Managing societal and institutional risk in child protection

MANAGING SOCIETAL AND INSTITUTIONAL RISK IN CHILD PROTECTION

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ABSTRACT

Public sector services have been re-shaped by two interacting factors: the growing dominance of risk management and the growing demands for transparency and accountability. For the caring professions, these have provoked radical reform. Using the child protection service as a case study, this article explores the impact of the changes on a service that deals with conflicting risks and has a poorly articulated knowledge base. Drawing on Rothstein, Huber et al's (2006) distinction between societal and institutional risks, it is argued that difficulties in managing societal risks are creating serious institutional risks. The latter are then being prioritised in the way the system operates. The preoccupation with such risks has been translated into concerted efforts to formalize the work of front line practitioners to make it transparent and auditable. Although done, in part, with the good intention of spreading good practice standards, this formalization has gone beyond the evidenced knowledge base to the extent that it is creating a new picture of 'good practice' that omits significant dimensions of work and is distinct from measures of children's safety or welfare. Moreover, the process of formalization acts as an impediment to knowledge development in disciplines where such learning is urgently needed.

Risk management

Child protection

Institutional risk

1. INTRODUCTION

The impact on the public sector of neoliberalism, new public management, and society's preoccupation with risk has been widely discussed and analysed. However, the child protection service illustrates some of the problems to a marked degree because it deals with an unusually complex set of risks and has an unusually poor knowledge base. For many services, the aim has been to encourage and disseminate good practice. In child protection, though, there is only limited knowledge about good practice and the major need is to increase this, to find out more about what methods are effective. This poses problems for the development of a governance regime.

The way that society has conceptualised and responded to parental cruelty to children has changed markedly in recent decades. A strongly regulated child protection system has evolved in England that is expected not only to identify and help the victims of cruelty but also to predict and prevent such cruelty. The prioritisation of risk management has necessitated fundamental changes and has been highly problematic. This article explores how it has been implemented and questions whether service providers are making progress in their overt aim of increasing children's safety and welfare or whether this aim is being subverted by efforts to protect workers and agencies from criticism.

The question can be rephrased in terms of the distinction between societal and institutional risks (Rothstein et al 2006). Societal risks, in this instance, are the risks to children of being harmed or even killed by their parents or carers. The agencies charged with managing these risks (predominantly social care, police, health and education services) cannot avoid failure in their task because of the 'inherent uncertainties, fragmented organizational settings, constrained resources, ungovernable actors and unintended consequences' (Rothstein 2006

p.217). Moreover, the governance mechanisms introduced as part of New Public Management (Hood 1991) mean that their failures are now more apparent because of the greater transparency and accountability demanded of them. While deaths have always been visible, the audit system has now created new criteria of success and failure with increased opportunities for visible failure in cases with less tragic outcomes. Agencies therefore need to manage the institutional risks of being blamed by finding some way of justifying their performance as rational and defensible. How this then interacts with their primary concern with societal risk is the topic of this article.

Child protection services are shaped by their social contexts. Most particularly, the nature of the welfare regime and the relationship between family and state, in general, strongly influence the way child cruelty is addressed. Countries which fit Esping-Anderson's category of liberal or neo-liberal welfare regime (Esping-Anderson 1990) have evolved very similar child protection systems whereas the social democratic or Scandinavian countries are radically different (Hetherington et al 1997). This article provides a case study of the system in England but the observations have relevance for the other UK countries, the US, Canada, Australia and New Zealand. In these neo-liberal countries, state intervention into the privacy of family life, whether in the form of helping or policing, has been traditionally kept to a minimum so that the coercively intrusive dimension to child protection is significantly different from the way most welfare problems are dealt with.

Child protection services have distinctive features. Unlike most areas of crime detection, the aim is not just to identify perpetrators and refer them to the criminal justice system but also, if possible, to help them to maintain their parental role in a less harmful manner. This combination of care and control influences the way the service operates. Historically, the worker-family relationship has been deemed of central importance as a means of investigating and helping families. This has contributed to the development of individual styles of practice that have mitigated against the formulation of a shared body of knowledge and shared

discourse, a feature that is found, to some degree, in all caring professions. Consequently, the research on effectiveness has been limited. Chaffin and Friedrich (2004 p.1098) summarising expert reviews of research, conclude: 'most field services provided to abused children and their families are not based on any clear evidence that the services actually work'. In trying to improve child protection services, it is not simply a case of demanding accountability and encouraging all agencies to adopt good practice but also of evaluating practice to learn how to manage the risks to children better.

In analysing the child protection service, this article uses the governance framework proposed by Hood, Rothstein et al (2001). They argue that, in developing a risk management regime, agencies need to develop some method of control. 'From a cybernetics perspective, governance could be understood as a control system that sets societal goals, gathers information on whether the goals are met and modifies behaviour to bring governed activities into line with goals' (Hood et al 2001). In child protection, there are two governance regimes, one of families by professionals and one of professionals by government. These have evolved concurrently and influenced each other. This article focuses on the governance of professionals but sketches the way that evolution of this governance regime has interacted with changing governance of families.

2. SETTING THE RISK MANAGEMENT GOALS IN CHILD PROTECTION

Children's services have a dual preoccupation with the safety and welfare of children, two factors that can be in conflict in specific decision making contexts since safety concerns tend to focus on immediate dangers while welfare assessments take a longer view. A child's immediate safety can be achieved by removing him from abusive parents but then his long-term welfare is highly likely to be damaged by separation from his established relationships. The decision on whether to remove a child from the birth family involves a complex weighing of positive and negative outcomes, both immediate and long term, in both options.

Although welfare services in England have been concerned about cruelty to children since the 1889 Prevention of Cruelty to Children Act, the language of risk, or indeed of abuse, was not used in talking about it. Services removed children once they had been seriously injured or neglected; professionals were not expected to predict and prevent these adverse outcomes. If a child died, the killer was punished but services were not criticised; there was little institutional risk in the event. Parents had considerable autonomy in child-rearing, with early legislation only proscribing extreme forms of physical harm or neglect. The risk agenda has slowly taken over since the 1970s, creating increased governance of families and increased responsibilities for professionals. Why society become more concerned about standards of parenting and child homicide is a moot point. There is some debate in the literature whether the rising social concern with risk generally indicates a rise in actual risks or a rise in concern about risk (Rothstein et al 2006). The actual rate of child cruelty and homicide by parents or carers in the 1970s is difficult to determine since official statistics are incomplete and unreliable. However, the rate of child death from any cause has been falling and it is unlikely that this drop concealed a rise in familial harm. Perhaps it was the increasing rarity of child deaths that put a stronger spotlight on the few that occurred. The risk of experiencing child abuse or neglect, however, *has* risen markedly but this is as a result not of changes in parental behaviour but of changes in the definition of unacceptable parenting. The concept of abuse has been gradually expanded to include sexual and emotional abuse and, for all categories, the range of behaviours deemed abusive has expanded to include moderate forms.

In the latest policy for England, the concept of 'a child at risk' has been expanded from one at risk of abuse or neglect to any child at risk of failing to fulfil their potential and professionals' duty to protect from significant harm has been augmented with a duty to safeguard all children from adverse outcomes (HM Treasury 2003). The increase in professional responsibility for overseeing children's development creates increased governance of families, with all children now to be registered on a national database, ContactPoint, to

facilitate monitoring. Child protection continues to function as a distinct sub-set in this 'safeguarding' agenda and is the focus of this article since the wider agenda is still in its infancy.

The growing social preoccupation with risk was evidenced in relation to children in a series of high profile public inquiries into the deaths of children known to children's services. In England, the death of Maria Colwell in 1973 triggered a major public debate about child abuse (Department of Health and Social Security 1974). Similar high profile child deaths occurred in other liberal countries, contributing to their parallel development of a child protection system. The Colwell report was followed by a series of such inquiries through the 1970s and 80s which created public pressure on professionals to accept responsibility for avoiding such tragedies. A child's death from familial abuse was reformulated as prima facie evidence of professional failure. Members of the public and professionals in contact with family members were encouraged to report any concerns about child abuse to the child protection service, leading to a sharp rise in referral rates (Parton 1997). Consequently, child welfare services became predominantly child protection services in which the key priority shifted from supporting families in difficulty to detecting and preventing child abuse (Department of Health 1995; Parton 1997). Similar changes occurred in North America (Lindsey 2004) and Australia(Thorpe 1994).

While the goal of changes in practice was to reduce the risks to children, this was done in ways that created new risks. The rise in reports of abuse led to many more families being brought into contact with child welfare service and, for many, it was a distressing experience without any benefit (Farmer and Owen 1995). Since the social pressure was for professionals not to leave any child in danger, the threshold for removing children was lowered to minimise false negatives. This created a rise in false positives – of removing children from families that were not dangerous enough to warrant such an intrusive response. Society reacted with hostility to this increased level of intrusion, with social workers in

particular being seen as becoming too powerful and 'trampling the rights of innocent victims' (Myers 1994). This hostility came to a head in 1987 when 121 children in Cleveland were removed from their parents because two paediatricians diagnosed sexual abuse, based on what was later deemed an unreliable physical test ((Department of Health 1988). The McMartin preschool abuse case played a similar role in the US, when a long, expensive trial of teaching staff culminated in no convictions (Myers 1994) The need to redress the perceived imbalance in power between parents and professionals in the governance structure led to the 1989 Children Act which set out to achieve a better balance 'between the need to protect children and the need to enable parents to challenge interventions in the upbringing of their children (Hansard, col.1107-08, 1989).

Faced with hostile social reactions to both false positives and false negatives, one option for professionals was to try to reduce the total number of errors by more rigorous investigations of any allegation of abuse. The aim was not only to determine whether children had suffered harm but to assess the risk of future harm if they stayed at home. This was very apparent in the way practice was subsequently carried out. Thorpe (Thorpe 1994) graphically describes how the therapeutic orientation of child protection was replaced by the 'forensic gaze', with police taking a more prominent role in conducting investigations.

For families, this made the experience of being investigated even more distressing but it also impacted on them in reducing the availability of welfare services. Families with problems other than abuse or neglect had difficulty in accessing help, e.g disabled children or parents with ill health or disability who needed help (Audit Commission 1994). This had the unintended consequence of leaving families in difficulties so that some deteriorated to the point where they became abusive enough to receive a service. Professionals frequently had the frustrating experience of dealing with a highly problematic family, knowing that if only they had been able to offer a service when the family first came to attention as not coping well then the problems would have been easier to resolve and less harmful to the children.

Service provision for those families judged abusive by the investigators were also restricted by the amount of resources devoted to investigations (Farmer and Owen 1995).

Government policy, in the light of these developments, was to recommend that investigations should be conducted with 'a lighter touch' (Department of Health 1995). The law sets out two responses to referrals. First, a child protection inquiry can be carried out under Section 47 of the Children Act 1989 to determine whether the child is suffering or at risk of suffering significant harm. This is heavily proceduralised and makes high demands on time and resources. Alternatively, under Section 17 of the Act, the family can be assessed for and offered support services. If more referrals were dealt with by the latter route, it would free up resources to provide the needed support services. The decision about which response to choose requires a difficult judgment since abuse tends to be hidden and an apparently innocuous presentation may conceal serious harm. Research has found a lack of consensus on such judgments when practitioners are presented with case scenarios (Spratt 2000). The Section 47 route, though more expensive, allows a more thorough assessment (helped by the authority it bestows on the investigator to demand confidential information from others such as doctors). Observers noted that this change in policy advice would have the effect of requiring professionals to make risk assessments on the basis of less evidence and therefore increased the probability of error (Munro 1999b; Parton 1997).

In summary, by the start of the millennium, parents were subject to greater rules about how they should raise their children while the children's services who monitored their compliance were faced with a conflicting set of messages: don't spend so much on carrying out investigations of alleged abuse; don't leave any child in danger; don't remove children from their families unless you have strong evidence. This adds up to a nightmarish risk management scenario and creates serious problems of institutional risks. Whatever the level of performance, failure against one of these goals seems almost inevitable.

3. GATHERING INFORMATION ON PERFORMANCE - NPM

Child protection services underwent a radical transformation in the 1980s as the Conservative government elected in 1979 sought to overhaul the public sector, bringing in the mechanisms of the market to improve efficiency (Hood 1991). This imposed new demands for transparency and accountability so that finding ways of gathering information on performance became a major project. The impact of New Public Management on the public sector has been well researched (e.g. (Power 1997)) but, for the caring professions, searching for a way to make practice 'auditable' has been particularly problematic (Munro 2004). The issues in social work are of particular interest partly because of its central role in child protection and partly because it demonstrates the problems in an extreme form. There are two main issues: firstly, the problem of describing workers' performance and, secondly, of linking that performance to children's outcomes, to measures of their safety and welfare.

3.1. Describing social work practice

Social work had been a relationship-based service operating predominantly within a humanist tradition with a relatively under-developed professional knowledge base. Social workers had a high degree of discretion in how they chose to work with clients (Adams 1998) and had few standardised forms to complete. Researchers had found that social workers had trouble in articulating their practice, of giving a clear account of what they were doing or what their aims were (Parsloe and Stevenson 1978). Most operated without any explicit theoretical framework and those using theories drew from a vast store, ranging, for example, in psychology from psychoanalytic to strict behavioural approaches.

This state of affairs posed serious problems. The audit system required some taxonomy of practice: some way of describing and categorising the different activities and purposes of practice. Moreover, since the aim was not just to monitor but to improve practice, it needed explicit criteria of good practice. In the absence of a detailed professional taxonomy, civil

servants rapidly devised some basic units of description and some documentation in which they could be recorded. Front line social workers played very little part in this process of development.

Efforts were made to prescribe as well as describe practice. However, the assumptions about what counted as good practice had a number of problems. They were based on expert opinion rather than empirical research so their validity was unproven. They were also constricted by the preference for readily measured aspects of professional behaviour (Audit Commission 2002; Tilbury 2000) such as time taken to respond to a referral, or how many children had been placed on the child protection register. This underplayed the significance of the relationships formed between professionals and family members or the quality of the thinking in making assessments and decisions.

The methodological choice of quantitative not qualitative data has had pervasive repercussions in the way practice has evolved. The aspects of the work that could not be measured in this approach have tended to become less valued. As time goes by, the cumulative effect of this neglect becomes more apparent. In child protection social work, the omission of three aspects in particular is proving problematic: relationship skills, emotions, and critical reasoning. No-one would deny their importance and, indeed, many agencies strive to encourage them but there is a strong pressure to give them less time and attention when the official system of rewards and punishments does not include them.

3.1.1. Relationship skills

Child protection work deals with people not with objects. To paraphrase Chapman (2004 p.10), you can deliver a pizza but you cannot deliver a child protection service:

> All public services require the 'customer' to be an active agent in the 'production' of the required outcomes. Education and health care initiatives simply fail if the

intended recipients are unwilling or unable to engage in a constructive way; they are outcomes that are co-produced by citizens.

Consequently, at the micro level, the tasks of obtaining information, making sense of it, and deciding what action to take are all dependent on the relationship skills of the people involved, both workers and families. A high level of skill is needed to talk to a young girl who is being raped by her father or to gain any information from a belligerent mother. There are particular deficits in workers' ability to relate to men and to children with serious adverse impacts on the quality of the data on which assessments and decisions are based (Farmer and Owen 1995; Munro 1996) A constant lesson from child death reviews is that workers lacked adequate skills and knowledge in these tasks (Rose and Barnes 2008).

3.1.2. Emotions

Child protection work is highly emotive. The knowledge of the pain and fear that a child is suffering is distressing to all but the most burnt-out worker. Parents can trigger fears for one's own safety as well as compassion for their problems. Unless the emotional dimension is brought into conscious review, workers are in danger of being unconsciously influenced in ways that damage their judgments and decisions. Compassion for a mother, for example, can distract attention away from the harm she is causing her children. Child abuse inquiries provide ample evidence of the adverse outcomes that arise from unreflective practice that ignores the emotional impact of the engagement with families (Reder and Duncan 1999; Reder et al 1993).

3.1.3. Critical reasoning

Social workers are vulnerable to all the cognitive biases of human beings (Kahneman et al 1982). The bias that is most frequently shown, to the stupefaction of the media, is the tendency to hold onto a belief despite a growing body of evidence that tells against it. Once social workers have formed a picture of a family, they can retain it, dismissing, ignoring or re-

interpreting new information that challenges it, thereby failing to notice a child is being seriously abused (Munro 1999a). Supervision has traditionally been seen as the forum in which workers are helped to take a more critical look at their reasoning. Research in psychology has demonstrated how hard it is for people to correct their own intuitive errors (Woods et al 1994) so supervision is crucial. However, the shift in recent years has been for supervision to be dominated with managerial concerns, of checking that workers are following procedures and meeting performance indicators, so that time for clinical review is squeezed out (Rushton and Nathan 1996).

Reducing time for critical reflection in supervision also decreases the opportunities for learning. Learning requires not only experience but reflection on that experience – time and attention paid to mulling over the experience and learning from it (Klein 2000). Workers who hurry from one task to the next without time for reflection fail to develop wisdom from their work.

The importance of relationship and reasoning skills argues for the need to develop more sensitive methods of evaluating practice and tells against efforts to reduce the work to the easily measured.

4. LINKING PERFORMANCE TO CHILDREN'S OUTCOMES

'Good' practice is that which is most likely to lead to good outcomes for children. The complexity of causation in the social world and the minor contribution made by social work to the whole of a child's experience both create serious problems in determining what effect, if any, the social work intervention has for any child. Measuring outcomes for children's safety and welfare is also problematic. Child deaths are one clear adverse outcome but, fortunately, these are relatively rare and so do not provide an adequate measure of a child protection service. Physical injuries are a more common adverse outcome that can fairly

reliably be measured but it can be problematic to decide whether the parent had any responsibility for them, i.e. whether they indicate abuse or not. Many other adverse outcomes are longer term, e.g. abused children exhibit higher rates of anti-social behaviour and mental disorder but the pathways to these outcomes are complex, with the experience of abuse being neither a necessary nor a sufficient condition (Sutton et al 2005).

The lack of a well-evidenced knowledge base for social work practice in child protection was, and is, a problem but the audit system has the potential for providing valuable data that *could* address the problem. However, the current system's reliance on readily measured data provides a very limited account of what happened in working with a family so that it is hard to determine what, if anything, played a significant role in improving the child's safety or welfare.

Considerable concern is now being expressed at all levels of governance about the paucity of data on outcomes so efforts are being made to find reliable measures (Cabinet Office 2008). However, there is a danger that a greater focus on children's outcomes alone will increase institutional risks by revealing the failings of the service even more clearly without providing useful information on why it is failing. More attention needs to be given to measuring the service inputs so that it becomes possible to make clearer causal links between inputs and children's outcomes. Progress on this issue, although difficult, will not only improve the accuracy of the audit system but also contribute to knowledge of what works in protecting children.

5. MODIFYING BEHAVIOIUR BY INCREASING RULES AND GUIDANCE

The third component of control in a risk regime is to modify behaviour of workers to bring governed activities into line with goals. The choice of mechanisms for modifying behaviour

influences the aspects of behaviour that get modified. In child protection social work, the choices have been biased towards providing targets, rules, guidance, and tools (particularly assessment and decision aids). There is a good rationale behind these choices but problems arise when the rules and guidance go beyond the evidence-base and when they only deal with some aspects of the tasks.

Setting targets and performance indicators for the child protection system is one central strategy. These have the well known hazards of creating perverse incentives and encouraging workers to take the action that meets the performance indicator even when they do not consider it the best action in relation to a particular child.

The government has also been very active in prescribing how practice should be conducted, by providing detailed procedural guidelines and a range of tools for data-storing, assessment and decision making. The first government guidance, given in 1973 after the inquiry into the death of Graham Bagnall (Salop County Council 1973), took the form of a short letter to local authorities. The current guidance in London – the London Child Protection Procedures – is 551 pages long. Tools that are more or less firmly prescribed are also proliferating. The government is introducing a number of databases that will contain a wide range of data about children (Anderson et al 2006). The Integrated Children's System (ICS) software for child protection social workers provides a complete framework for case management. Research on the use of ICS raises serious doubts about its value in improving services to children. It significantly alters workers' use of time by creating strong pressures to meet prescribed deadlines for inputting data. In one agency, there was an e-tracking device of traffic lights warning staff how much longer they had to enter data. Time spent in front of the computer has risen to 60-80%, markedly reducing the time spent with families (Bell et al 2007; Broadhurst et al forthcoming).

Rasmussen's discussion (Rasmussen 1986) of rule-based (RB) behaviour versus knowledge-based (KB) behaviour provides useful insights when considering the extent to which child protection work can be reduced to formalised procedures. Rule-based behaviour requires a person to look at a situation and use the rules to classify it into some familiar category. The rules may be derived from legislative or policy prescriptions, or they may be rules learned from experience or acquired through formal training, which are then retrieved from memory when engaging in a practice task. Under this approach, if a situation is mis-classified, this is called a rule-based error. For example, a social worker may judge a referral to fit the category of 'family support' and so follow that route not the alternative child protection route, as happened in the case of Victoria Climbie (Laming 2003). Had the social worker followed the rule that, with hindsight, we know to have been right of conducting a thorough child protection investigation, she might well have perceived the severity of the abuse Victoria was suffering.

In comparison, according to Rasmussen, knowledge-based behaviour is more appropriate in complex situations, when people have to find the answer to a new problem. They do so by working out what would happen if they tried particular sets of actions. Knowledge based behaviour involves responding to a significant amount of feedback from the situation. However, with experience and learning, kinds of situations that were initially resolved using a knowledge based approach may become more amenable to a rule based approach. In contrast, professional expertise involving knowledge-based responses to situations will continue to be required in those situations that are not adequately encompassed by the rules.

The pertinent question in child protection work then becomes 'how much of practice is more appropriately responded to using a rule-based approach?' Clearly, if the evidence exists to show what the right course of action is in particular circumstance then it should be expressed in the form of a rule. However, it can be tempting to formulate rules going beyond the evidence-base. Partly this is due to the fact that we have limited cognitive resources and it is

easier to apply rules than to concentrate on the hard work of thinking through potential solutions.

> When confronted with a problem, human beings are strongly biased to search for and find a pre-packaged solution at the RB level *before* resorting to the far more effortful KB level, even where the latter is demanded at the outset. … Only when people become aware that successive cycling around this rule-based route is failing to offer a satisfactory solution will the move down to the KB level take place. (Reason 1990 p.65).

Another reason for opting for rule-based practice is that it creates a 'right' way of acting that workers and agencies can point to as justification in the event of adverse outcomes. For the same reason, it is tempting to interpret what was offered as 'guidance' as if it were a set of rules, denying the option of workers exercising their discretion in case of future criticism. The tendency to transform guidance into rules has been found in social work (Stevenson 1999). In circumstances where the evidence to form a rule is lacking, the advantage of operating with rules over professional judgement is that when the rule leads to error, no one person is to blame. If a worker exercises discretion, then he or she can be blamed for any adverse consequence. In a system grappling with serious institutional risks, creating a set of rules to prescribe 'good practice', or 'protocolizing' practice, becomes an effective way of neutralising blame (Hood et al 2001). It has the serious defect of stifling the opportunities for learning better ways of handling the problems and thereby reducing risks to children.

6. LEARNING FROM INQUIRIES INTO CHILD ABUSE DEATHS

High profile public inquiries into child deaths have been so influential in shaping the development of the child protection system that the nature of their recommendations deserves scrutiny. The numerous inquiries into child abuse deaths have followed the format that has been traditional in other high risk areas such as aviation and surgery, that is, they have looked

for technical failings and, failing that, for flaws in human performance (Reason 1990; Woods et al 1994)[1]. Once human error has been identified, then the search for causation stops. Typically, around 70-80% of inquiries have concluded that human error was to blame, a statistic that was also found in a review of child protection inquiries (Munro 1999a).

The findings of such inquiries take the form of counterfactuals: 'if only the social worker had checked with the police, she would have learned of the father's violent record'. The central problem is seen as errant human beings and so solutions then take the form of strategies for controlling them. The three main strategies are: psychological pressure to perform to a higher standard, minimising the scope for individual judgement by automating or formalizing practice as much as possible, and increasing the level of managerial surveillance to ensure workers are complying with the increased set of rules and protocols (Woods et al 1994). In the child protection system, these three strategies have all been implemented (Munro 2005). The psychological pressure has created a high level of anxiety among workers about making a mistake, leading to serious problems in the recruitment and retention of staff (Audit Commission 2002). Increased formalization through standardised procedures and documentation has radically altered the individual style of practice.

In a study of SCRs 2001-2003, it was noted that:

> The focus of the recommendations was surprising … The conclusions were generally related to information about the case and its analysis. The solution to enable these lessons to be learned, however, was not in improving practice by increasing knowledge and skills but on creating more procedures (Rose and Barnes 2008 p.55).

[1] In engineering and aviation, the traditional person-centred approach has been replaced by the systems-centred approach and initial steps in adapting this to child protection have been taken, e.g. Fish S, Munro E. and Bairstow S. (2008) *Learning together to safeguard children*. London, SCIE.

The cumulative impact of the series of inquiries has been to increase proceduralization and reduce the space for professional expertise and discretion. Moreover, the focus on individual human error in the traditional inquiry places a heavy burden on each worker and makes the option of using one's judgement unappealing. It looks a far safer option to follow rules and procedures at all times, even if one's experience suggests it is not in a particular child's best interests.

7. CONCLUSION

When child welfare services in England came under the influence of the risk agenda in the 1970s they were operating with a high degree of professional autonomy and a remit that prioritised supporting families in difficulty. The increased social concern about the dangers of familial abuse and neglect radically re-shaped services and, by the 1990s, the services, now known as the child protection system, faced a set of conflicting risk demands: prevent abuse and neglect, intervene coercively in the privacy of families as little as possible, and re-focus priorities so that more resources are available for supporting families. In these circumstances, both societal and institutional risks were high.

The audit and inspection system instigated by the Conservative government in the 1980s provided a way of managing institutional risks by creating a model of 'good practice' defined in terms of targets, performance indicators, and procedure manuals. While the content of these new criteria for judging organisational success or failure was informed by expert wisdom on good practice, it was limited by the lack of an extensive empirical evidence base on what worked and by the methodological choice of opting for readily observed and measured aspects of performance, thereby neglecting qualitative aspects and the expertise needed to administer a service that was basically reliant on human relationships. There was no strong case for expecting that the new model of good practice would reduce societal risks – the harm experienced by children- and there is no strong evidence that it has done so.

However, there is emerging evidence that the risk management strategy adopted has led to *new* societal risks for children. The child protection system is being perceived by some families as powerful and irrational. Research by the Association for Improvements in the Maternity Services found that mothers with postnatal depression were not seeking help in case they were seen as child abusers and that parents were failing to seek appropriate medical help for their children's non-abuse problems for fear that they might be mis-diagnosed (Association for Improvements in the Maternity Services 2007). A recent campaign by the Times correspondent Camilla Cavendish, fuelled by allegations of bad legal judgements, is challenging the secrecy of the family court system which prevents the public scrutinising the quality of the professional evidence and reasoning on which the decisions to remove children from their birth families are based.

Power (2004) argues that 'the risk management of everything' is a ritual of verification to deflect blame. His critique seems to apply to child protection system in that so many of the criteria of 'success' have little connection to children's safety and welfare. However, in this area of practice, ritualistic verification has a limited power to deflect blame because history has shown that, from time to time, a particularly brutal death of a child will provoke public criticism that is not deflected by the assurance that 'workers followed procedures'. The current survival strategy may well be challenged by such an event and, possibly, lead to a more constructive public debate about how to manage institutional risk so that it more closely mirrors the management of risks to children.

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