

Leading for Learning Following a Child Fatality

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4th Australasian Conference on Child Death Inquiries and Reviews

**Soft is Hardest,
Leading for learning following a child fatality**

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Tragedies occur — the issue for child protection

How child protection leaders respond to a serious child injury or death

- so the responses themselves do not generate adverse effects, but
- rather, assist the organization to become focused on learning how to improve protective services



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The traditional reaction to a troubling death

- public declarations by politicians and child protection leaders that ‘lessons will be learned’
- child death reviews to find those lessons and to develop recommendations on how to avoid mistakes or practice deficiencies in the future



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Child death reviews have been drivers for change in child protection services in many countries

Key lessons:

- Continuous, cumulative not episodic assessment
- Communication across the agency and between partner agencies



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Child death reviews have also often been counterproductive

- Some professional did something wrong
- ‘Top down’, rapidly implementable, set-piece solutions such as increasing practice monitoring and compliance measures
- Greater defensiveness in an already anxious workforce
- Ignoring the complex reality of predictions and action in conditions of uncertainty



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Child protection work is anxious work

- The myth that every risk is calculable, every problem solvable and every death chargeable to a particular professional's account drives anxiety
- Anxiety drives the impulse to 'get it right', from the politician and CEO to the supervisor and the practitioner, all can be misled that the right *something* will prevent future tragedies
- These conditions drive human beings, and child protection agencies, towards being defensive and reactive in practice
- Child protection leaders must constantly challenge the corrosive effects of anxiety and the compulsion to pursue unattainable certainty



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The crisis of a child death is a critical point for leadership

- A constructive response is essential for workers coping with the anxiety and uncertainty inherent in the work
- A blaming reaction has an exponentially negative impact



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**Probe into
injured
foster
toddler**

**Toddler
on life
support**

“Whatever the initiative, policy or program, in the end you are only as good as how you deal with the next child death.”

(Tony Morrison)

The case involved a toddler who had been removed from her birth parents and placed with a couple in the extended family who themselves had a past history of alcohol abuse and domestic violence. Nine months after placement, the child suffered a major head trauma and died a few days later. A member of the kinship family was the prime suspect. This situation was of course a massive crisis for the birth and caring families, made significantly worse by the fact that on admission to hospital, the case drew extensive media and political attention. This continued up to and well beyond the child’s death.

Five key leadership principles (Munro, Turnell and Murphy 2013)

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

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



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The first few days were dominated by a scramble to assemble the facts, and at this time it was vital for the CEO to help everyone maintain a calm head and to synthesize the inevitable complexity of the facts to determine the key issues, looking both at what was done well and what was not, determining whether culpability was likely, and the extent and nature of the organizational vulnerabilities. This synthesis informed clear and measured advice to staff, the Minister, and the public channels.



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The facts, in essence, were that there were clear indications that there had been risks in the placement but that these had been identified and assessed as low given there had been a lengthy period of sobriety and non-violence. It was also found that while the placement was monitored regularly initially, when the file was transferred to a new office there was a delay in case assignment, and the quality but not the quantity of the contact with the family diminished.



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1. Avoiding hindsight error and being rushed into blaming someone

In this case:

- Hindsight view? Obviously risky to place a child with kin who had a history of alcohol abuse and violence
- For workers operating with only foresight? Weighing up both the risks and the benefits to the child of this placement compared with other options, the risk calculus looked quite different.
- A first task is *not* to jump to conclusions but to seek to understand the professional reasoning behind the actions.

1. Avoiding hindsight error and being rushed into blaming someone

- The certainty afforded by hindsight is often compelling
- Vital to lead with a sophisticated and compassionate understanding of managing risk - to avoid the knee-jerk reaction of blaming workers for tolerating some degree of risk
- All child protection interventions and placements involve risk - requiring professionals to weigh the different risks and benefits
- Something considered to be of low probability occurred
- This is not evidence of a poor decision since, by definition, low probability events do occur, albeit infrequently



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2. *Managing political and public reactions*

- Crisis management involves close co-operation of the CEO and the Minister (political leadership), a good working relationship is essential
- Gathering and assessment of the facts needs time, but the CEO in concert with the Minister must respond promptly to external demands for information.
- The immediate media and political response communicated two things clearly:
 - The seriousness of the tragedy and that the thoughts and prayers of the Minister, the agency and the workers are with the family
 - That police and departmental investigations are being expedited and that a detailed public statement will be provided at the earliest opportunity.
Holding this line in the face of intense pressure from the media and political opponents to rush to judgment and promise that someone will be punished.



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signs
OF
safety

Enough facts were assembled in the three days following hospitalization (including a full weekend) that the CEO and the Minister were in a position to hold a press conference to report initial findings. The media conference was packed and aggressive. The Minister made a general statement of concern for the family and said that investigations were continuing, and that the CEO would provide the details that were now known. The conference was long and exhaustive, with close questioning on the placement assessment process and the monitoring of the child, with the CEO emphasizing that no culpability by a member of staff was evident. It was also stated clearly again that those inquiries were necessarily ongoing.



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Perhaps most importantly, the CEO indicated that, if shortfalls in the Department's performance were identified, then these would be faced and he would accept responsibility.



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After this, the CEO conducted several live radio interviews – a good opportunity for clear messaging since there was no risk of subsequent editing distorting the message. Media messaging and political management continued in this vein, through the child's death and beyond for around two weeks

During this period, the CEO continually talked to the many professional stakeholders to prevent and address the potential for their anxieties to lead to destructive public statements.



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3. Supporting the families

- In the maelstrom of crisis management, it is essential not to lose sight of the core work of the child protection agency, which is to keep children safe, as well as support families and assist them to do so.
- In this case, practical and emotional support had to be extended to both the birth and relative foster care families, and the risk of conflict between these families mitigated. Staff were permanently stationed at the hospital.
- Complicated by the necessary investigations, both by police, regarding the circumstances of the death, and child protection authorities regarding the safety of other children in the family, that need to occur concurrently.



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4. *Supporting staff*

- Proactive management of the external political environment and building resilience in the face of inherent anxiety requires persistence and consistency on the part of senior management. Not just the crisis event.
- CEOs and organizations are tested. With every test handled well, trust and resilience increases. Any failed test has an exponentially greater negative impact. Progress is incremental.



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In this case example, visible support and sensible management by the CEO and senior staff were essential. Some quotes from CEO emails to all staff are indicative:

This is a tragedy, and our hearts go out to the child and her family. My thoughts and gratitude also go to all the staff who have been involved with this child and her family, to those who have worked tirelessly . . . The Minister has asked me to investigate this case, and that is underway now and will take at least a few weeks. As I explained on radio, this is to look at how we have followed our procedures, and identify any gaps or missed opportunities in order to improve how we work. This is not, as some have advocated, in order for 'heads to roll'. If there are issues with our practice, we will take responsibility and I will take that responsibility.



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And later:

...In the field, anxieties have been raised for all the children in our care and the child protection risks that we manage every day. The scrutiny has been intense. It also seems that wherever there are issues that highlight the difficult and uncertain environment in which our work occurs, and there always are, someone has been ready to comment in the media. It is incredibly important that we all pull together at this time. If you have particular worries and need support, please raise it with your manager, and I will be involved with issues that come to my attention.

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



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

. . . a very brief message to thank you on behalf of the management team and all the staff here . . . for your support during what has been a very difficult time. Your backing and reassurance has been very important to all involved.

Staff were particularly grateful and reassured by your statement that you would take the responsibility for any shortcomings identified in this case.

Just wanted to say how much I appreciated receiving this email last night. It has been a baptism of fire . . . and most days have been pretty tough, especially the last few . . . I am confident though that we will get through this time and I am especially grateful for the support.



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5. *Developing expertise*

- It is also necessary to examine practice and consider what can be learned
- Reader et al have observed “*little new ever comes out of inquiries into child abuse tragedies*” (p. 89, 1993b).
 - Key recurring lessons from child death inquiries:
 - Assessment being based on episodes rather than being cumulative
 - Poor communication, usually between agencies
- Organizational processes, culture, resources, staff learning all impact - the “latent conditions for error” (Reason 1997)



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Thank God that is behind us.....

**DAD, 15,
ON BABY
BASHING
CHARGE**

“It is too easy to look back at a tragic event, find problematic behaviours and sheet home the cause to that, it simply is not that,” Mr Murphy said.

Deaths review danger

EXCLUSIVE

KATIE ROBERTSON

Social Affairs Reporter

REVIEWS into child deaths are often “counterproductive exercises”, says a government boss whose department is under fire over a fatal assault on a newborn baby.

Department for Child Protection and Family Support director-general Terry Murphy said child death reviews rarely improved the situation – often creating an atmosphere of anxiety among frontline staff.

He will go to the UK next month to present a journal article he co-authored in which he argues against a common view that every death is “proof that some professional did something wrong”.

Not seeking to erase individual responsibility rather to re-contextualise it

- Managing distress and anxiety throughout an agency following a child's death is essential to enable staff to put their primary focus on helping children, not on covering their backs in case of trouble
- Staff need to feel supported and able to be open about their work, having the courage to examine it critically — this does not occur in risky environments and fearful organisations
- Recognizing and addressing BOTH human error and organisational issues is essential
- The bottom line? Never 'hang the individual out to dry'



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Dept backs its staff in baby death

■ Rhianna King

The Department for Child Protection says a preliminary review into the case of a baby who died after he was allegedly assaulted by his teenage father has found no evidence of negligence by its staff.

The month-old baby died just over a week after receiving critical head injuries in Bunbury Hospital on February 15.

The boy's father, a 15-year-old ward of the State, is facing a charge of aggravated grievous bodily harm.

At a public agency review hearing yesterday, DCP director general Terry Murphy and executive director of country services Emma White were questioned about the department's involvement with the boy.

Mr Murphy said while the teenager was a "seriously disturbed young man" who had a history of problems, there was nothing in his behaviour that could have predicted the baby's death.

"On the contrary, he was caring for the baby ... the indicators were in the opposite direction," he told the hearing.