Soft is Hardest: Leading for Learning in Child Protection Services Following a Child Fatality

Andrew Turnell
Resolutions Consultancy
Victoria Park, Western Australia

Eileen Munro
London School of Economics

Terry Murphy
Department for Child Protection
Government of Western Australia, Perth

The way in which a child protection agency responds to a child fatality always has a strong influence on subsequent practice. Very often, organizational responses and child death reviews are punitive and escalate an already anxious and defensive organizational culture. This paper outlines an alternative approach that not only helps staff to manage their emotional responses but also encourages and prioritizes a learning culture within the organization throughout the crisis and in the longer term.

In this special issue on preventing severe child maltreatment injuries and fatalities, we focus our paper on how child protection leaders can respond constructively to a serious child injury or death so the responses themselves do not generate adverse effects but rather assist the organization to become focused on learning how to improve protective services. The traditional reaction to a troubling death usually involves public declarations by politicians and child protection leaders that "lessons will be learned." Much effort then goes into child death reviews to find those lessons and to develop recommendations on how to avoid mistakes or practice deficiencies in the future. Such reviews have been major drivers of change in child protection services in many countries (Brandon et. al., 2009; Kuijvenhoven & Kortleven, 2010; Munro, 2004, 2005, 2010; Parton, 2008), but we contend that these types of reviews have also often been counterproductive.

Societies increasingly hold the view, fed by sensationalist media coverage, that a child death is proof that some professional did something wrong. Public criticism and the political salience of these events biases the change agenda towards "top down," rapidly implementable, set-piece solutions such as increasing practice monitoring and compliance measures. Such changes tend to be instigated in an atmosphere of distress and blame, encouraging greater defensiveness in an already anxious workforce. This narrow approach to creating change ignores the complex reality of what it means to make predictions and take action in conditions of uncertainty that operate in and around every child protection case.

The heart of a child protection system's capacity to improve children's safety lies in the quality of service that front line workers offer to families. Procedures and monitoring are important, but they have little value unless agency practitioners have the skills to:

- Think through family strengths and dangers, enabling explicit risk assessments,
- Lead explicit decisionmaking about the best course of action for children, and
- Engage with families to help them to change

There is a saying in management that "the hard is easy and the soft is hard."[1] Deliverables such as legislative change, a policy rewrite, a new computer system, an organizational restructure, a child death review, compliance measures, or adopting a particular practice model, while challenging to implement, are the more brick-like components of an effective child protection organization. They are necessary but not sufficient. The harder work almost always lies in the soft stuff, the mortar that holds these tangible elements together. The "soft" stuff resides in the skillfulness of the professionals, which is determined by the human attitudes and responses to the uncertainty and anxiety of child protection work that either elicit or diminish intelligence and practice depth.

Transforming child protection practice depends on professional leadership focused on the actual interactions frontline practitioners have with parents and children, paying attention to the emotional as well as the cognitive dimensions of the work, and continually learning about the impact of the work on children and families. The defensive compliance culture that has become dominant in many jurisdictions prioritizes deliverables that can be counted, and constantly undermines the capacity to pay attention to what counts most, namely the skills: (a) to determine how safe children are, (b) provide effective help, and (c) find out whether children are being helped, or possibly even harmed, by their contact with child protection services.

In our view, the most critical "soft" issue within and around child protection is the pervasive and debilitating problem of anxiety. Western culture in general, and child protection agencies in particular, has been increasingly co-opted into the myth that every risk is calculable, every problem solvable and every death chargeable to some professional's account. This sensibility escalates blame and defensiveness (Ferguson 2004, 2011; Munro, 2010; Parton 1998; Reder, Duncan, & Gray, 1993).

1 The authors thank Dan McCormick from Connected Families for bringing it to our attention. For more information see: http://www.tutor2u.net/business/people/hrm_hard_soft.asp and http://www.strategy-business.com/article/ac00034?gko=f5243; Covery, S. R. (2011). *The 3rd alternative: solving life's most difficult problems*. New York: Free Press.

The anxiety engendered by child protection in turn feeds anxiety's boon companion, the impulse to "get it right." Whether it's the politician, the CEO, the head of the child death inquiry team, the policy writer, the supervisor or the practitioner, all may go along with the idea that they can come up with the right *something* that will prevent future tragedies—whether that right *something* be legislation, policy, theory, practice model, training program, assessment method, decisionmaking tool or compliance measure.

In these conditions human beings become more defensive and display their worst dysfunction in the face of anxiety and fear. Child protection leaders who want to grow an understanding of practice (Chapman and Field, 2007) and create a culture of continual learning must constantly challenge the corrosive effects of anxiety and the compulsion to pursue unattainable certainty. There is no more critical point at which leadership for learning must be demonstrated than when a child protection organization faces the crisis of a child death.

Just as reactions to children's deaths have been so influential in creating defensive, overly bureaucratized systems, so a more constructive reaction can be pivotal in developing a system in which workers feel supported in coping with the anxiety and uncertainty inherent in the work. To illustrate our thinking about constructively and proactively leading a child protection agency through the aftermath of a challenging fatality, we use a case study from Terry Murphy's experience as Director General of the Western Australian Department for Child Protection. In the text that follows, the italicized sections are Murphy's first record of the scenario and how it was managed.

> The case involved a toddler who had been removed from her birth parents and placed with a couple in the extended family who themselves had a past history of alcohol abuse and domestic violence. Nine months after placement, the child suffered a major head trauma and died a few days later. A member of the kinship family was the prime suspect. This situation was of course a massive crisis for the birth and caring families, and this

was made significantly worse by the fact that on admission to hospital, the case drew extensive media and political attention. This continued up to and well beyond the child's death.

Leadership Principles

The next section of the article presents five key leadership principles to address this situation.

1. Avoiding hindsight error and being rushed into blaming someone.

"Whatever the initiative, policy or program, in the end you are only as good as how you deal with the next child death" (Tony Morrison to the New Zealand Children Youth and Family Services Senior Management).

Handling well the crisis of a child death involves:

- Intellectual work, finding out and appraising the facts of the situation.
- Emotional work, managing the widespread anxiety, distress, and anger to create time for a measured judgment of practice.
- Engagement with a range of different groups: politicians, the media and public, the birth and caregiver families, and the workforce.

With hindsight, it may seem that in this case, it was obviously risky to place a child with kin who had a history of alcohol abuse and violence. With hindsight, judging by the outcome, it seems clearly to have been a faulty decision; and the media and the public had a predictably clear disposition to blame child protection services for this decision. However, for workers operating with only foresight, and weighing up both the risks and the benefits to the child of this placement compared with other options, the risk calculus looked quite different. A first task is *not* to jump to conclusions but to seek to understand the professional reasoning behind the actions.

> The first few days were dominated by a scramble to assemble the facts, and at this time it was vital for the CEO to help everyone maintain a calm head and to synthesize the inevitable complexity of the facts to determine the key issues, looking both at what was done well and what was not, determining whether culpability was likely, and the extent and nature of the organizational vulnerabilities. This synthesis informed clear and measured advice to staff, the Minister, and the public channels.
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> The facts, in essence, were that there were clear indications that there had been risks in the placement, but that these had been identified and assessed as low given there had been a lengthy period of sobriety and non-violence. It was also found that while the placement was monitored regularly initially, when the file was transferred to a new office there was a delay in case assignment, and the quality of the contact with the family diminished.

While the certainty afforded by hindsight is often compelling, it is vital to lead with a sophisticated and compassionate understanding of managing risk, in order to avoid the knee-jerk reaction of blaming workers for tolerating some degree of risk. All child protection interventions and placements involve risk—requiring professionals to weigh the different risks and benefits of possible courses of action and choosing the one that looks most likely to be best for the child. The fact that, on this occasion, something considered to be of low probability occurred is in and of itself not evidence of a poor decision since, by definition, low probability events do occur, albeit infrequently.

2. Managing political and public reactions

A good working relationship between the CEO and the Minister (or the political leadership relevant to the particular jurisdiction is essential as major crises demand the involvement of the responsible political leader. So crisis management involves close cooperation of the CEO and the Minister if it is to be effective. While the gathering

and assessment of the facts needs time, the CEO in concert with the Minister must respond promptly to external demands for information. The immediate media and political response, in this case as in general, needed to communicate two things clearly:

- Acknowledge the seriousness of the tragedy and that the thoughts and prayers of the Minister, the agency and the workers are with the family.
- Explain that police and departmental investigations are being expedited and that a detailed public statement will be provided at the earliest opportunity. Holding this line requires discipline in the face of the inevitable intense pressure from the media and political opponents to appear in public and respond to statements that rush to judgment.

Enough facts were assembled in the three days following hospitalization that the CEO and the Minister were in a position to hold a press conference to report initial findings. After this, the CEO conducted several live radio interviews—a good opportunity for clear messaging since there was no risk of subsequent editing distorting the message. The media conference was packed and aggressive. The Minister made a general statement of concern for the family and said that investigations were continuing, and that the CEO would provide the details that were now known.

The media conference was long and exhaustive, with close questioning on the placement assessment process and the monitoring of the child, with the CEO emphasizing that no culpability by a member of staff was evident. It was also stated clearly again that those inquiries were necessarily ongoing. Perhaps most importantly, the CEO indicated that, if shortfalls in the Department's performance were identified, then these would be faced and he would accept responsibility.

Media messaging and political management continued in this vein, through the child's death and beyond for around two weeks. Calls for immediate and independent public inquiries

were made by the media and opposition politicians, and were met with a commitment to expedite departmental inquiries and take any necessary action; and pointing out those standard procedural inquiries by the Ombudsman and the Coroner would occur in due course. During this period, the CEO continually talked to the many professional stakeholders to prevent and address the potential for their anxieties to lead to destructive public statements.

3. Supporting the families

In the maelstrom of crisis management, it is essential not to lose sight of the core work of the child protection agency, which is to keep children safe, as well as support families and assist them to do so. In this case, practical and emotional support had to be extended to both the birth and foster families, and the risk of conflict between these families mitigated. Transport and accommodation were provided as necessary for attendance at the hospital, and staff were permanently stationed there, as well as accompanying families for various purposes at different times.

In a case of a child death in a family, the provision of emotional support is complicated by the necessary investigations, both by police regarding the circumstances of the death and child protection authorities regarding the safety of other children in the family, that need to occur concurrently. Establishing a working relationship with the families, demonstrating that there will be no rush to judgment even when precautionary actions with respect to the placement of other children may need to be taken, and clear and constant communication are all fundamental.

4. Supporting staff

Creating the space for risk-sensible learning rather than entrenching risk aversion while the ramifications of a child fatality unfold depends on two key factors. First, proactive management of the external political environment in which the agency operates, and, secondly, the extent to which the agency has already built resilience

in the face of inherent anxiety. This second factor requires persistence and consistency on the part of senior management. Two key messages communicated to all new staff directly by the CEO, and to all staff in the organization frequently and whenever there was an opportunity are indicative of how chipping away at defensiveness and building resilience needs to occur over time. In this agency, these messages have been:

- First, "our work is anxious work; as a child protection worker, never carry anxiety alone; always share it with your supervisors so it is carried together, including with all other levels of management, as necessary."
- Second, "given the nature of our work, tragedies can occur. If a tragedy occurs on your watch, and you have done your best and have been open and frank about what has occurred, your bosses will stand with you, including the CEO, who will be explaining the situation in front of the TV cameras, if necessary."

As much as a CEO and a child protection organization hope not to be tested by these commitments, tragedies do occur, and CEOs and organizations are tested. With every test handled well, trust and resilience increases. Any failed test has an exponentially greater negative impact. Progress is incremental because deep in the history of every child protection organization will be the large or small stories of where blame usurped responsibility and learning.

In this case example, visible support and sensible management by the CEO and senior staff were essential:

> The CEO maintained a highly visible dialogue about the case across the organization. Emails to all staff ensured that they knew of the tragedy prior to its appearing in the media, and showed recognition of the anxiety that this causes for all staff, about their own cases and about how they will or will not be supported. The emails thanked staff for their tireless efforts in the face of the tragedy, and provided assurance that the organization would support the staff, and asked staff to support each other. Calls to the responsible managers and visits

to the districts directly involved by the executive directors occurred quickly. All organizational messaging to the staff was consistent.

Some quotes from CEO emails to all staff are indicative:

This is a tragedy, and our hearts go out to the child and her family. My thoughts and gratitude also go to all the staff who have been involved with this child and her family, to those who have worked tirelessly . . .

The Minister has asked me to investigate this case, and that is underway now and will take at least a few weeks. As I explained on radio, this is to look at how we have followed our procedures, and identify any gaps or missed opportunities in order to improve how we work. This is not, as some have advocated, in order for 'heads to roll'. If there are issues with our practice, we will take responsibility and I will take that responsibility.

Every one of us feels this event and the intense scrutiny it brings. As well as turning your thoughts to the family, I ask you to do what we also do best, to support each other through this difficult and testing time.

And later:

In the field, anxieties have been raised for all the children in our care and the child protection risks that we manage every day. The scrutiny has been intense. It also seems that wherever there are issues that highlight the difficult and uncertain environment in which our work occurs, and there always are, someone has been ready to comment in the media.

It is incredibly important that we all pull together at this time. If you have particular worries and need support, please raise it with your manager, and I will be involved with issues that come to my attention.

> As well as doing it tough, I have been very proud of how we have managed ourselves and the support that we have shown each other, and I have greatly appreciated the support I have received. Most importantly, we continue to do fine work with families and children.

The success of this strategy is evidenced by the feedback received by the CEO; some representative examples are:

> . . . a very brief message to thank you on behalf of the management team and all the staff here . . . for your support during what has been a very difficult time. Your backing and reassurance has been very important to all involved.
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> Staff were particularly grateful and reassured by your statement that you would take the responsibility for any shortcomings identified in this case.
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> Just wanted to say how much I appreciated receiving this email last night. It has been a baptism of fire . . . and most days have been pretty tough, especially the last few . . . I am confident though that we will get through this time and I am especially grateful for the support.

And in retrospect, from the local manager:

> I experienced the entire process within a trusted and safe environment free from fear, where I was able to lead my district whilst you led the department around the wider responses to media and the Minister - I felt secure in knowing you 'had my back' and trusted my leadership.
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> I felt enabled and empowered, understanding that you were ensuring support that went beyond platitudes and resulted in resources being made available expediently, and knew that the corporate family cared from the top down.

While we have so far addressed the need to manage the distress and anxiety around a child's death, it is also necessary to examine practice and consider what can be learned from it. Sometimes, it becomes clear that practice was sound and defensible, and the child's death arose from factors that were not predictable or preventable. In a study of forty-five child death reviews in the United Kingdom, the inquiry team concluded in 25% of cases that no professional lapse or error had contributed to the fatality (Munro, 1996).

When flaws in practice are identified, they need close scrutiny. Often, people want to rush to blame the individual at the centre of the action, and think they can solve the problem by getting rid of this "bad apple." This has been a common pattern in child death reviews in many jurisdictions, but its limitations are evidenced in how the same problems keep coming up: "Little new ever comes out of inquiries into child abuse tragedies" (Duncan, Reader, & Grey, 1993b, p. 89). However, as other disciplines such as health and engineering have found, a poor outcome is rarely due to malicious or incompetent individuals, but usually arises from a complex interplay of factors in the work context and the individual that come together to produce an adverse result (Munro, 2005; Fish, Munro, et al., 2008). Adopting a more systems view of the complex causation of problems has arisen because:

> The more safety researchers have looked at the sharp end, the more they have realized that the real story behind accidents depends on the way that resources, constraints, incentives, and demands produced by the blunt end shape the environment and influence the behaviour of the people at the sharp end (Reason, 1997, p.126).

An inquiry and examination of a fatality therefore must not stop when it finds human error, but needs to delve into *why* people acted as they did. This may involve organizational processes, culture, or resources, as well as factors in the individual such as their learning—including the training they may have undertaken, level of expertise,

etc. Even when there is no evidence of professional culpability, close scrutiny of practice may show up areas of organizational weakness—what Reason (1997) calls the "latent conditions for error" that, left unchanged, make future error more likely.

5. Developing expertise

Managing the distress and anxiety that emerges throughout an agency following a child's death is necessary, not just as a feature of compassionate management, but also because organizational competence in managing anxiety and uncertainty is essential to enable staff to put their primary focus on helping children, not on covering their backs in case of trouble. Above everything, child protection is a human undertaking, and good outcomes depend on the caliber and capacity of the human beings who are doing the work. If this is true, then those of us who are child protection leaders need to control our obsession with models, policies and compliance, and distil a clear vision of the sort of people we believe can best carry out the work.

We would suggest that at every level we are seeking people of imagination, compassion and intelligence who can think themselves into and through the complexity and the wicked nature of child protection problems. These are people who can apply an acute intelligence to complexity that arises not just from the families themselves but is also generated by the organization and the political milieu that surrounds the child protection undertaking Rather than being defensive and risk averse, child protection organizations that wish to function well and with high reliability (Bigley & Roberts, 2001; Roe & Schulman, 2008) must recruit, develop and sustain professionals who have the courage to embrace the reality that child protection work at every level is always uncertain.

For a child protection service to be able to learn about how well it is doing, it needs good feedback about both the processes and the outcomes of the services provided to families. In many jurisdictions, managerial oversight focuses primarily on service inputs and outputs. Have workers followed procedures? Did they meet

prescribed timelines? How many children have been removed from their families? Over time, the importance of compliance with these indicators has come to dominate practice so that attention is distracted from questioning the *quality* of work, and the *impact on child and family* (Munro, 2010; Tilbury, 2004). Easily measured aspects of practice fail to provide a good enough picture of quality, so agencies need to create more sensitive ways of examining the quality of practice.

The foundation for developing a strong workforce expertise lies in creating an organizational culture that sustains and deepens critical reflection and continual learning. This requires time for "slow thinking," and needs to rest on an understanding of how the work draws on people's intuitive and analytic reasoning skills, as well as their emotions (Kahneman, 2011).

To achieve this requires staff feeling supported and able to be open about their work, having the courage to examine it critically, and being willing to explore with the whole agency what is going well and badly. This is essential if an agency is to have any chance of managing the real work of child protection that occurs in the relationships between professionals and service recipients. The key leadership task here is to set up strategies and structures to elicit and grow practice wisdom built from workers and supervisors being willing to expose, explore and think through their practice, and make their views vulnerable to the experience of children and parents, foster caregivers and other stakeholders. These processes have been described as creating a culture of appreciative inquiry around frontline practice (Turnell, 2004, 2006, 2012). This is fragile work, and one of the hardest of "soft" tasks in leading a child protection agency. Since child protection practice is so pressurized, it is always possible to find problems and practitioners always feel vulnerable about their work.

Conclusion

cour·age [kur-ij, kuhr-]: The mental or moral strength to venture, persevere, and withstand danger, fear, or difficulty.
—Webster's Dictionary

Our capacity to prevent severe child maltreatment depends above everything on building and sustaining intelligent, compassionate and imaginative staff who have the courage to engage with the complex circumstances our societies' most vulnerable children live in. What makes the task harder is that these practitioners must do this work within risky environments and (often) fearful organizations.

The child protection field, which must daily face and respond to wickedly complex social and organizational problems, has generated a perverse intellectual culture, hungry for set-piece linear causes and answers whether in policy, practice guidance or casework. What has come to count most in child protection are things that can be easily counted and what counts most, the actual interactions between families and professionals, is often overlooked.

Sadly, these bad habits of thinking seem only to escalate when a child protection system is faced with a child fatality. Child death inquiries repeatedly manufacture the notion that the cause of the fatality can be isolated, those culpable identified, and then new procedures can be put in place to make sure the tragedy will never happen again. We would suggest that over 40 years of refining this linear approach to fatalities has led to little improvement and in fact made our systems significantly more defensive and anxious.

Determining culpability for a fatality, to the extent it can be determined within a child protection system is complex and imprecise. Approaching such crises as if an exact truth can be ascertained and blame allocated to particular workers or practices overlooks the complexity of the systemic issues and the organizational context for failure. As Reason states:

> Rather than being the main instigators of an accident, operators tend to be the inheritors of system defects created by poor design, incorrect installations, faulty maintenance, and bad management decisions. Their part is usually that of adding the final garnish to a lethal brew whose ingredients have already been long in the cooking (Reason, 1990, p. 173).

We are not seeking here to erase individual responsibility rather we are seeking to recontextualize it. The issue of responsibility needs considerable rethinking if a truly systemic approach is to be applied to child fatalities. Recognizing human error and dealing with that with the individuals involved remains essential. At the same time explicit consideration of the balance that needs to be struck between addressing individual and organizational issues and the consequent organizational messages from leadership needs much more discussion. Moreover, to the extent that individual error must be remediated, it is vital to avoid the simplistic trap of "hanging an individual out to dry."

It is often said that the Chinese word for crisis is opportunity, but the Chinese word for crisis is actually formed by two characters representing danger and opportunity. The opportunity available to child protection professionals within the crisis of a child fatality can only be won through courageous and purposeful leadership across the organization and we have endeavored here to articulate some of our thinking about what such leadership looks like in practice.

Competence is often defined more in its absence than in its presence. The nuances and particularities of leadership that is generative rather than defensive in the face of crisis are hard to capture. Since the impact of child fatalities is such a defining moment for any agency and there is so little written about how to constructively lead in this context, we are convinced that this is a discussion that needs considerably more attention in the child protection field.

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