Learning to reduce risk in child protection

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Abstract

This article argues for a systems approach to learning how to improve performance, conceptualising child protection services as complex, adaptive systems. This requires an acceptance of the complexity of the work, the essential role of professional judgment, and the need for feedback loops in the system where lower level workers are not afraid to communicate honestly about their experiences, both good and bad, and senior managers treat their feedback as a valuable source of learning. It is argued that current strategies to manage risk in child protection are, paradoxically, making it harder for professionals to learn how to protect children better. Three factors are identified as combining in such a way that they promote a culture in which professional practice is being excessively controlled and proceduralised: the person-centred approach to investigating child deaths, the blame culture, and the performance management system. The way they reduce the opportunities for learning are explored.

Key words: child protection, complex systems, errors, organisational learning

Introduction

Reducing the incidence of child maltreatment is a key policy aim in most countries. In developed nations, sophisticated systems of child welfare and child protection have been implemented. However, in many countries and states there have been recent high profile, critical reviews of performance (e.g. the Royal Commission on child protection in New South Wales, Australia (Woods Commission, 2008); the independent review of child protection services in British Columbia, Canada (Hughes, 2006); and the progress report on child protection in England (Laming, 2009). There is public concern that, despite intensive effort and considerable investment, there has been insufficient improvement. Child deaths from maltreatment are the extreme evidence of failure and public reaction is harsh when, with hindsight, it looks as if they could and should have been prevented by professionals.

This article argues for a systems approach to learning how to improve performance, an approach that takes as a fundamental assumption that 'to make sense of the complexity of the world, we need to look at it in terms of wholes and relationships rather than splitting it down into its parts and looking at each in isolation' (Ramage & Shipp, 2009 p.1). Child protection services are conceptualised as complex adaptive systems. The 'complex' part of the label refers to the nature of causality within the system – to nonlinear dynamics which limit the predictability of actions so that the system should not be seen as a machine where, once the correct causes are put in motion, all will proceed in a precise and predictable way. The 'adaptive' part of the label follows on from this - a system needs to be able to receive feedback about what is happening to self-regulate, i.e. adapt its behaviour in the light of this learning.

The systems approach offers a potentially fruitful way of reducing risk to children of inaccurate assessments and ineffective interventions through improved organisational learning but it requires some radical changes in the way that services currently operate. In outlining how it would operate, the obstacles to such a reform become apparent, obstacles that have, ironically, arisen from attempts to improve performance interacting in such a way that the cumulative effect is negative. The responses to public criticism combined with the person-centred approach to investigating tragedies and managerialism have contributed to creating a very controlled and proceduralised workforce that mitigates against learning and adapting in response to new information.

The focus in this article is specifically on the English system but the argument will be applicable, in varying degrees, to other countries. The issue of blame has been significant in the other countries of the UK, the US, Canada, Australia and New Zealand. Mainland European countries, which tend to have a more generous welfare approach to supporting families, have seemed to avoid a high level of public condemnation of professionals when children die (Hetherington, Cooper, Smith, & Wilford, 1997) but recent high profile cases in the Netherlands and Germany raise the question whether a more blaming approach may be developing (Kindler, 2008). All of these countries, however, share with England a move to 'New Public Management' in public sector services and this, it will be argued, is one of the contributory factors to the current problems.

Large-scale empirical studies have a major role to play in improving our knowledge of how to recognise abuse and which interventions are effective. However, this article is concerned with organisations' ability to learn about and improve their own performance.

A systems approach to learning

Viewing organisations involved in providing a child protection service as systems will be familiar to many readers since the concept of system has long been used in theorising about families. A system is a collection of parts (or subsystems) that interact to accomplish an overall goal. Systems have inputs, processes, outputs and outcomes, with ongoing feedback among these various parts. If one part of the system is removed, the nature of the system is changed Complex systems, such as social systems, are comprised of numerous subsystems as well. These subsystems are arranged in hierarchies, and integrated to accomplish the overall goal of the overall system. Each subsystem has its own boundaries of sorts, and includes various inputs, processes, outputs and outcomes geared to accomplish an overall goal for the subsystem

Complexity refers not to the number of parts but the nature of their causal interactions, specifically to non-linear causality where minor differences in initial values can lead to radically different outcomes, often referred to as the 'butterfly effect'. In contrast to the classical linear view of the world in which it is assumed that small differences converge to a point and that approximations can give a fairly accurate picture of what might happen, 'when a system is nonlinear and webbed with feedback loops, repetition feeds the change back on itself, causing it to amplify and grow' (Wheatley, 2006 p.120). Therefore, although subsystems are seen as being in

hierarchies, a systems approach challenges the widespread assumption that top-down control is possible and desirable. Senior management are not able to predict with accuracy the precise consequences of the various instructions they issue. They therefore need to ensure that there are good feedback loops so that they gather the necessary evidence about how well their instructions are operating.

This raises the question of how we define 'improvement' in performance. In a top-down control system, improvement is typically seen as greater *compliance* with procedures, rules, etc. In child protection, there is considerable scope for improving practitioners' compliance with principles of good practice. Child abuse inquiries repeatedly identify significant deviations. The inquiry into the care of Victoria Climbie concluded that:

> 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 (Laming, 2003, para.6.94).

However, in a systems approach there is also recognition of the need to dig deeper to understand *why* practitioners break rules rather than just focus on ensuring compliance through more control and monitoring. Practitioners can break rules for good reason. The range of decision scenarios they confront is so varied that, at times, the rules or accepted good practice do not apply. Also, when there are constraints of time and resources in the system, workers have to make pragmatic decisions about what to prioritise. Moreover, the behaviour within any one subsystem is influenced by the behaviour of the other subsystems with which it interacts. Therefore the work

environment can make it difficult or undesirable to follow the official procedure. Woods and Hollnagel (2006) point out that practitioners are often blamed for causing mistakes but their role in creating safety is at least as important. In child protection where inter-agency working is so crucial, senior managers need to recognise that those at the front line have more knowledge than they do about how the behaviour of their subsystem is interacting with that of other subsystems, e.g. how changes in police procedures are affecting social work investigations.

The systems approach, therefore, conceptualises learning within organisations not only in terms of compliance with prescribed behaviour but also in terms of reflecting on the rules and processes. Argyris and Schon (1978) formulate these two goals in terms of single- and double-loop learning. The theory will be familiar to many in child protection in terms of individual learning through reflective practice. However, the principles apply also to organisational learning.

Argyris and Schon argue that people have mental maps about how to act in situations, guiding the way they plan, act, and review their actions. These maps are more influential than the explicit theories that people adopt but many people are unaware of the maps they are using. They propose two theories of action: 'theories-in-use', governing actual behaviour and usually tacit, and 'espoused theory', how we explain our behaviour to others. Developing congruence between the two will improve effectiveness and this requires us to become more aware of our theories-in-use through reflection and discussion.

Learning involves the detection and correction of error. Responses to error can involve either single-loop or double-loop learning:

> When the error detected and corrected permits the organization to carry on its present policies or achieve its present objectives, then that error-and-correction process is *single-loop* learning. Single-loop learning is like a thermostat that learns when it is too hot or too cold and turns the heat on or off. The thermostat can perform this task because it can receive information (the temperature of the room) and take corrective action. *Double-loop* learning occurs when error is detected and corrected in ways that involve the modification of an organization's underlying norms, policies and objectives (Argyris & Schon, 1978, p.2).

Applying these ideas to child protection systems, the history of the past four decades shows major developments in formulating rules, guidance, and systems of accountability for front line workers. There are excellent reasons for these developments: they involve formulating best practice and seeking to ensure it is implemented widely. However, it can be argued that *the way* that they have been realised has tended to encourage single-loop learning – of assuming that they are essentially the correct way of operating and seeking new ways of ensuring they are enacted. Double-loop learning which would look more critically at the way improvement is being sought has therefore been undervalued. Compliance with existing procedures, rules and audit regimes is the key focus of appraisal rather than whether those procedures, rules and so on are the best way of protecting children.

This is contributing to professionals' dissatisfaction with their work. Recruitment and retention problems have become severe in many countries. Research has shown that the dominance of managerial control has been a contributing factor (Audit Commission, 2002; Gibelman & Schervish, 1996) and 'the erosion of opportunities for professional discretion at the practice front' (Healy & Meagher, 2004 p.245; Laming, 2009)

In England, Lord Laming's report on the progress of child protection services was highly critical of the way practice has developed in recent years, painting a worrying picture:

> Professional practice and judgement, as said by many who contributed evidence to this report, are being compromised by an over-complicated, lengthy and tick-box assessment and recording system. The direct interaction and engagement with children and their families, which is at the core of social work, is said to be at risk as the needs of a work management tool overtake those of evidence-based assessment, sound analysis and professional judgement about risk of harm (Laming, 2009 p.46).

New technology, e.g. software to structure case records, has been widely introduced in many countries to facilitate good practice but there is a growing body of research giving detailed accounts of how it is, in practice, having negative effects and disrupting the reasoning processes of professionals (Bell, Shaw, Sinclair, Sloper, & Rafferty, 2007; Gillingham, 2009; Peckover & Hall, 2008).

While many will agree that over-control is stifling good quality front-line work, it is not easy to change direction and move to a more reflective organisation able to support more creative and adaptive performance at the front line. Child protection systems operate within wider social systems and are subject to a number of factors that push them towards a defensive, controlling mode, key factors being the response to error, the dominance of blame, and the managerial approach which are now explored.

Responding to error

A child's death provokes strong reactions and when that death looks as if it could and should have been prevented by precisely those people employed to protect children, the degree of public anger is intense. The deaths of Victoria Climbié in England, Savanna in the Netherlands, Dean Shillingsworth in New South Wales, are examples of the way that individual cases have, in so many countries, been the major trigger for evaluating child protection services.

Child death reviews, or Serious Case Reviews in England, are a widespread procedural response to deaths or serious injuries of children known to the child protection system. The aims are to understand what happened and to identify any lessons for improving practice. This inevitably involves making judgments about whether professionals could have and should have protected the child better. Any such judgment rests on assumptions about causality, about how errors are produced. The standard views on causality have tended to push the system towards ascribing responsibility mainly to individuals and therefore tended to produce solutions aimed at controlling the errant individuals.

Reason (2009) identifies four basic components in an error: the intention, the action, the outcome, and the context. Errors of intention encompass whether there was an intention to act (as opposed to an involuntary action), whether the actions went as planned (absent-minded slips and lapses), and whether they achieved their intended outcome (was there a flaw in the plan of action) (Reason, 2009 p.29). Analyses of the action component raise questions such: was the action based on a good assessment of the problem and plan of intervention; was it executed as planned; and was it adequately monitored to ensure it was going as planned (Reason, 2009 p.32)? Much of the analysis in child abuse inquiries has focused on these aspects. For example, inadequacies in the assessment of the child's safety are frequently linked to flaws in communication between different professionals in contact with the family (Munro, 1999; Reder & Duncan, 2003).

Analysing errors according to the third component - outcomes is problematic in child protection. An adverse outcome in child protection may not, on investigation, be considered to be due to any professional error. However distressing the outcome, the blame may rest with the perpetrator alone. A good decision process can lead to a poor outcome and a poor decision process can be followed by a good outcome.

The fourth component, the context, is being increasingly recognised in other high risk services as the most useful focus for solutions (Department of Health, 2000; Institute of Medicine, 1999). Reason contends that:

> The situation in which errors occur is at least as important as its psychological antecedents (if not more so) in triggering its occurrence and shaping its form.

> We cannot easily change human cognition, but we can create contexts in which errors are less likely and, when they do occur, increase their likelihood of detection and correction … situations can be more or less error-provoking (Reason, 2009 p.32).

Reason (1997) distinguishes between 'active' errors and 'latent' conditions. The former are the actions or omissions of individuals at the front line that contributed to the adverse outcome. The latter are the underlying features of the organisational context, the policy priorities, resources, training and supervision, tools provided, etc. These create conditions in which error is more or less likely.

For example, a child protection agency that adopts a policy priority of meeting performance indicators sends out a message that other aspects of the work are less important. If supervisors are short of time, there is a high likelihood that supervision will focus on whether the worker has met the indicators, reducing time spent on critical review of their reasoning. This creates the scenario where errors of reasoning are less likely to be picked up and corrected. We know from research that individuals have great difficulty in challenging their own reasoning (hence the need for supervision) (Woods & Hollnagel, 2006) and so the error is likely to persist with higher probability of an adverse outcome for the child.

Systemic investigations seek to find solutions that alter the latent conditions so that the worker operates in a better designed context:

> The aim is to make it harder for people to do something wrong and easier for them to do it right (Institute of Medicine, 1999 p.2).

Work has been done on adapting the systems approach to case reviews in child protection (Fish, Munro, & Bairstow, 2008) but the dominant form of inquiries has been person-centred. The first three categories of error analysis - intention, action, and outcome - have been the main focus on inquiry so that error tends to be explained by reference to factors within the individual. Underlying this approach is an assumption that the individual professional 'could have' acted differently; a high degree of autonomy is assumed. As Reason (2009 p.74) points out, this fits with Western culture where we place great value in the belief that we are free agents, the controllers of our own destinies. He cites in support research that found that 'when people are given accident reports and asked to judge which causal factors were the most avoidable, they almost invariably pick out the human actions'.

This view of error results in solutions aimed at controlling the performance of those errant individuals. There are three main mechanisms for this, all apparent in child protection systems. First, there are psychological strategies, using punishments and rewards to shape behaviour and encourage people to work at a higher level. Secondly, the autonomy of the individual is reduced where possible. This produces solutions that primarily take of the form of prescribing in detail how the action should be carried out. In common with other countries, the past decades of inquiries in England have produced an ever-expanding set of procedures and guidance which seek to disseminate and standardise good practice (HM Government, 2006). Technology is also increasingly being used to influence how professionals function. For instance,

many countries and states now have prescribed software packages for social workers to use in recording which impose a structure on the reasoning of the workers (e.g. Structured Decision Making in Queensland, Australia and the Integrated Children's System in England). Thirdly, organisations put more effort into monitoring the workforce to ensure they are complying with all the rules and guidance.

In many ways, all of these strategies make sense. Ensuring that people adopt the right priorities in their work is very sensible. Equally, protocols, guidance, and technology can help to spread the lessons learned around the organisation and minimise the risk of people unknowingly repeating mistakes. Some degree of monitoring practitioners is a standard part of any organisation.

However, problems arise when efforts to control workers lead to a level of standardisation that goes beyond the established wisdom and so may not have demonstrable links to improved outcomes for children. Two other developments in child protection have encouraged the drive to excessive standardisation and control: the impact of a blame culture and the design of the performance management system. These have led to an over-valuation of the standardised, measurable aspects of practice and a consequent under-valuation of professional expertise and judgment. This has a serious impact on the potential for learning from experience because it creates a bias towards single- not double-loop learning.

The impact of blame

One of the worst consequences of a person-centred approach to explaining error is that it reinforces the drive towards a blame culture, a drive already fuelled by society's increasing concern about avoiding risk (Beck, 1992; M Power, 2007).

> No longer do we see accidents as meaningless, uncontrollable events. On the contrary: accidents are evidence that a particular risk was not managed well enough. And behind the mismanagement, there was a person, or multiple people. … we expect experts to make accidents comprehensible. We want them to explain which risk factors were not controlled, where, when, and by whom. Accidents are no longer accidents at all. They are failures of risk management (Dekker, 2007 p.x).

There are many psychological and organisational factors that contribute to creating a blame culture.

Firstly, it offers a satisfying explanation. Those practitioners closest to the tragic outcome are readily identifiable and available to blame. Blaming someone is psychologically satisfying; it distances oneself from any responsibility and feeds the belief that errors are avoidable, not just acts of fate. One bad apple has caused the problem and everything will be fine if they are removed. The world, therefore, seems less dangerous and less beyond our control.

Secondly, hindsight bias distorts our judgment. Once we know the outcome, we have a tendency to over-estimate what could have been anticipated with foresight (Fischhoff, 1975). The significance of new information, such as an observed change, looks so clear to those who know how significant it turned out to be that they grossly over-estimate how easy it was to see it at the time when it was hidden in a mass of other information.

> To the retrospective observer all the lines of causality home in on the bad event; but those on the spot, possessed only of foresight, do not see this convergence (Reason, 2009 p.75).

Thirdly, judgment is biased by the fundamental attribution error. We tend to explain other people's behaviour differently from our own (Plous, 1993 p.174). When analysing our own actions, we are very aware of the context, of the factors that led us to frame the situation in a particular way that then led to the choice of action. Explanations therefore tend to focus on those contextual factors. When explaining other people, however, we are most aware of the behaviour itself and so focus our explanations on that rather than the context. Consequently, we tend to explain their actions in terms of their own characteristics.

> When we see or hear of someone making an error, we attribute this to the person's character or ability – to his or her personal qualities. We say that he or she was careless, silly, incompetent, reckless or thoughtless. But if you were to ask the person in question why the error happened, they would almost certainly tell you how the local circumstances forced them to act in that way. The truth of course lies somewhere in between (Reason & Hobbs, 2003 p.15).

Fourthly, organisational factors encourage blaming. To politicians and senior management, person-centred explanations have the obvious attraction of distancing themselves from the adverse outcome. It is also a simple route to take. It is usually easy to identify the people close to the tragedy who made mistakes and target them

for improvement whereas a study of the wider organisational context would take considerably more effort. Individual responsibility also fits readily into the legal system where it is easier to ascribe individual than corporate responsibility.

The cumulative effect of blame is to create what Reason (2009 p.73) terms the 'vulnerable system syndrome'. This is characterised by three pathological entities: 'blame, denial, and the single-minded and blinkered pursuit of the wrong kind of excellence – the latter usually takes the form of seeking to achieve specific performance targets'. A vulnerable system is particularly prone to focusing only on single-loop learning – on monitoring and enforcing compliance with existing prescriptions – while double-loop learning is severely hampered by individuals' reluctance to report problems for fear of being criticised.

The impact of New Public Management

The potential for pursuing the 'wrong kind of excellence' is increased by the changes in how child protection services are managed. Since the 1980s, public sector management has been transformed by the introduction of techniques from the private sector aimed at making the services more efficient and effective, generally referred to as New Public Management (NPM). Two major features of this change are increased managerial control of professional behaviour and a greater demand for transparency so that services show they are spending public money wisely. The resulting performance management system has created a detailed framework of practice, specifying targets and performance indicators to measure and shape practice plus, to meet the need for transparency, a paper (or electronic) trail documenting professional activity.

These strategies can be seen as improving the feedback loops in the system, of giving senior management a more detailed picture of how the organisation is operating. They therefore have the potential for improving organisational learning. However, the difficulties lie in specifying what information gets fed back and what gets missed. For social work, this has been problematic and led to feedback being based on a very biased set of data that omits some of the key quality aspects of a relationship-based service.

Adapting to the NPM culture has required a transformation of practice, reducing the privacy and autonomy with which social workers had operated (Munro, 2004). The audit system requires some way of describing practice and of specifying 'good' practice. As social workers had previously operated in a predominantly individualistic and humanist manner with a limited explicit knowledge base, this has been a major project. It has been complicated by the limited evidence on what leads to good outcomes for children. We cannot confidently give a detailed specification of what good practice looks like in each case (Chaffin & Freidrich, 2004). The performance management system that has been devised has a model of good practice that is based on expert opinion, not empirically validated. It therefore should be proposed with some caution and a recognition of the need to test its adequacy. However, there is little explicit acknowledgement of the extent of uncertainty in the knowledge base and this poses a risk of overconfidence that discourages learning.

The most visible aspects of the performance management system are targets, performance indicators, and procedures detailing how tasks should be carried out. Current systems tend to opt for the more easily measured and so have a focus on

quantity in preference to quality, with an emphasis on fixed timetables and service inputs more than user outcomes (Tilbury, 2004).

The system of targets which is widely used in the public sector has been subject to numerous criticisms of leading to skewed priorities and failing to capture key dimensions of effectiveness (Bevan & Hood, 2006; M. Power, 2004). In England, its adequacy was challenged in the case of Baby Peter where the relevant London Borough was praised and awarded three stars in an inspection conducted after his death. The subsequent submissions to Lord Laming's progress report on safeguarding children contain many examples of how the management system is seen by practitioners as damaging their effectiveness (British Association of Social Workers, 2008; UNISON, 2008).

The cumulative impact

Person-centred explanations of error, a blame culture, and the current performance management system interact in counterproductive ways to produces systems that are defensive and discourage creativity and learning.

Power's (2007 p.5) analysis of the influence of risk on management practices offers some explanation of why the audit system has understated the degree of uncertainty. Drawing on Luhmann's (1992) work, Power argues that introducing the language of risk into discourses previously characterised by danger and uncertainty 'implies a domain for decision making about the future and a corresponding allocation of responsibility for that decision' (p.5). It suggests a social expectation that dangers can be managed and that it is the responsibility of some agency or person to manage them.

In child protection, the public have clearly stated just such an expectation. It is professionals' job to manage the risk to children effectively.

Unfortunately, in practice 'managing risk effectively' is often judged by the outcome not the process. In the abstract, everyone acknowledges that, however good a child protection service, it cannot eliminate harm to children. In practice, however, the first reaction of the public to the death of a child is generally to take it as prima facie evidence of ineffective risk management. Organisations have to prove, rather than defend, their innocence in the debate about whether any identified errors were avoidable, warranting censure, or unavoidable due to the uncertain conditions in which judgments and decisions are made.

In this emotionally charged atmosphere, Rothstein *et al.*'s (2006) distinction between societal risk (the risk to children of maltreatment) and institutional risk (the risk to professionals and agencies of being criticised) helps to illuminate organisational responses. The cost of the latter has been increased by the intensity of public reaction to mistakes and the closer scrutiny of the inspection processes. Ideally, the steps that professionals take to avoid criticism for poor practice should lead to a higher standard of practice and hence to reducing risk to children; managing the two forms of risk can be complementary. In relation to some of the more developed technologies in other high-risk areas of work, this is less problematic because there is a larger set of well-evidenced actions. In child protection, with its limited knowledge base, discriminating between avoidable and unavoidable errors is problematic. When examining any case with a tragic outcome, it is often possible, with hindsight, to see that information was available that we now know was evidence of heightened risk. 'If

only the social worker had done X then the child would be alright' is all too easy a conclusion to reach. When the analysis of error causation gives little attention to the context in which it occurred, it reinforces the tendency to consider the error was avoidable and to blame the individual.

Faced with an unrealistic expectation of safety, one option for organisations is to engage in 'blame prevention engineering' (Hood, Rothstein, & Baldwin, 2001), trying to transfer or dissipate blame by means other than reducing harm to children, i.e. seeking to reduce institutional risk without reducing societal risk. Their research has found that one strategy is 'protocolization', introducing more and more detailed formal procedures setting out the 'correct' way to deal with a case in steps that can be readily performed and measured. This move necessitates going beyond the evidence base in specifying what should be done and limiting that specification to tasks that can be readily observed and recorded – to provide the clear evidence trail that will deflect blame. Thus, in child protection, formal procedures set out the timescale within which an initial assessment must be completed, when a case conference should be held and so on but say little about the more challenging aspects of the work such as how to assess a family where the father is violent, the mother withdrawn, and the child terrified.

This managerial strategy provides the defence of 'due diligence' if a tragic outcome occurs. Senior management can demonstrate how their staff followed all the correct procedures in working with the case and therefore cannot be blamed. With the notable exception of the recent death of Baby Peter, this defence appears to be operating in England where inquiries into child deaths often focus on checking

whether procedures were followed, rather than judging whether competent professional assessments and decisions were made. Rose and Barnes, in their review of serious case reviews, note the priority given to procedures as the mechanism for improving practice:

> What was marked was the emphasis in the recommendations on reviewing or strengthening existing procedures or developing new procedures. This was supported by the views of some of the respondents that the systems were adequate but the problem was one of staff compliance. There was less emphasis than might have been expected on issues of management, supervision, staffing resources and staff knowledge, skills and experience. The organisational context, which in some agencies at the time was undergoing major change, resulting in disruption and discontinuity in staffing, also rarely featured in issues to be addressed (Rose & Barnes, 2008 p.88).

For practitioners, this 'protocolization' can be frustrating or reassuring, frustrating because it constrains their range of action, reassuring because it limits their personal responsibility for their actions. The more punitive the work culture and risk-averse the worker, the more practitioners will opt for the safer route of following procedures, however inappropriate they seem in a particular case.

'Protocolization' carries dangers. Procedures, however detailed, are always incomplete specifications to some degree:

> There is always a distance between a written rule and an actual task. This distance needs to be bridged; the gap must be closed, and the only thing that can close it is human interpretation and application (Dekker, 2006 p.134).

In child protection work, procedures tend to refer to visible tasks but, to carry them out, the worker needs to exercise expertise. For example, conducting an initial assessment requires interviewing skills, in order to elicit relevant information, and reasoning skills to analyse and reach conclusions on the basis of that incomplete and often ambiguous information. An organisation that prioritises procedures runs the risk of undervaluing the professional skills needed to apply the procedures competently. In child protection work, evidence of this risk is seen in the reduced time workers have to spend with children and families (Peckover & Hall, 2008) and the erosion of supervision of casework, with priority being given to supervising managerial tasks (UNISON, 2008) .

Rasmussen's (1986) work on rule-based (RB) and knowledge-based (KB) actions offers a framework for considering how much child protection work can be rule-based. Rules prescribe what the worker is to do in a given situation; the worker has to use judgment to decide what kind of situation it is and then apply the appropriate rule. KB behaviour is needed, however, in complex situations where it is not clear what needs to be done and the worker has to draw on their expertise and make judgments about the best course of action. If it is known what needs to be done in specific situations (e.g. if applying for a care order then complete the Public Law Outline) then it is desirable to have a rule. If, however, the desirable action is not so specific, then professional judgment will be more appropriate. What happens in a defensive culture

is a tendency to convert as many actions as possible into rule-based not judgment-based. Hence, the finding in Rose and Barnes' review of serious case reviews of the tendency to create more rules despite these not addressing the identified weaknesses in practice. It is also evidenced in Lord Laming's (2009) progress report where recommendation 19 is that social care agencies stop j*udging* whether a referral from other professionals merits an initial assessment, and *create a rule* that all referrals receive one. Such a rule will have repercussions for both staff and service users. For families, many more will be subjected to an unpleasant inquiry that offers them nothing positive. For staff, it will increase their caseloads and so create new problems of deciding what to omit in order to create time for the additional duty.

Despite the lack of empirical backing for such an expansion of rules, its great attraction is that, when following a rule leads to an adverse outcome, the worker can offer the defence 'I was doing what I was told to do' and an agency can plead due diligence. In contrast, when following a judgment leads to an adverse outcome, the individual is clearly identifiable and available to blame for making a poor judgment. However, one necessary step in creating the space for professionals to be able to exercise expert judgment and be creative and flexible in responding to children's needs is to work on clarifying which aspects of practice are appropriately dealt with by rules and which require judgment.

Conclusion

This article has argued for taking a systems approach to learning how better to manage risks to children. Conceptualising child protection services as complex, adaptive systems challenges the view that the 'top-down, command and control,' style of management is feasible. Interactions between the subsystems are too complex to

permit accurate prediction. Instead organisations need good feedback loops so that senior management can learn of problems and facilitate adaptations to avoid them. Moving to such an open, reporting culture, however, is very difficult in the current social and political context. The currently dominant way of managing risk and error in child protection has produced a set of solutions that has cumulatively encouraged increasing standardisation and control, reducing the scope for professional judgment and flexibility in responding to children.

Error investigations have focused on the individual elements of errors with insufficient attention to the context in which they occurred. This person-centred approach has a great deal of intuitive appeal. However, it has two major weaknesses. First, it has been tried for decades and led to increasing efforts to control workers' performance that have resulted in a system that is not only failing to protect children sufficiently but also creating work conditions that are counterproductive, leading to distorted priorities and growing alienation of the workforce. Secondly, the focus on control and standardisation is hostile to learning about the weaknesses in practice and hence to finding ways of reducing the risks to children.

The current design of management information systems produces feedback on a limited range of data and omits areas of work, such as the quality of relationships, that are at the heart of good practice. Moreover, because of its top-down design, it tends to look for compliance with prescribed behaviour and be critical of variations thus encouraging single- not double-loop learning.

The defensive, controlling style of management is an understandable reaction to the level of blame from society when children die. However, it is a response that inadvertently encourages people to place the protection of themselves and their agencies above the protection of children. Courage is needed to step out of this and that courage is needed first and foremost in senior managers:

> Change has to start at the top because otherwise defensive senior managers are likely to disown any transformation in reasoning patterns coming from below If professionals or middle managers begin to change the way they reason and act, such changes are likely to appear strange – if not actually dangerous – to those at the top p(Argyris, 1991 p.108).

In child protection, we have limited knowledge about how best to protect children. We need to learn and, so, need organisations that encourage learning. Accepting this will be more constructive for children in the long run than over-estimating our knowledge and believing that we just need a bit more control of front line workers to make the system work properly.

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