp end' of the system, practitioners interact with children and parents. Effective help or failure arises from the interplay of the difficulties presented by families' problems and the expertise and resources of practitioners. Influences on the actual level of performance achieved can be grouped into three layers:

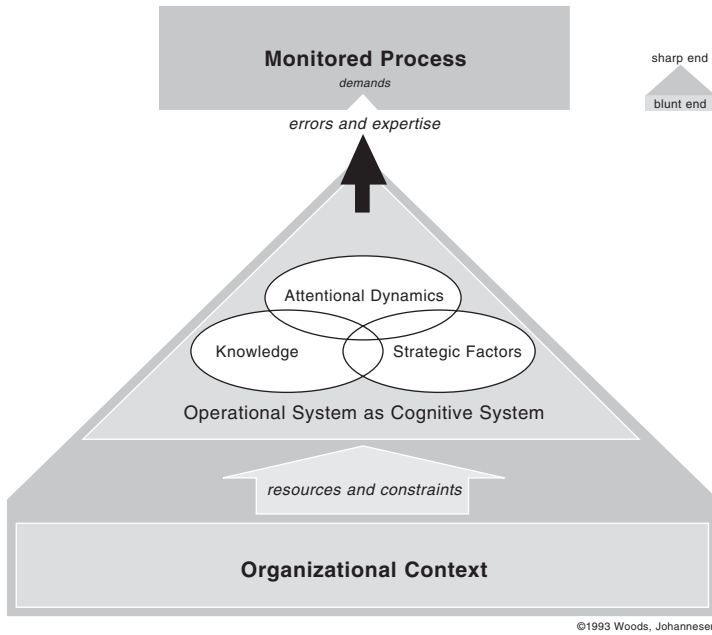

Figure 1 Elements in an organizational system

1 factors in the individual;
2 resources and constraints;
3 organizational context.

(1) Factors in the individual

When we are looking at a tragedy, we are blessed with hindsight, so it is strikingly obvious to us which items of information were crucial or what actions were essential. We therefore feel amazed at the apparent stupidity of the people involved at the time. However, psychology research has shown that we are profoundly influenced by knowledge of the outcome when we look at past events and hindsight makes us overestimate what other people should have been able to anticipate in foresight (Fischhoff, 1982).

> For those who pick over the bones of other people's disasters, it often seems incredible that these warnings and human failures, seemingly so obvious in retrospect, should have gone unnoticed at the time. Being blessed with both uninvolvement and hindsight, it is a great temptation for retrospective observers to slip into a censorious frame of mind and to wonder at how these people could have been so blind, stupid, arrogant, ignorant or reckless (Reason, 1990, p. 214).

Lord Lamming, the Chair of the *Climbie* inquiry, expresses this sense of puzzlement on hearing the history of Victoria's contact with professionals:

> Even after listening to all the evidence, I remain amazed that nobody in any of the key agencies had the presence of mind to follow what are relatively straightforward procedures on how to respond to a child about whom there is a concern of deliberate harm (Department of Health, 2003, para. 1.19).

There is both a moral and a legal need to judge professional practice but if our aim is to minimize future mistakes, we need to go further and try to understand the 'local rationality' (Woods *et al*., 1994): how the situation looked from the point of view of those involved so that they mistakenly saw that particular course of action as a reasonable option. It is by investigating the factors that influenced the cognition and the behaviour of groups of people that new, more effective solutions can be developed.

In reconstructing local rationality, we need a realistic idea of human reasoning skills. The paradigm image of rationality is of an individual rapt in thought, contemplating all the evidence before reaching a conclusion (exemplified in Rodin's statue, 'The Thinker'). However, in reality, cognition is rarely an isolated act. In child protection work, it is (a) part of a constant stream of activity, (b) often spread across groups, not located solely in an individual, and (c) those groups exist within an organizational context that limits their activities, sets up rewards and punishments, defines goals that are not always consistent and provides resources (Woods *et al*., 1994, p. 45).

In place of the ideal thinker, Simon (1996) put forward the notion of 'bounded rationality'. People have finite capabilities and so simplify the tasks they face in order to make them achievable. We should therefore not judge with the perfect rationality of hindsight but try to understand how they saw the world and their tasks within it so that we can see how their judgements and actions looked rational to them.

Woods *et al*. (1994, p. 48) list three classes of cognitive factors that govern how people form intentions to act: knowledge, attentional and strategic factors.

(a) Knowledge factors—factors related to the knowledge and skills they can draw on in solving problems. It is clear that many of the practitioners involved in Victoria's care lacked the necessary knowledge and skills. The report contains numerous references to the lack of expertise:

> A lack of sufficient numbers of staff with the skills and training necessary to perform the tasks required of them, meant that the systems in place were on the verge of collapse (para. 5.190).

Some of the witnesses acknowledged that they felt insufficiently skilled (see, e.g. para. 6.394). Victoria's key social worker had never conducted an investigation into suspected child abuse before or taken a case through to case conference (para. 6.578). Senior managers in Haringey even confessed that they were not confident that all of the staff had literacy skills and offered this as an explanation of their failure to read procedure manuals (para. 1.60).

Emotional wisdom is another crucial dimension of the skills needed in child protection work (Reder and Duncan, 1999, 2003). Practitioners need to be able to deal with the strong feelings that permeate the work. They bring their own experience, and sometimes painful memories, to the situation, as well as having to deal with the powerful reactions of parents accused, rightly or wrongly, of being abusive. Physical violence is a common hazard of the job. The children themselves provoke an emotional response; there is a strong human instinct to protect vulnerable children. Failure to deal well with the emotional component of work can adversely affect the families and the practitioners themselves. At the extreme, workers are vulnerable to burnout which has three dimensions: emotional exhaustion, depersonalization (or cynicism) and reduced personal accomplishment (Maslach *et al*., 2001). Exhaustion is the main symptom and it prompts people to distance themselves emotionally and cognitively from their work, with repercussions for the families in contact with them. Research has found that burnout is mainly attributable to situational factors not the personality of the worker (Maslach *et al*., 2001).

Burnout may be responsible for one puzzling aspect of Victoria Climbie's care, namely the apparent lack of compassion shown to her. The media's emotive coverage of the case gave the impression that those involved in Victoria's care were feckless, uncaring people who were indifferent to the suffering of a child. A moment's reflection shows that this is unlikely, or, at least, if they are now feckless and uncaring, then something must have happened to them since they made their career choice. Historically, members of the caring professions have been seen as benign; social workers have even been mocked for their kind hearts as 'do-gooders'. Previous child abuse inquiries have often criticized professionals for being too emotionally involved, often developing such a strong relationship with the parents, for instance, that they are deceived about the child's suffering. Victoria's case was very different. She clearly aroused forceful emotions in the inquiry team and the general public but what is sadly apparent in the report is that, in her last few months of tortured existence, she met little compassion or concern from those employed to help her. There were a few notable exceptions, e.g. the childminder and the duty doctor in the Central Middlesex Casualty Department, but the general impression in the detailed accounts in the report is of a set of professionals busy with specific tasks but not paying attention to the human child at the centre.

(b) *Attentional dynamics*—factors that govern the control of attention and the management of workload as situations evolve over time. The attentional factors are particularly significant when staff are working in adverse conditions. Where was their attention at the time? The inquiry noted that Victoria' s key social worker had a very heavy caseload: she had a total of nineteen cases, half of them child protection, seven more than the maximum set down in the staff handbook (para. 6.209). This meant that information about Victoria was only one component in the new data she was receiving daily and the total amount may have been more than the human brain can easily manage. The inquiry comments on several things that she *failed* to do but tell us nothing about what she was doing *instead*.

Presumably, they seemed more important to the worker at the time and, without further detail, how can we judge whether she was wrong or not?

One attentional factor that has been found in countless accident investigations in all industries is people's failure to give critical attention to new evidence that should have made them revise their assessment of the situation. 'Evidence discrepant with the agent's or team's current assessment is missed or discounted or rationalized as not really being discrepant with the current assessment' (Woods *et al*., 1994, p. 72). The error has also been noted in reviews of previous inquiries (Reder and Duncan, 1999; Munro, 1999). This failure to revise assessments was apparent in Victoria's case, where the initial decision to classify her as a child in need not as a possible victim of abuse had an enduring effect on the way that social workers responded to new information. Research on reducing this type of error has found that it usually takes a person with a fresh point of view on the situation (Woods *et al*., 1987). Supervisors have, classically, been the people charged with this task in social work but, in Victoria's case, supervision was very limited in time (to thirty minutes over two-hundred-and-eleven days) and scope (para. 6.551). If the system fails to appreciate how hard it is for people to be critical of their own judgements and so undervalues the mechanisms, such as supervision, that help them reflect, then a high rate of errors can be expected.

(c) *Strategic factors*—the tradeoffs among different goals that conflict, especially when the people in the situation must act under uncertainty, risk and the pressure of limited resources (e.g. time pressure, resources, costs).

Child protection work has such conflicts in abundance, some apparently endemic to the work and others created or amplified by the recent organizational changes. How these conflicts are perceived and resolved by practitioners needs to be studied, since they are so influential in the decisions on what course of action to follow.

One enduring conflict in working with children and families is between care and control, between supporting parents and investigating them as abusers, preserving families versus rescuing children. This conflict is currently embodied in the distinction in the 1989 Children Act between section 17—children in need needing support services—and section 47—allegations of abuse, needing investigation. Ideally, social workers should keep both agendas in mind when working with a family, but the *Climbie* report is highly critical of the way that Victoria' s case being classified as a section 17 biased people's perception of the evidence and led to a poor-quality investigation. Her social worker believed the false account of her injuries offered by her great-aunt and told the inquiry 'I had no reason to doubt what she said'. This assumption of honesty suggests the social worker was not seeing the case of one of investigation: if you are asking someone whether they have committed a crime, you have good reason to doubt what they say when they deny it.

Another area of conflict for front line workers that has arisen from recent managerial changes is between spending time with families and completing paperwork.

The audit system, in its current form, imposes a heavy burden of paperwork on front line workers. It may also, inadvertently, be posing a new dilemma. It

tends to measure quantity more than quality. Therefore, extra time and effort put into completing the task as a high level will not be recorded or rewarded and, under pressure, practitioners may be opting for completing the visible aspects of their work for which they will be praised or blamed.

(2) Resources and constraints

This layer of the system includes not only the obvious issues about what services are available to help practitioners resolve families' problems, but also the measures introduced as a result of earlier inquiries to improve performance. One strategy for reducing error has been to increasingly guide and prescribe the actions of front line staff by developing a range of information-processing tools. The design of these tools needs to be examined: do they, as intended, improve human performance or do they, in practice, hinder good reasoning and constructive working relationships with families?

Social work discovered many years ago that good intentions in professionals do not guarantee good outcomes for clients. A similar lesson has been learned in engineering. Good intentions in designers do not necessarily lead to good tools. The problem has been that the traditional approach of technology has taken a machine-centred view of life (Norman, 1993). This has permeated the approach to developing equipment and to automating aspects of any process. In deciding which aspects to automate, engineers have tended to select those that it is technically easy to automate. It seems to be assumed that automation is intrinsically good and any addition is desirable. Little thought is given to whether these are the aspects that humans do badly and where technical assistance is needed. In this approach, humans are left to deal with whatever is left over, regardless of how well suited they are to performing these functions. In designing the equipment, engineers have focused on the problems of designing a machine that performs the desired function; the users of the machine—the human beings—have had to adapt to the needs of the machine rather than vice versa. Subsequently, when errors have occurred, if no mechanical problem can be found in the machine, the tendency has been to blame the human operator. It has been said that a poor workman blames his tools but designers have a comparable weakness in tending to blame the operators for misuse rather than checking whether their design is user-friendly.

This machine-centred approach is now being questioned (La Porte and Consolini, 1991; Pool, 1997). The alternative is user-centred design. The designer starts by looking at the range of tasks involved, considers which bits humans do well and where they might benefit from assistance, and then tries to design a tool that helps them, checking what impact use of the tool has on their overall performance.

It is possible that the development of information-processing tools in child protection work has followed the traditional model, with designers focusing on

the parts of practice that are readily formalized, without studying the impact this has on professional expertise. Do the assessment guides help practitioners make good assessments or do they produce an unwieldy heap of uninterpreted data? There is a growing body of evidence that the tools are not being as helpful as expected (Doueck *et al*., 1993; English and Graham, 2000). Fluke (1993), for example, found that front line workers were using a decision-making instrument *after* making their decision and seeing it as only an administrative chore rather than a practice aid.

Another important issue to address is: How far can the tasks of child protection be formalized? The core skills of interviewing people to get the basic data and of interpreting those data both seem to require expert human beings. The *Climbie* report contains numerous examples of people following the procedures correctly in a narrowly technical sense, but since they lacked the relevant knowledge, skills and attention, they did not reach well thought-out decisions. Victoria's aunt, for example, was questioned about Victoria's injuries but discrepancies and gaps in the information she provided were not probed.

One complicating factor in designing tools in child protection has been that they are expected to serve a double function. They are not only intended to improve practice, but also to meet the needs of managers and auditors to monitor what is going on. Whether the one tool can meet both goals is debateable.

The increased monitoring of professional practice in child protection work has been so great that its impact on practice needs to be evaluated (Munro, 2004). It has been part of a wider sea change. In public sector services in general, there has been increased financial and political surveillance. Economic concerns about the cost of the public sector services, combined with a political shift to neo-liberalism, have led to a demand for greater transparency and accountability (Power, 1997). The Conservative government elected in 1979 was highly critical of public bureaucracies which it saw as dominated by self-serving interests and unresponsive to user needs (Henkel, 1991, p. 11). This led to a set of measures aimed at making services more efficient and bringing professionals under stricter managerial control. Targets, performance indicators and management information systems are now all features of everyday working life, restricting the options that the individual has.

(3) Organizational context

Organizational culture exerts a strong effect on the performance at the sharp end of the system. The overt and covert messages about what is valued or disparaged influence the choices made by front line staff.

It shapes what is prioritized, for example. In child protection work, there is a persistent dilemma between supporting families and protecting children. If the organization puts pressure on to achieve one goal (e.g. supporting families)

without openly acknowledging the potential conflicts with other goals (e.g. protecting children), practitioners can find themselves in a double-bind: attempts to achieve one goal may involve sacrificing achievement of another. They are therefore vulnerable to criticism, whichever option they choose.

The system of rewards and punishments, again both overt and covert, helps to shape performance. The current audit system explicitly sets out targets for child protection work and lists the performance indicators by which success or failure will be measured. While the aim is to make practice 'transparent', the current audit system is relatively crude, providing a very sketchy picture of practice. The performance indicators seem selected more because they are easily measured than because they provide an accurate picture of the service received by the family. Whether a case conference was held is recorded but no measure is made of whether a well evidenced, critical discussion took place or whether good plans were made for helping the child (Munro, 2004). Therefore, the system inadvertently encourages practitioners to concentrate on the elements that get measured and, by failing to reward the rest, discourages putting effort into improving the quality of how those tasks are carried out.

The organizational culture also reflects and responds to the wider society's values and expectations. In child protection, the strength of public condemnation of the error of missing a case of serious abuse has tended to lead to defensive practice, erring on the side of caution. Agencies, realizing that the risk of child deaths cannot be wholly removed, may take steps to protect themselves. They may try to transfer or dissipate blame by engaging in 'blame prevention engineering' (Hood *et al*., 2000). Hood *et al*.'s research found that one strategy for doing this is 'protocolozation': the organization introduces more and more formal procedures to guide practice so that they create a 'correct' way to deal with a case. Then, if a tragedy occurs, they can claim the defence of 'due diligence' and show that their employees followed these correct procedures in working on the case. A child may have died but the agency staff can show a clear audit trail of what they did and cannot be faulted for the tragic outcome. In an organization where this approach is operating, avoiding blame is valued more highly than avoiding tragedies and so practitioners will be under pressure to follow procedures, even when their professional judgement tells them it is not the best course for the child.

The *Climbie* report shows compassion for the front line staff, who were working in very adverse conditions, and directs the strongest criticism at senior management. However, they, too, are human beings and their mistakes require analysis. In the above discussion, the focus was on the local rationality of front line workers with senior management at the blunt end of the system. Senior management can also be classified as at the sharp end of a system, acting under the constraints of their own knowledge and skills, the resources available and the priorities and conflicts set, in their case, by central and local government and the general public.

The *Climbie* inquiry

How does the traditional inquiry compare with this systemic approach? Since I have been able to draw on material from the *Climbie* report in my earlier discussion, it clearly covered some of the same ground. Key differences, however, lie in (a) the issue of blame, (b) the scope of the investigation, and (c) the nature of the solutions.

The traditional inquiry has two aims in reconstructing the causal sequences that led to the tragedy: to learn how to avoid a recurrence and to assign blame. I have been arguing that a systemic investigation would be a more useful source of solutions but it is less functional as a way of assigning responsibility. Its concern is to go beyond human error and understand how it occurred so the findings can be seen as providing mitigating circumstances. However, there is clearly a social need for judgements of responsibility but it might perhaps be better to separate the two aims of an inquiry, dealing with culpability in existing mechanisms for staff discipline and allowing the investigation to take a non-judgemental approach to reconstructing the causal sequences.

In judging responsibility, there is an important distinction between a faulty process and an undesirable outcome. In a complex area such as child protection, professionals are working with fallible data and limited understanding. Judgements and decisions have to be made in conditions of uncertainty, so some degree of error is inevitable (Munro, 1996). Good decisions may be followed by bad outcomes (Fischoff, 1982). However, in Victoria's case, the inquiry team found all too many such deviations from standard principles of practice. Neil Garnham, QC, the Counsel to the Inquiry, in his opening address to the inquiry, listed twelve key occasions when professionals had the opportunity to identify the risk to Victoria and intervene to protect her. During the course of the inquiry, several more opportunities emerged. In each case, the sequence of events could have been significantly altered, not by any exceptionally gifted work, but by adherence to basic principles of practice: '... not one of these required great skill or would have made heavy demands on time to take some form of action' (Department of Health, 2003, para. 1.17). The inquiry concluded that Victoria's case was 'characterised by a consistent failure to do basic things properly' (Department of Health, 2003, para. 6.557).

In terms of scope, the traditional inquiry is narrower in two ways. The central focus is on the management of one case, with the wider work environment only being discussed as it impacted on that case. In a systemic investigation, the focus is on the interactions of the different layers of the system so that a more vivid picture is drawn of how the particular case fits into its context.

In relation to solutions, the first major inquiry—into the death of Maria Colwell (DHSS, 1974)—was unusual in that it concluded that her death was due to a failure of the entire system of policy and procedures. Before Maria's death, the subject of child abuse was not well known to the general public or, indeed, to many professionals working with children. There were no systems in place to facilitate communication and co-operation between professionals, but Maria's

story revealed how essential they were for getting a full picture of what is happening to a child. The inquiry recommended a radical set of changes: prioritizing child abuse in training, creating the now familiar mechanisms of case conferences and registration, and introducing formal procedures for professional collaboration.

This report marked a major change in society's concern about child abuse and led to a new system for dealing with it. Subsequent inquiries, however, have been more ready to criticize the individual practitioners. A review of forty-five reports published between 1973 and 1994 found that 75 per cent concluded that human error had significantly contributed to the failure to protect the child (Munro, 1999). Consequently, like the traditional engineering investigations, it is assumed that in seeking to avoid further deaths, the key problem to address is human fallibility. The recommendations of the *Climbie* report illustrate the three traditional types of solution: psychological pressure, closer monitoring and increased formalization.

The report and the associated media coverage ensured that this inquiry exerted psychological pressure, not just on those directly involved, but all working in the child protection system. The message that society expected better was compellingly and unambiguously communicated.

The continuing impact of the psychological pressure will be maintained through more surveillance of practice so that poor performance can be identified and punished. The report asserts:

> The single most important change in the future must be the drawing of a clear line of accountability, from top to bottom, without doubt or ambiguity about who is responsible at every level for the well-being of vulnerable children (Department of Health, 2003, para. 1.27).

Accompanying this clear accountability must be mechanisms for policing the system. Most of the recommendations set out principles of good practice plus a requirement that compliance should be monitored. The health care recommendations, for instance, include the sentence: '... hospital chief executives must introduce systems to ensure compliance with this recommendation.'

The third traditional strategy for improving services—increased formalization—is evidenced in the number of recommendations that entail adding to practice guidance manuals. None of these recommendations is controversial or novel. Indeed, they reiterate what has long been known to be good practice. Recommendation 18, for instance, is:

> When communication with a child is necessary for the purposes of safeguarding and promoting that child's welfare, and the first language of that child is not English, an interpreter must be used.

The idea of conducting interviews in a language the child can understand is not revolutionary. But the question the inquiry does not answer is: Why do you need to say something so basic and obvious to qualified professionals? This is a central difference between a traditional and a systemic investigation and, I have been arguing, it is only by addressing this question and understanding the

interplay of factors that led professionals to lapse from common-sense principles that we can hope to devise solutions that will significantly improve performance.

Conclusion

The main solutions offered by the *Climbie* report are structural changes, clearer lines of accountability and closer monitoring to ensure compliance with procedures and practice guidelines. The main problem identified was a high rate of professionals' failing to carry out basic elements of practice. As in previous inquiries, the key recurring errors relate to the communication and interpretation of information (Reder and Duncan, 2004).

Would stricter management oversight, however, have *detected* the poor quality of the service offered to Victoria? This is questionable, since, as the report acknowledges, (para. 17.66) current performance indicators are crude and focus more on quantity, not quality. Even if it could detect poor quality, could stricter managerial control *improve* the quality of work? We cannot answer this without a clearer understanding of the factors influencing the poor-quality work of both front line and senior staff.

The *Climbie* inquiry follows the traditional model in that it does not probe why such a large number of agencies were operating with a high rate of violations of standard principles of good practice. Victoria did not die because of one major mistake by one professional; there were numerous occasions when the evidence was available to alert professionals to her danger. The inquiry concludes with puzzlement that people could fail to take such basic and sensible steps but this, I have been arguing, is where the investigation should start, not end. Until we understand why those errors looked the reasonable thing to do to the individuals at the time, we cannot devise solutions that ensure that, in future, they will be more likely to opt for the right course of action. This requires a radically different type of research from the traditional inquiry focused on the services provided to one child and this article has sketched a framework for doing so.

Child protection services appear to have got into a vicious downward spiral. Efforts to improve performance appear to be inadvertently distorting practice. It is now time to step back and reappraise those efforts, not just re-apply them with greater energy.

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