

In 2004, Eileen Munro, a British philosopher of science who has written widely on child welfare practice, sent managers within the Children's Administration (CA) a draft of an article she has written on system reform efforts following high profile child deaths. At the time, information regarding the Rafael Gomez fatality review was in the news, and CA management was in the midst of discussions regarding agency responses to the Gomez fatality review's findings. This article will be published in the British Journal of Social Work in 2005.

Munro wrote this article in response to the publication of the report on Victoria Climbié, a high profile child abuse death in England. The Climbié report has a strong focus on managerial accountability for the quality of child protection. Regarding the Climbié report, Munro comments: "it describes a level of practice breathtakingly worse than any of its forerunners (other fatality reviews)." "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."

Munro goes on to say that "Despite strenuous efforts to improve children's safety, services seem to be getting worse." "The long series of public inquiries has 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." The parallel with events in Washington state is obvious.

Munro notes that reform agendas developed in response to abuse related child deaths have utilized three strategies for the most part, "psychological pressure (on practitioners) to work more diligently, increased automation or formalization of the tasks to reduce or remove the scope for human (fallible) judgment, and, thirdly, closer monitoring of front line operators (social workers) to ensure instructions were followed." Munro points out the similarity to engineering responses to plane crashes and nuclear power plant accidents. "... Repeated inquiries into disasters ... produced well reasoned recommendations, and were followed by further disasters, revealing that proposed solutions were either not fully implemented or failed to have the desired effect." "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." "This approach did not eradicate the problems and, indeed, in some cases appeared to create new problems."

Munro describes a better approach to investigation of disasters as follows: "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?' Munro asserts that disasters rarely occur because of one major mistake by an incompetent worker. Disasters are, she claims, "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."

Munro asserts that "The parallels with child protection are clear." "Inquiries have typically ended once professional mistakes have been found." These types of fatality reviews lead to 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 judgment through use of standardized protocols, assessment frameworks and decision making aids." However, the "solutions are not working as expected but appear to be creating new problems."

Munro advocates for a paradigm shift in how public child welfare systems go about achieving an understanding of human error, i.e., "take human error as the starting point of an investigation, not as the ending." "A system - centered approach looks for causal explanations of error in all parts of the system not just within the individual." For example, in Washington state, one of the most troubling characteristics of some recent high profile child deaths has been the failure of supervisors or Child Protection Teams (CPTs) to question the practice and decisions of line staff. What went on in these interactions which reduced or eliminated critical feedback by persons or groups whose role it was to carefully review high stakes decisions?

Munro notes that it is very difficult for reviewers to restrain their judgmental attitudes when they encounter social work practice which, in hindsight, appears egregiously flawed. "... Psychological 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." The task for reviewers utilizing the systems approach described by Munro is to restrain moral judgment while attempting to reconstruct "local rationality". In reality, according to Munro, "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."

Munro comments that the key social worker in the Climbie case was inexperienced, and that agency managers were not sure if their staff had the literacy skills to read agency procedural manuals! The real possibility that inadequately trained inexperienced social

workers in child protection may often be making life and death decisions regarding children's lives without much guidance is a cause for great concern. Of perhaps equal importance, according to Munro, is the "emotional wisdom" needed in child protection. Munro notes that in the Victoria Climbié case, "she (the child) met little compassion or concern from those employed to help her." ".. The general impression is of a set of professionals busy with specific tasks but not paying attention to the human child at the centre." A systems approach as described in this article attempts to understand how this failure of compassion can arise in an organization dedicated to child protection.

Munro reviews her past research on abuse related deaths which revealed that child welfare staff are resistant to revising their assessments, even in the face of new evidence of inflicted injuries. "If the system fails to appreciate how hard it is for people to be critical of their own judgments and so undervalues the mechanisms, such as supervision, that help them reflect, then a high rate of error can be expected."

Munro questions whether the assessment tools adopted by child welfare agencies over the past 15 -20 years have actually helped practice, or do they "hinder good reasoning and constructive working relationships with families?" Munro states that designers of assessment tools often blame line staff and supervisors for not utilizing the tools in the manner required by policy, but she wonders whether the fault lies in designing tools that are not user friendly or poorly suited to the actual context in which they are used. Furthermore, "Do the assessment guides help practitioners make good assessments or do they produce an unwieldy heap of un - interpreted data?"

Finally, Munro calls attention to the increased monitoring of professional practice and to the ever increasing regulatory framework in child welfare. The emphasis on data driven practice has led to questionable performance measures which "seem selected more because they are easily measured than because they provide an accurate picture of the service received by the family." Munro thinks that child welfare systems have created incentives for looking good at the expense of "putting effort into improving the quality of how those tasks are carried out."

Munro concludes by saying that "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." These investigations need to "take a non -judgmental attitude to reconstructing the causal sequences" while allowing some other sort of inquiry into judgments of responsibility.

This is one of the most incisive and thought provoking discussions of human error in child protection ever written. It is worth reading carefully and then rereading.