

# ***RESPONDING TO THE DEATHS OF CHILDREN KNOWN TO CHILD PROTECTION AGENCIES***

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## **Abstract**

Reviews of maltreatment deaths of children known to child protection authorities spring from a desire to improve practice and enhance safety for children. As such, they may be failing their core purpose. This article explores the use made of such reviews and how limiting our learning to these tragic events may have unintended consequences in terms of building strong systems of support for children. It is argued that the risk-averse systems that can result from political and organisational responses to child death reviews have the potential to impact negatively on services for at-risk children. A systems framework is proposed as a more productive way of exploring the complex and multi-faceted aspects of case work invariably associated with these tragic events. A systems analysis provides a change of focus from the conduct of an individual social worker, by extending examination across a set of related dimensions – the family system, the worker system, the organisational system and the wider system. The authors conclude that child death reviews that place practice in a wider context are more likely to contribute positively to the strengthening of services for children overall.

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## INTRODUCTION

Although death by assault is relatively rare for children, the impact of a child dying in this way is felt far beyond the child's own family context. These deaths touch a deep vein of public emotion as people wonder why anyone would harm a child in such a way. They stimulate media frenzy, followed by public outcry, calls for accountability, and expectations of statutory reform. The first significant child homicide death review was undertaken in the United Kingdom in 1973. The tragic death of Maria Colwell brought child homicide to the forefront of public attention, and since that time reviewing high-profile deaths has become a common response in English-speaking countries. Despite their rarity, child death reviews have become influential to the understanding of professional systems of response as well as child abuse more broadly. Within the current climate it is possible for the death of a single child to result in calls for widespread child welfare reform (Ferguson 2004). Although it is clearly important that we understand the circumstances surrounding child deaths, it is wrong to assume that one tragic situation necessarily characterises practice with children and family across an entire system. Indeed, such situations may just as likely reflect a set of idiosyncratic circumstances located in a particular time and place.

This article explores the use made of New Zealand child maltreatment death reviews – carried out either by Child, Youth and Family Services (CYF) or the Office of the Children's Commissioner (OCC) – and how limiting our learning to these tragic events may have unintended consequences in terms of building strong systems of support for children. It is argued that the risk-averse systems they unintentionally foster may ultimately be harming some of the vulnerable children they seek to protect.

## CHILD PROTECTION, RISK AND CHILD HOMICIDE

In his thoughtful analysis of protecting children in time, Ferguson (2004) ponders a paradox: why are we consumed by child homicide risk anxiety when throughout history it has never been less risky for children? Contemporary systems of child welfare are more sophisticated than ever before in identifying and responding to risk, and children probably face less danger than they ever have in history:

The upshot of [this] is a greatly increased sense of risk and danger in child protection, although the actual numbers or proportion of cases involving life-threatening situations for children is small. (Ferguson 2004:116)

Risk consciousness, according to Ferguson, has turned into risk anxiety and social workers carry the burden of it.

To understand this phenomenon it is useful to consider what has happened as child homicide has gained greater public exposure. Children have always died at the hands of adults, and the number of child deaths has remained relatively stable over recent times. But the degree of public awareness of situations of child homicide has varied. In the United Kingdom, child maltreatment deaths known to the National Society for the Prevention of Cruelty to Children (NSPCC) were recorded from 1915 until 1936 (Ferguson 2004). Subsequently, deaths of children known to agencies disappeared from view, partly because of changes in the management of information and partly because the numbers had dropped to the point of being of limited significance to practice. Over time, according to Ferguson, “death went out of sight in order to promote public trust and feelings of security in child protection and to repress people’s worst social fears about families and violence” (p. 90). Social workers became the “containers” for community anxiety or, as Munro (2005:378) puts it, people who can “bear the guilt for the disaster and ... be the target of feelings of rage and frustration”.

By the mid-1970s, however, child protection had become more visible. Knowledge about child abuse was developing, and increased awareness of the sexual abuse of children thrust child protection work into the limelight. The public was no longer protected from the horrors of child abuse, and the media relentlessly pursued every opportunity to bring tragic stories to public attention. Enquiries into these deaths began to open systems of child welfare to public scrutiny:

With the invariably aggressive attentions of the media, public disclosures of child deaths and inquiries into system “failures” have played a crucial symbolic role in opening out child abuse and protection services, as well as professional anxiety, to public view ... They were also shocking in the sense that they appeared to be completely new and to reflect a real decline in professional standards. (Ferguson 2004:110)

They were not new, of course, but they *seemed* new. Systems of child welfare went from being *protectors of public anxiety* to being *inadequate protectors of the nation’s children*. The notion that social workers could, and should, protect all children from harm, took hold.

## PUBLIC ENQUIRIES INTO CHILD HOMICIDE AND CULTURES OF BLAME

There have been many child death enquiries over the past 30 years and much analysis has gone into the search for practice patterns that may have been associated with such deaths (Reder et al. 1993). Reviews have variously identified ways in which more coordinated responses can strengthen practice and support workers to do what they want to do most: protect children. In recent years, however, writers have begun to question whether these processes, and the “reforms” flowing from them, are contributing in the positive way they were originally intended:

They are a clumsy and expensive way of tackling them. Repetitive, high-profile reviews can be counter-productive in other ways. They can reduce morale in protection agencies and drive them into unhelpfully defensive practices. They can repeatedly raise public expectations that will inevitably be disappointed, leading to scepticism and loss of support for efforts to deal with the essential problem of ill-treatment of children. (Hassall 2006)

According to Munro (2005:378), such enquiries have the potential to satisfy a community need to find a scapegoat, “meet[ing] that need by focusing primarily on whether any professional was at fault”. She goes on to argue that this search for a scapegoat identifies three mechanisms aimed at minimising and controlling erratic professional behaviour:

- punish the culprits and so encourage the others to be more diligent
- reduce the role of individual human reasoning as much as possible, formalising the process where possible with increasingly precise instructions to the human operators
- increase the monitoring of practice to ensure compliance with instructions (Munro 2005:378).

For social workers in practice, these three mechanisms will ring an uncomfortable note of familiarity. In terms of the first, practitioners are left in no doubt who will be blamed when a child dies. Even when professional judgements are necessarily equivocal and seem reasonable at the time, with the benefit of hindsight and increased information, practice pathways invariably become much more clear-cut. The second mechanism tries its utmost to create practice infallibility. However, trying to replace professional judgement with protocols, tools and guidelines ignores the fluidity of child protection practice. Relying on management checklists to guide practice is counter to the development of frameworks that encourage deeper understandings of human motivation, and responses that require reflexive action in partnership with families. Attempting to make complex matters relating to professional judgement simple by developing tools and checklists is a naïve response that is more likely than not to fail.

Munro’s third mechanism captures the notion of the public sector “audit society” (Power 1997). While public accountability is clearly important and offers a means through which services can be improved, social work has become subject to rationalisation and re-shaping in a managerial culture that seems to regard social work practice as either irrational or pre-rational (Hough 1996). This makes it more difficult for social workers to assert the benefits of reflection and supervision over prescription and measurement.

Munro ponders the lack of success these responses have had. She notes that while child maltreatment deaths have not reduced, services in the United Kingdom and United States have become increasingly “crisis-reactive” in response to abuse allegations, concentrating resources at the risk averse front-end of the response

system. This has meant fewer resources dedicated to early intervention and the needs of children who are at serious risk.

## RISK-AVERSE RESPONSES AND THE PROTECTION OF CHILDREN

In New Zealand, high-profile child death reporting is one of a set of reinforcers that have influenced risk-averse responses in recent years. Perhaps most closely linked to the high-profile reviews is the media response to them, increasing attention on abuse and the consequent community reaction. Research into media attention and the number of child protection notifications received by statutory child protection services in New Zealand reveals a close correlation (Mansell 2006). Periods of high levels of media attention also have higher notification rates. Interestingly, periods of extreme growth in notifications follow the most intensive periods of media attention. Counterintuitively, it does not seem to matter that the media attention is negative – notifications still flood in.

However, it is not clear that this upward trend in notifications necessarily reflects higher actual levels of child abuse and neglect. More likely it reflects changes in reporting behaviour and a lack of more appropriate services that would better suit the presenting need. In New Zealand, writers have also argued that surges of demand largely result from a decrease in community tolerance with respect to the abuse of children, and a consequential expected level of community risk assurance (Mansell 2006).

Over the past 15 years, increasingly high community expectations that social workers must protect all children and never miss a single case of abuse have driven practice toward increasingly forensic investigations of any allegation of abuse or concern. In the context of the history of New Zealand practice, this represents an interesting shift in emphasis over time. Traditionally New Zealand practice has emulated international jurisdictions, closely following practice in the United Kingdom. In the 1960s and 1970s New Zealand built an infrastructure of alternative care – foster care and residential care – to provide for the needs of children who could not be cared for at home. The Children and Young Persons Act of 1974 generally supported a benign child rescue model of practice. And indeed, social workers did rescue children in reasonably large numbers and placed them in care situations, often for long periods of time. This imitated the way of other English-speaking nations' systems of child welfare.

In a radical shift away from this approach, New Zealand introduced innovative legislation in 1989 that changed the way social workers respond to children and families. It was a brave step toward greater family participation in decision making and was deeply imbedded in strongly held cultural belief systems. Rather than continuing to copy the ways of English-speaking systems, the new law introduced a family-led

process of decision making that harnessed the strengths of the extended family to support the best interests of the child. It was a very different way of thinking, setting the foundation for greater decision-making involvement by family and support for them to care for their own children. The battle of practice between “child rescue” and “family support” had been won by the latter. At least that is how it seemed in 1989.

As it turned out it was only a skirmish. The 1990s brought new struggles with respect to practice ascendancy. New Zealand child welfare began to emulate international developments that saw increased emphasis on risk assessment within investigation-driven bureaucracies. Paradoxically, these practices found a sympathetic place within a new managerialism aimed at controlling, prescribing and making certain that which is fundamentally uncertain – the practice of child protection. The kind of family-led practice that was envisaged by the 1989 legislation struggled to coexist with this forensic child protection orientation. Once again, New Zealand practice started to look, and sound, like any other English-speaking system. It was also beginning to experience the same problems.

Barter (2001) maintains that child protection systems as they currently exist are ill-equipped to deal with the contemporary realities that confront families and communities and, as a consequence, many are experiencing multi-dimensional crisis. Despite many families presenting with more generic problems, increasingly forensically driven child protection systems result in all families being responded to as “high risk” and therefore being exposed to a full child protection investigation. This “one-size-fits-all” approach means that families are subjected to high-level child protection interventions regardless of their need. With increases in notifications, systems become overloaded. Spreading investigative resources too thinly makes them less and less able to respond to children who are at high risk. Social workers end up doing narrowly prescribed and often relentless statutory tasks, usually with the most difficult families. Scott (2006:1) in a provocative and insightful plenary address, recently argued that child protection systems have “become demoralised, investigation-driven bureaucracies, which trawl through escalating numbers of low-income families to find a small minority of cases in which statutory intervention is necessary and justifiable, leaving enormous damage in their wake”.

## RESPONDING DIFFERENTLY TO CHILD DEATHS

We argue that reviewing child maltreatment deaths in the way we have described in this paper has played its part in reinforcing risk-averse practices within child care and protection. When a child dies, New Zealand has closely followed other countries in adopting child death review recommendations and applying bureaucratic responses, including the introduction of more protocols and revised procedures and concurrent demands for professional compliance. This response assumes – in our view, incorrectly

– that the circumstances surrounding a single child’s death can be generalised across the statutory child protection system. Unfortunately for children and their families, a consequence of this is that more conservative, risk-averse practice begins to be reinforced across the whole system. Hence the death of one child powerfully affects the services provided for all children. In reality, this means that social workers and other professionals become less and less prepared to carry the burden of managing risk because they will be blamed if something goes wrong. Taking a child into care, despite the huge emotional damage this can cause, becomes less risky for the social worker than working with a family to maintain the child within the family system.

The first question we need to ask ourselves is: why do we undertake reviews of practice when a child dies? If our response is “to find and punish the culprit”, then our enquiry will not only fail to offer understanding in terms of the complex dynamics surrounding these situations, but is also likely to feed the very fears that produce risk-averse practice that disadvantages the majority of children who are notified to protective services. If we want to understand what has happened so that we can make improvements to systems that respond to children, then reviews need to be undertaken in an environment of service improvement where these issues can be explored and lessons learned. This is unlikely to happen if critics selectively identify the most sensationalist aspects of a case out of context and reinforce a culture of blame.

In our view, a review can make no assumptions about the circumstances surrounding a death. Nor can it make the assumption that the involvement of protective services will guarantee child safety. A real-life situation will always be much more complex than that. What a review can do is examine the dimensions of a case and understand the way in which factors influence other factors as practice decisions unfold.

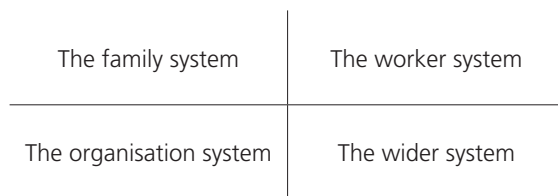
The current review process employed by CYF and OCC primarily revolves around identifying case chronology and examining social worker and organisational actions relating to each identified case event. This is done by examining records maintained by workers and by interviewing staff who have had case involvement with the child and his or her family – social workers, coordinators, supervisors and managers in the main. Reviewers sometimes contact external sources, including the wider professional system (health and education workers, for example) in the analysis. Even when this occurs, though, the focus is primarily on what the child protection social worker did or did not do and how well these actions or omissions reflect best practice as assessed by the reviewers. This is largely a one-dimensional approach.

Reviews have tended to identify similar issues – workers overwhelmed by case complexity; workers failing to follow established procedures or guidelines; and workers not recognising and responding to signs and symptoms that in retrospect seemed obvious to the reviewers. Where reviews examine organisational context at

all, they identify workload issues, failures in social work supervision practice and deficits in organisational control and task specification. These sorts of findings help reinforce external perceptions that these professional and organisational errors are direct and primary contributors to maltreatment deaths.

A systemic framework can better help explore the complex and multi-faceted aspects of case work in these tragic situations. Systems thinking has the capacity to create a broader analysis across a set of dimensions that can impact on case-work practice with a family. A systems analysis recognises that issues relating to child safety may be located in one or many contexts. From this beginning, a systems analysis extends the examination across a set of related dimensions – the family system, the worker system, the organisational system and the wider system:

Figure 1 A Systems Framework for Reviewing Child Deaths



### EXPLORING THE FAMILY SYSTEM

Ultimately, the responsibility for the death of a child rests with the person who took that life. A child may die as a result of family factors that persist regardless of professional involvement. A review, therefore, needs to carefully examine family factors that have resulted in a child being unsafe within the family system. It is important to understand the boundaries of the family system – to ask who are the family members, what is their history and who has been involved in the care of this child? What are the nature and quality of the relationships within the family and, in particular, the attachment relationships between caregiver and child? What are the family dynamics, belief systems, communication patterns, history of violence, family hierarchy, minimising behaviours, family secrets, receptiveness to help and family strengths? What the family brings to the situation critically influences how the social worker responds throughout the life of a case. A person undertaking a review of practice also needs to understand what the family brings – otherwise they will lack insight into professional responses.



## EXPLORING THE WORKER SYSTEM

Understanding professional responses is also critical to a systems analysis of child death situations. Once involved in a child protection response, a worker's own belief system, experience and views about children and risk become woven into the work. Given the value-driven nature of abuse work, the degree to which these ideas influence professional judgement and conduct is important (Connolly et al. 2006). It is critical to understand the dynamics between the worker and people within the family system because of the way these shape practice responses. Are there parallels between the family and the worker's personal experiences, and do these parallels influence the way in which the family is being responded to? How does the worker understand what is happening within the family, and how does this analysis influence the chosen practice pathway and the way in which the work unfolds? Does the worker feel physically safe with this family, or do fears of potential violence limit a worker's ability to confront issues when necessary?

## EXPLORING THE ORGANISATIONAL SYSTEM

Practice relationships with children and families exist within a statutory organisational context. Munro (2005) argues that this context is infused with overt and covert messages that influence the way in which a social worker might approach the work with a family. Messages about where to focus professional effort can result in a worker having to choose, for example, between seeing a child or completing paperwork. As Munro (2005:389) notes, "this creates dilemmas about which matters most – the child or the performance indicator". Compromising quality for quantity critically impacts on the worker's capacity to know and understand the family and the complex safety issues for the child.

The organisational system also includes collegial responses and the social work team context, the provision of high-quality supervision and the training and supports needed to foster in-depth high-quality practice. How has the organisation supported high-quality practice with this family? What opportunities have there been to reflect on and think through complex practice decisions? Have organisational processes helped or hindered the work?

## EXPLORING THE WIDER SYSTEM

Finally, a systemic practice review cannot ignore the influence of the wider system. The wider system includes the community and political pressures that influence, whether overtly or covertly, social work decision-making. Exploring the wider system involves understanding the connections between the worker, the family and the

network of people and systems surrounding the child. This might include other professionals – for example, medical or legal systems of response. Professionals can powerfully influence interventions with children and families. Professional hierarchies can also influence the way in which a social worker approaches a particular investigation. A practice review would need to understand how professional knowledge has influenced practice decision-making and the management of the situation. Has there been uncritical reliance on external professional opinion? Has this affected the social worker's capacity to exercise professional judgement? Are professional hierarchies undermining good practice? Have professionals worked together to provide a consistency of response, and have professional systems been sufficiently integrated to strengthen the safety net around the child?

We consider it important to reassess the way we undertake child death reviews – themselves potential reinforcers of risk-averse practice – so that they can more usefully inform practice responses. A systemic approach to reviewing a child's death provides a change of focus from the conduct of an individual social worker to the more complex factors and interrelationships that invariably surround a child at risk. Child death reviews, regardless of their focus, can be used to improve services or they can be misused to search for a scapegoat. In recent years, media and political focus on social worker error and calls for accountability and system reform have undermined the credibility and work of statutory child protection systems internationally. Ironically, they have also had the effect of weakening services and creating defensive practices that do little to support children and their families. Rethinking our responses to child homicide has the potential to increase understandings of the dynamics that place children at risk, and to foster a culture of service improvement. It could be that using a systems framework of review that places practice in a wider context is more likely to contribute positively to the strengthening of services for children overall.

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