Child death inquiries

Moving beyond the rhetoric of learning

Judith Gibbs

The process of reviewing deaths of children who had formerly been known to a child protection agency is emotive, and its value is often contested. This paper is written with the frontline practitioner in mind, and grapples with the complexities of how inquiries can make a difference in the world of all relevant stakeholders. It is contended that a goal of individual and systemic learning can be achieved if inquiries take place in a healthy, collaborative learning culture, if they are embedded in a multi-sectoral systemic framework, and if a reflective analysis is undertaken. Such inquiries would prioritise an understanding of the individual, organisational and systemic factors that influence thinking, feeling and doing. When constructed and experienced as opportunities for individual and collective learning, inquiries have the potential to add value to the whole service system and the practice of frontline workers, along with meeting the need for public accountability.

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> On reading the child death review I felt that my entire work history was being defined by this one awful outcome. All the other positive outcomes for countless families were lost in the shadow of this child's death. The work I had done with the family wasn't acknowledged in the report. Incorrect assumptions were made about my knowledge and practice. I didn't have a voice in the review process, and the document was already printed. I had no way of responding to the criticisms of my work. I was devastated. I felt angry, upset, powerless, and gagged. I still remember my face burning with humiliation when I read the review. The impact of that review still follows me many years later. In the moments when the work becomes overwhelming, if I think about that feedback, it can still dent my confidence. I still question whether I am in the right job ...

Embedded in this heartfelt statement from a former child protection worker are a number of messages about child death inquiries that, when poorly conceptualised and conducted, have the potential to add to the unavoidable pain and distress that follows the death of a child who had been known to child protection services. Stories such as this one are the impetus behind writing this paper as they resonate with my personal experiences as a practitioner, team leader, manager, and researcher in a statutory child protection setting. As a trainer working with groups of workers drawn from across the child and family welfare field, I am struck by how frequently participants spontaneously talk about their experience after a child dies. For these participants, vivid memories of inquiries can evoke painful feelings of failure, fear and personal criticism years after the experience. Even though with the passing of time some of these feelings may seem irrational, they are understandable given the way in which some statutory organisations manage the aftermath of a child death and the subsequent formal procedures that occur. Media coverage that seeks to blame and defensive responses from politicians serve to heighten feelings of vulnerability and distress across the child protection workforce.

Membership of a review body overseeing completed reports and my more recent work as a case reviewer have led me to advocate for system-wide inquiries where reflective analysis leads to new knowledge and learning. This is in sharp contrast to an investigative approach that is characterised by a search for practice deficits and procedural solutions. Moving beyond the rhetoric of systemic learning may mean

changes at the level of organisational and wider culture, which must be led by senior bureaucrats and, perhaps, politicians.

A systemic framework as an overarching conceptual model for inquiries is proposed in order that they are more likely to enhance the quality of the information we get about how the whole system engages with children and families and, at the same time, can enable those who participate from the frontline of practice to have a voice and be supported to reflect on what happened with a view to individual and collective learning. Such inquiries would not take place under legalistic rules where evidence was being taken. Instead, they would be less formal, and participants would agree to be interviewed and be able to 'tell their story'. A deliberate choice was made to write this paper with the worker in mind, although much of the material applies to other participants in the inquiry process. The resurgence of interest in relationship-based practice based on evidence that the worker's capacity to engage with clients enhances the quality of the risk assessment and leads to change, supports maximum effort towards strengthening frontline practice (de Boer & Coady 2007; McKeon 2000; Ruch 2005).

CURRENT PRACTICE IN AUSTRALIA

All Australian jurisdictions, as in the UK, USA and New Zealand, have processes through which they are able to review the deaths of children following abuse and/or where the child and family have had involvement with a formal child protection system (Bunting & Reid 2005; Connolly & Doolan 2007a; Fanning 2006; Reder & Duncan 2004a). An independent inquiry following a child's death can contribute to the public accountability of services that engage with some of the most vulnerable members of the community. In Victoria, the annual report of the Victorian Death Review Committee is tabled in Parliament. On an annual basis, that committee details the deaths that occurred during the previous year which fell within the scope of the legislation (Child Wellbeing and Safety Act 2005), provides an analysis of the cases reviewed during the year, and also an historical analysis of trends across the total number of child deaths that have been reviewed since the first report in 1996 (Office of the Child Safety Commissioner [OCSC] 2009).

Across the eight Australian child welfare statutory authorities, all of which are subject to their respective state legislations, there are significant variations between inquiry processes. Those processes include which child deaths are reviewed, the internal and external bodies conducting and overseeing inquiries, which service providers are involved, and whether the findings are reported individually or collectively to governments and the community. The words *review* and *inquiry* are often used interchangeably in this context and, unless otherwise stated, both are used here to describe the process that follows the death of a child who was a client of child protection or had been known to the child welfare system for a predetermined period prior to the death.

The significant differences across the jurisdictions were discussed at a seminar on child death inquiries held in June 2008 in Melbourne (Office of the Child Safety Commissioner, Melbourne, unpublished results). In Victoria, for example, deaths are only reviewed by the Child Safety Commissioner when the child had been the subject of a report to the Department of Human Services in the three months prior to the death, whereas in New South Wales the Ombudsman reviews the deaths of all children reported to the Department of Community Services in the previous three years. It is lamentable that these inconsistencies have resulted in an inability to establish reliable Australian national data about child protection deaths for comparison and research. It was, however, evident at the seminar that all jurisdictions aspire to review cases with the aim of improving practice and increasing the safety and well-being of children as well as achieving public accountability.

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LEARNING FROM THE LITERATURE

Hochstadt (2006), when reporting on the work of Child Death Review Teams in the USA, states that these teams:

> ... have made an important contribution to the protection of children through identification of case specific interventions for surviving siblings and their families, the formulation of prevention strategies, and the development of public policy designed to prevent child fatalities and serious injuries from maltreatment and other preventable causes (Hochstadt 2006, p. 654).

Stanley and Manthorpe (2004, as cited in Brandon, Dodsworth & Rumball 2005, p. 163) suggest that inquiries may also succeed in raising 'the profile of child protection as a legitimate and shared multiagency concern'.

Many international experts, however, adopt a critical position and argue that, despite the allocation of extensive resources in terms of both time and money, on the whole inquiries have not succeeded in making a difference to practice and, in a number of respects, have had a dysfunctional impact on child welfare practice (Connolly & Doolan 2007b; Corby 2004; Ferguson 2004; Munro 2004, 2005; Scott 2006).

It would appear that in many countries the findings and recommendations arising from inquiries have helped to shape child protection practice toward a model that seeks to identify and manage risk rather than one that seeks to strengthen the entire child welfare system and enable and support parents to raise children safely (Connolly & Doolan 2007b; Ferguson 2004; Howe 1992; Munro 2004; Scott 2006). Reflecting a technical rational approach to child protection, many inquiries appear to have led to bureaucratic responses such as new procedures, checklists and guidelines, but these may add to a level of anxiety and dependence within the child protection workforce rather than enhancing analytic skills and reflective frameworks that promote sound assessments and good professional judgment (Bingley Miller & Fisher 1992; Gibbs 2002).

One consequence of risk-averse responses may also be a spurious message to the public that, if only practice had been better, the child would not have died. This is not only a simplistic perspective, it may also raise the anxiety and lower the morale of workers (Hassall 2006). Corby (2004) and Munro (2004) suggest that in this climate workers fear making a mistake and being blamed and, as a result, adopt defensive and bureaucratically-constrained practice that can lead to either under or over-intervention in family life.

Cooper (2005) has offered an extensive and valuable critique of the Victoria Climbié Inquiry Report in the UK. He recommends the use of inquiries that engage with the complex transactions between workers and clients at the deeper level of psychological processes in order to examine the impact of emotion on child protection practice. While recognising the challenges for those conducting inquiries, he writes of:

> ... the absolute necessity to attend to the connection between the instruments which organise the surface of child protection work ... and the processes of deep engagement via relationships with children, parents, carers, and others involved with the child and the work this entails (Cooper 2005, p. 9).

A model for conducting inquiries, and the recommendations that follow, should take into account the 'harsh, painful realities of practice' that cannot be simplified and controlled through surface level procedures and processes (Ruch 2007, p. 374). In a similar vein, Stanley and Goddard (2002), writing in Australia, argue that, in the absence of other 'research data' about what happens to children when they enter the child protection system, the scope of child death inquiries must be broadened and public reports should contain far more detailed analyses of the individual case practice and outcomes. In particular, they advocate for an analysis which takes account of the psychological impact of violence on child protection workers and their practice.

Looking at individual and collective reports following inquiries from the UK, it becomes apparent that there are many similar findings about practice deficits (Brandon et al. 2008; Reder & Duncan 2004b; Sinclair & Bullock 2002). These overviews present sound research and invaluable insights into practice, but often resemble each other and echo findings from similar reviews in Australia (NSW Child Death Review Team 2003; OCSC 2008, 2009). The implication is that inquiries have not led to the desired changes in frontline practice or to improved outcomes for children.

The few writers who have considered the process from the viewpoint of practitioners have not painted a promising picture either (see Lawson, Masson & Milner 1995; Munro 2004). King (2003) suggests that participants find the process 'daunting and difficult'. In their work as trainers with frontline managers who had recently gone through a review process, Lawson et al. (1995) found that many of the workers perceived the process as being one that sought to blame rather than as one that offered a framework for learning. They also comment that some practitioners showed a reluctance even to read the report that was produced from the review. My own experience and the statements of workers I have encountered in training confirm this. Too little attention appears to be given to the process of inquiries and the psychological needs of participants.

Connolly and Doolan (2007b, p. 27) suggest that:

> ... finding ways of learning from child deaths without them becoming a mechanism for promoting more risk-averse practice has become a major challenge for child welfare systems in recent years.

From the perspective of the practitioner, the question might become: How could this process aid professional development and learning without being experienced as one of individual blaming and potentially a secondary source of stress?

THE IMPORTANCE OF ORGANISATIONAL AND WIDER CULTURE

One means of achieving inquiries that encourage learning at a deeper level is to consider the organisational context and culture in which inquiries take place. Newcomers are quickly acculturated into an organisation and learn, often at an unconscious level, 'the way things are done around here' as well as 'the rewards, punishments and expected outcomes that follow work responses' (Hemmelgarn, Glisson & James 2006, p. 75). As Hemmelgarn et al. point out, these mental representations are extremely powerful shapers not only of behaviour but also of the way workers make sense of their experiences.

When a child dies, many of those who have been involved with that child are likely to experience feelings of anxiety, vulnerability, fear and powerlessness, and the manner in which both individuals and groups are helped to recognise and manage their emotional responses is an important aspect

of the organisational culture. Many unconscious defensive responses such as blaming and projection can be particularly unhelpful, and they contribute to high levels of distress felt by those who worked with the child and others. Horwath (1995, p. 351) writes that:

> the situation may be exacerbated [for workers] by colleagues avoiding them 'as if we were contaminated'.

The provision within the organisation of supportive supervision, along with opportunities for reflective space, assumes even more importance when workers struggle with a wide range of rational and irrational feelings.

The dominant organisational culture impacts on how practitioners experience any child death inquiry process. If the cultural messages they are given by supervisors and managers is that the inquiry is conducted to find out what mistakes were made and by whom, that perspective will be a powerful shaper of how they will approach participation—whatever the guidelines may suggest. A key area for reflection among senior managers concerns the challenges and difficulties, such as high attrition rates and low experience levels, in the wider context of the organisation, rather than defaulting to a defensive position that often leaves individual frontline workers feeling scapegoated and the workforce damaged with regard to morale. Poor management of anxiety can have a corrosive impact on the very nature of a process designed for supporting and enabling workers to do their work more effectively. Indeed, one could argue that the way senior managers collectively respond to and manage the process of a child death inquiry is a clear indicator of the health of an organisation and of how likely the organisation is to incorporate any learning into practice in the future.

Through the way they conduct an inquiry, and the way they write reports, people who conduct inquiries play a pivotal role for influencing cultural messages about the process. High levels of social competence are needed so that participants experience the process as being fair, and so that they have an opportunity to tell their story and feel they have been listened to. Practitioner learning and development will not result from technical or superficial solutions, and if workers experience the process as blaming they may well leave an organisation. Fish, Munro and Bairstow (2008, p. 21) draw on the work of Vincent (2006, p. 158) in suggesting that participants in an inquiry process need to experience 'an open and fair culture' that, while recognising frontline workers as being accountable for their individual practice, does not hold them fully responsible for a set of complex, interrelated factors, many of which are beyond their control. Inquiries may well examine practice in a particular case and suggest that 'avoidable mistakes' (Munro 1996) have been made, but it is of paramount importance that reviewers explore and document the complex nature of the factors that contributed to the poor or ineffective practice.

Creating within inquiries an environment of exploration, learning and practice improvement is a major challenge in any social or political context where risk management and proceduralisation dominate over complexity, relationships and emotions. Inquiries often operate within a whirlpool of collective anxiety, and internal and external reviewers can easily become drawn into, and entangled in, an unhealthy defensive culture where the outward signs are tense, hostile interactions and serious chasms in the inquiry process. Without a shared commitment to organisational and systemic reflection and learning, the findings from inquiries are likely to be sidelined and seen as a waste of resources.

Collective defence structures also operate at the wider level of the community. Obholzer and Roberts (1994) suggest that we manage our social anxieties as a community through public sector organisations such as those involving child protection. The child welfare system acts as a container for the community's distress and anxiety concerning child abuse, but that mechanism can no longer operate effectively when a death or extremely serious incident occurs. The search for a scapegoat or a rational explanation for how such a thing could have happened is understandable, but it often leaves individual workers vulnerable to the full impact of the community's collective anger and distress. Politicians and senior bureaucrats need to look for opportunities to present balanced and informative coverage of the systemic and structural challenges inherent in providing a child protection service, rather than reinforce a simplistic and dangerous message that child deaths occur solely because of mistakes made by individuals.

THE IMPORTANCE OF UNDERSTANDING THE PURPOSE OF INQUIRIES

In some jurisdictions, inquiries are held only when a child has died as a direct result of abuse (Connolly & Doolan 2007a, 2007b). These deaths are fortunately rare. I am advocating that a much wider group of child protection deaths be reviewed, as in Victoria where the cause of death could be, for example, illness, disability, high-risk behaviour or SIDS (OCSC 2009). The aim of reviewing this wide range of cases is not only to identify ways in which such child deaths might be avoided; it is extremely important that workers are assisted to understand that the learning here is rarely related to the reasons for the death. The review is 'essentially an audit of case practice and service provision triggered by each child death' (OCSC 2009, p. v.). Conversely, an adverse, event-driven, causally-focused analysis about a death is flawed because it does not sufficiently acknowledge or investigate the complexity and interrelatedness of many factors about the child, the family, the workers, and organisational service network—all of

which influence practice (Munro 2005). Far from representing practice with a minority group of children, the inquiry process should provide a window into the entire child protection system, and lessons learnt could therefore have much wider implications (Armytage & Reeves 1992; Falkov 1996). An extension of this argument is that, if similar cases where a child did not die were reviewed, many of the same insights could emerge about how the system is functioning. Child death inquiries have enormous potential as one mechanism through which continuous practice improvement can occur, but that improvement can occur only if attention is directed at understanding the emotional and cognitive aspects of frontline practice and decision-making.

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A number of Australian jurisdictions focus primarily on practice in the statutory child protection service, and deal with the wider service system only incidentally. It can be argued that this is a missed opportunity in terms of systemic learning, and may contribute to child protection workers feeling blamed and that they are carrying the responsibility for an entire service system. A more useful approach would be a broad multi-sectoral inquiry that involves all the agencies and systems associated with the child and family. While some service providers may raise concerns about confidentiality and individual and institutional liability, such concerns should not stop those who conduct inquiries from broadening the process as far as possible. It is important for participants to understand that people have different perceptions of the same experience, and that it is only when hearing about multiple perspectives that some aspects of collective learning take place. Inquiries provide one opportunity for people to hear and understand how others have experienced the events.

The process of conducting a child death inquiry needs to occur in an emotionally competent organisation (Morrison 1997) that encourages people to reflect critically upon the ways in which they have been doing things—both individually and collectively. Participants need detailed and accurate information about the inquiry process and likely outcomes, including the possibility that reflecting on what happened, and analysing practice, may well lead them to feeling uncomfortable, challenged, vulnerable and anxious. In a child protection system it is important to remember that this is also what is likely to occur within families. Acknowledging how participants might be feeling, and encouraging them to process their emotions rather than suppress and deny them, is critical.

THE IMPORTANCE OF A SYSTEMIC FRAMEWORK AND MULTI-THEORETICAL APPROACH FOR INQUIRIES

Fish and colleagues (2008) recommend a multi-agency systems approach as a conceptual model for conducting inquiries in the UK. Based on what happens in the field of engineering, where the starting point for analysis occurs after problems or practice deficits have been ascertained, their model of inquiry seeks to determine what led to an occurrence, in a similar way to a root cause analysis (Brandon et al. 2005). Connolly and Doolan (2007a) describe a systemic framework for child death reviews with attention to a set of related dimensions, namely the family system, the worker system, the organisational system, and the wider system. They recommend taking attention away from the individual and looking at more complex factors and interrelationships that could lead to better insights about the system and how it operates. In an inquiry, it is the analysis of the interconnectedness between factors in different parts of the broad system that is pivotal for making sense of what happened. The value of identifying contributory factors such as low staffing levels and high workloads at an organisational level is that they may help to explain why team leaders and frontline practitioners acted in the way that they did.

One of the most frequent criticisms of inquiries is that they describe, with the benefit of hindsight, what should have occurred. Within a systemic framework, the concept of looking at 'local rationality' is important (Woods et al. 1994, as cited in Munro 2005, p. 534). This means that reviewers should try to determine how the situation looked from the point of view of those involved, and why a particular course of action appeared to them to be reasonable. The emphasis is on 'error management' rather than 'error prevention' because, in a field such as child protection, it is impossible to reach a point where 'mistakes' are not made. Many inquiries, both here and overseas, identify a failure to undertake a holistic family assessment, and inquiries provide a mechanism through which the many possible contributory factors, such as a lack of knowledge, inadequate supervision, complex risk-assessment tools, and time constraints can be identified and explored.

Organisational culture and messages are possible contributors to problems in practice. Cultural messages can be conflicting in nature and, if so, add considerable stress and complexity to the work environment (Connolly & Doolan 2007a; Munro 2005). These need to be understood as part of the inquiry ambit because role conflicts, role ambiguities, and role overload can all provide explanations

for mistakes or practice deficits. For example, an overt message about the need to read historical information that can lead to a sound assessment of cumulative harm to a child can be hard to reconcile with a covert message that there is no time for reading prior reports and that priority should be given to getting out and assessing immediate risk. Supervisors seeking to implement a policy that tells them to offer regular sound reflective supervision to workers may find themselves significantly challenged when they also receive a cultural message from their managers that their primary responsibility is to manage unallocated cases and avoid serious incidents at all costs (Gibbs 2002). It is therefore necessary for inquiries to acknowledge how much participants consciously wrestle with such competing messages and how they reconcile them in practice, particularly as the knowledge gained could be incorporated into training, practice guidelines and supervision.

Many of the situations facing practitioners in the child protection field are emotionally intrusive and ambiguous. It is therefore desirable that reviewers be able to draw on a range of theoretical perspectives to assist in the analysis of why things happened as they did. There must be a focus on how people think as well as on the emotional and psychological processes that influence cognition (Munro 2005). The work on reasoning in child protection (Munro 1999), the work on communication mindsets (Reder & Duncan 2003), the work on the impact of violence on child protection workers (Stanley & Goddard 2002), and the work on practice expertise (Brandon et al. 2005) all demonstrate the value of inquiries when the analysis moves away from human error and toward a consideration of what shapes professional practice and expertise. Based on their detailed analyses of the dynamics of the Victoria Climbé case, Cooper (2005), Ferguson (2005) and Rustin (2005) have all argued convincingly that attention should be given to the psychological and emotional aspects of child protection work, or reviews run the risk of being superficial where identified problems lead only to procedural solutions.

THE IMPORTANCE OF A REFLECTIVE ANALYSIS

A systemic, deep-level approach to child death inquiries can occur in a reflective analysis where the focus is on enabling participants to look back on their practice and learn as a result of being able to understand the many factors that shaped what happened. For an inquiry to be effective, the four types of reflection identified by Ruch (2000, p.101) might usefully be employed. Using technical reflection, which is the lowest level of reflection, the reviewer would compare practice to the external/technical sources of knowledge derived from formal theory, procedures and processes. This type of reflection would focus on accountability and identify how well practice adhered to legislative and procedural requirements and, at the same time, it would attempt to throw light on the barriers to, and supports for, good practice. Second, and at a deeper level of learning, inquiries like this can assist workers to reflect on their practice using practical reflection. By asking questions about formal theoretical and tacit-intuitive knowledge, reviewers would seek to understand the theories, values, assumptions and beliefs that shaped practice and what happened. Third, using critical reflection, there would be an explicit focus on power relations (Fook 1996), which are particularly important given the structural forces that can impact on child welfare practice. Finally, process reflection would be used in which the conscious and unconscious elements of practice are considered and the application of psychoanalytic theory to shed light on the impact of emotion on individual and collective behaviour. The main conduit in this challenging inquiry process is good reflective questioning that goes beyond action and that helps people to think about the emotional and cognitive aspects of practice.

> *... the role of the reviewer is to reflect and analyse, and subsequently present what can be learnt from the whole situation with a view to promoting improved outcomes for children and their families.*

An inquiry that relies solely on an audit of case files has serious flaws, not the least of which is that case notes were originally created for a very different purpose (Stanley & Goddard 2002). Files give the reader a 'flat' picture and limit how much can be understood about why people acted in the way they did. An outsider reading an account for the first time frequently feels angry and horrified about practice. This emotional reaction is often prompted by something that occurred some time prior to the death. Such an emotional response points to the need for talking with people and trying to understand why they did what they did. There seems to be little point in persisting with inquiries that provide a description of behaviour that did not adhere to standards without attempting to provide an explanation for that behaviour.

My experience in this challenging area has led me to prioritise building a degree of trust by giving participants in an inquiry an opportunity to tell the story of their intervention with the child and family. I would start with general questions such as 'Can you tell me about your involvement with ...?', 'I would like to hear about the work you did with ...', and 'What do you recall as key episodes in your work with ...?' This approach could comprise both therapeutic and empowering processes for the workers because they would be given an opportunity to talk about

their practice and not to feel they were being interrogated. It would also allow reviewers to gain an understanding of critical episodes in practice where it is likely that learning could occur. Importantly, reviewers would be alerted to examples of good practice such as efforts made to establish meaningful relationships with children and carers.

Reflective analysis is most usefully conceived of as a broad approach to an inquiry interview and process. It should not be a rigid technique to be applied in all situations (Osmond & Darlington 2005). The skill of the reviewer is to formulate questions that are individually tailored to a particular situation. Connecting to strength-based principles is useful here, where questions are characterised by 'curiosity about and appreciation of experience, context and constraints' (McCashen 2005, p.53). Reviewers should constantly check with participants that the way they, as reviewers, are interpreting what they are reading and hearing about, as well as the hypotheses that are being generated during the inquiry process, are valid. Below I present examples of broad themes that might assist in an inquiry. I have included some examples of questions that have proved to be useful in inquiries that I have undertaken because they have allowed me to understand the way in which practitioners made sense of situations and the factors that shaped how they acted.

- What was the context in which assessment, decision-making and action took place? Can you tell me about what was happening in the office at the time? Can you use a metaphor to describe those relationships at the time? Can you describe your relationship with the child and family at the time?
- How did you experience what happened? How did this case compare with your other cases in terms of risk and urgency? When you first went into the home and saw the child, what were your thoughts? When you heard about that decision [specify], what did you feel?
- What led you to respond in the way you did? What were the factors that influenced your assessment? Can you tell me about the discussions you had in supervision about this family? What were the sorts of theories that influenced your recommendation? How did you make sense of that episode?
- What were some of the issues, or processes, that may have affected intra- or inter-agency relationships? When you spoke to the service about the family, what was your understanding of their involvement? How do you think the agency staff felt about you contacting them? What things helped the care team to work well together?

When children die, it is likely that there will be very few instances of gross incompetence at an individual worker level, and there are processes within organisations to manage performance issues, so inquiries need to have an appropriate focus that will also lead to the greatest number of positive outcomes. As Reder and Duncan (2004b) point out, people cannot learn when they are under a threat of disciplinary action, and any processes associated with disciplinary action must be quite separate from a learning forum such as an inquiry. In the planning stage of inquiries, managers sometimes say that workers directly involved in the child's life should not be involved because it is likely to distress them further, and that managers have the responsibility to be interviewed. Participation by frontline workers in an inquiry process should be voluntary, although in my experience workers are pleased to be invited to participate. It is a painful and demanding experience, but generally frontline workers want to learn and they want a voice in the process. It is not uncommon for workers to come to an inquiry process feeling guilty and believing they have failed because they know practice could have been better. The worker quoted at the start of this article said she felt cheated because she had not been given an opportunity to talk about what happened. She said that assumptions had been made about her as a worker, but with an opportunity to explore her practice she would have been able to reflect on her own assumptions and what had influenced what she did. Some of these factors lay at an organisational level and were not within her control. Reflective analysis has the potential to promote both individual and organisational learning.

Having listened to participants telling their narratives and exploring the factors behind what happened, the role of the reviewer is to further reflect and analyse, and subsequently present what can be learnt from the whole situation with a view to promoting improved outcomes for children and their families. In doing so, reviewers must make explicit the theories and frameworks that they have applied as a way of making sense of what they heard and read about during an inquiry, thereby mirroring sound practice principles. Report formats may vary, but it is important that those who read a report are able to hear about the many interrelated factors that shaped practice at all levels of the system. Participants should also be given a draft of the report—taking account of privacy and mandatory reporting legislation—and have an opportunity to comment on it and raise additional points. It may well be that inquiries can prompt the need for local workshops to look at issues raised and provide participants with opportunities to engage in further learning together. Enhancing practice change and improvement at a local level can be an important and valuable function of this type of process.

CONCLUSION

The impetus for writing this paper came in part from talking with workers such as the one whose quotation is presented at the beginning of this article. We need to persevere at making the inquiry process more meaningful and less emotionally intrusive for participants. Inquiries conducted insensitively and without a sufficient degree of appropriate preparation

run the danger of alienating the workforce and, even worse, causing secondary stress responses in participants if they feel blamed and victimised. Reviewers need to focus on establishing a fair and transparent process and to be emotionally attuned to the needs of participants.

Evidence suggests that child death inquiries frequently result in policy and procedural change aimed at reducing the chance of a reoccurrence of perceived mistakes. The inherent danger of such a deficit-seeking model is that it leads to widespread dissatisfaction and distrust in the process itself as well as to systems that are dominated by risk-averse thinking and practice. The explanatory approach described here is embedded in a systemic framework that recognises the interconnectedness between contributory factors in different parts of the system and draws on theories that take account of the emotional and cognitive dimensions of practice. Enhancing practice and improving outcomes for children requires an engagement with frontline practitioners and using processes such as those suggested here to influence how practitioners understand and make sense of complex and ambiguous situations. This mirrors the casework process where workers must be able to engage in an emotionally attuned and cognitively informed way to clients if children are to be protected.

Organisational and wider context and culture are aspects to consider. Individual and collective learning can occur through an inquiry process within an emotionally competent organisation where there is attention to thoughts and feelings as well as action. Politicians and senior bureaucrats must take a lead role in advancing this culture. Participants need to understand that inquiries provide one mechanism through which an organisation can engage in reflective analysis with a view to creating new knowledge and improvements in practice with children and families. Even though the message needs to be about multi-sectoral systemic learning, participants should nevertheless be challenged to look at what they did, painful as that might be at times, and investigate the many contributory factors that shaped their practice. ■

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