Almost every complex system has its methods of looking into mistakes that have led to large-scale tragedies or terrible consequences. Retrieving the contents of the “black box” in plane crashes is the method of tracking the source of airline disasters. Searching for the “x” on the wrong site for surgery or counting the number of sponges missing are methods of identifying operating errors. When a child known to the child protection system is murdered or dies under unexplained circumstances, the system is opened up, briefly, for public scrutiny and an intense inquiry is initiated, shaped by the search for an explanation.

In November 2005, Eileen Munro, Reader in Social Policy at the London School of Economics, spoke at an interdisciplinary forum hosted by the University of Minnesota’s Center for Advanced Studies in Child Welfare on the topic, “Sorting Out the Evidence for Interventions that Work in Child Protection: Intuition, Experience, and Technology.” The forum was sponsored in part by the Center for Urban and Regional Affairs. This article provides a brief summary of Munro’s remarks.

According to Munro, in about 70 to 80% of inquiries into unexplained deaths in the child protection system, there is a consistent result: The blame is placed on human error. The thrust of the response to reduce error is to bring erratic human behavior under control and “make them behave better in the future.” Blaming the frontline worker usually results in increased surveillance of staff to make sure they are following all the instructions. With respect to child protection, the system is changed to reduce their role, adopt rigorous protocols, and formalize and mechanize child protection to limit individual judgment. Not only does this increase paperwork but it also leads to defensive practice in which there is a strong impression that the primary purpose of the work is to protect the worker and the agency. Protecting the child is third in priority. This adds up to a huge distortion of practice.
For Professor Munro, an alternative “systems” approach in explaining mistakes could lead us to genuine improvement. This approach assumes one can identify human error, but then proceeds to ask, “Why did they make a mistake?” There is a pattern to child fatality reviews: imperfect decisions made in imperfect circumstances. In using a systems’ approach, there are three key areas for understanding what contributes to a final outcome: factors in the individual, resources, and organizational context.

For factors in the individual, we look to the child protection workers’ skills and knowledge and their emotional wisdom. We expect pilots to have emotional maturity, and we should have the same expectation for child protection workers. As Munro puts it,

Are we training them in the right kind of reasoning skills and knowledge to actually do the kind of assessments we want . . . [I]n fatality reviews there is clear evidence that workers do not have adequate skills in interviewing children . . . and in interviewing men . . . [W]orkers find it easiest to talk to the adult mother rather than the partners or the children. Yet a wide range of sources of information are needed to make a proper assessment.

Critical thinking—which includes a space for our intuitive grasp of the situation—means actively dealing with information, testing a hypothesis, and rejecting or adding to it. And supervision is the key for helping frontline workers to think. An overworked and understaffed system does not provide time for critical thinking. Supervision is a major support, both emotionally and intellectually, in managing a caseload. There are a variety of instruments for collecting information and it is the role of the supervisor to prevent the frontline worker from being overwhelmed and paralyzed by the enormity of information collected. In Britain, supervision is tilting toward checking on paperwork, not the quality of thinking about the information for assessment and case planning. Reduced time for this kind of supervision is a serious matter.

Stability of resources is another factor in managing a caseload of families in crisis. The availability of support services for strengthening families enables a frontline worker to be effective in tangible ways.

With respect to organizational context, we need to be reminded of three key features of a good system: (1) we want it to be effective—that is, to “do no harm” in the process of trying to help children, to be aware of the unintended consequences of intervention, and to avoid traumatizing a family in the process of investigating maltreatment reports; (2) we want it to be efficient through a careful use of public money; and (3) we want it to be ethical, balancing respect for a family's privacy with a child's safety. The organizational context has become an audit and inspection system with an emphasis on completion of paperwork, with minimal attention to the accuracy and usefulness of documentation. We could say there is a conflict between putting the child's well-being first or putting the audit system first. In general, we have prioritized paperwork over casework. Paperwork has increased to the point where it is unusable—for example, procedural manuals, giving guidance on how to work, are printed in several volumes. There is a strong sense that paperwork represents documentation primarily for management and has little value for the worker. This has resulted in a certain kind of insincerity with a casual regard for entering data accurately. The organizational context should ensure a protective, nurturing working environment allowing frontline workers to focus on the children and not on the administrative tasks required by an audit system.

Finally, there is a very serious complication that needs to be studied: Political interventions are now providing loads of change in education, health, criminal justice, and child welfare. Every part of these systems is trying to change the way we are dealing with children. But it is only at the frontline that you are going to see how these changes, in an interactive way, affect the child and the family. The frontline worker will be required to understand and interpret the impact of these changes. In this context, we may have to scrutinize complex interactive systems to see whether they have delivered their message of good practice with clarity. Then we may fully understand the sources of error when children are murdered or die under unexplained circumstances.

Commentary from the Judicial System

The court of appeals appears to be a source for understanding errors from the perspective of parents. When parents think that an error in judgment has been made regarding their capacity to parent, they can turn to the judicial system to speak their truth to the power of the system. According to Judge Terri Stoneburner, once the court system is involved, the central issue is whether the decision (most appeals are challenges to a termination of parental rights) is supported by “clear and convincing” evidence. The focus is not on the best interests of the child.

Inta Sellars, human services judge, observed that her office has a surveillance role: looking at the evidence that the county presents when the maltreatment determination is challenged. Counties with limited resources to transcribe all interviews have to rely on summaries of caseworker notes. In a legal sense, the judge has to sort out hearsay from direct evidence. A caseworker's notes may not disclose the details that satisfy the standard of “clear and convincing” evidence.

Anita Fineday, chief judge for the White Earth Band of Ojibwe, discussed the struggle of caseworkers to grasp the cultural context of maltreatment reports. The judicial system at the White Earth Reservation is creating a children’s court. Children are always welcome in the courtroom. Judge Fineday invites children to talk to her in her chambers. This procedure provides information and insights that can reduce the margin of error.

Concluding Remarks

Professor Munro observed that public sector services in all developed economies have had to face new demands for accountability and transparency leading to the creation of complex audit systems. Professor Munro reminds us that while the audit system is concerned with efficiency, our professional commitment must be focused on effectiveness: to ensure that children are securely attached to persons who are capable of providing safety, nurturance, and well-being for the duration of childhood. Reconciling these demands of a child protection system is a formidable challenge.

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A full-length version of Dr. Munro's talk, on which this summary version is based, is available online at www.cura.umn.edu/publications/Munro.pdf.