Avoidable and unavoidable mistakes in child protection work

Eileen Munro

Avoidable and unavoidable mistakes in child protection work

Eileen Munro

Summary:

This article argues that social workers and the general public need a clear understanding of the distinction between avoidable and unavoidable mistakes in child protection work. The public is understandably distressed when a child dies and is right to demand an inquiry to check the quality of help provided. But a child's death is not proof that any professional was incompetent. Our limited knowledge and the complexity of assessing risk mean that professionals can only make the best judgement on the available evidence. Analysis of 45 inquiry reports shows that inquiries appreciate this; in 42% of them social workers were not criticised. The analysis however also reveals one persistent error: social workers are slow to revise their judgements. Psychology research indicates that this error is widespread and by no means peculiar to social workers but it means that misjudgements about clients that may have been unavoidable on the limited knowledge available when they were made continue to be accepted despite a growing body of evidence against them. Social workers need a greater acceptance of their fallibility and a willingness to consider that their judgements and decisions are wrong. To change your mind in the light of new information is a sign of good practice, a sign of strength not weakness.

In child protection work, it is every social worker's nightmare to make a mistake that contributes to the death of a child. But some mistakes are inevitable because of the complexity of the work and our level of knowledge. Ideally, social workers should protect all children who are at risk of abuse while not disrupting any family providing adequate care. Abused children should return only to families who have changed and no longer pose a threat to their offspring. These ideals however are impossible to achieve. Our understanding of human nature in general and of child abusers in particular mean that we are always making decisions based on imperfect knowledge. Predicting which children will be safe and which at risk is an uncertain business. We can only aim to reach the decision that is 'best' according to our current general knowledge and understanding of the particular case. This will not always be right in the sense of turning out to be the correct prediction. Sometimes children will be left with parents who abuse them. Sometimes they will return to parents who, despite apparent improvement, continue to harm them. Some judgements will be 'false positives', i.e. the children are deemed at risk and taken into care though they might have been left safely with their parents.

The inevitability of some mistakes in this type of work has been overshadowed by cases where the errors seemed avoidable. Society's horror and outrage at some well-publicised cases where children endured terrible abuse before being killed has fuelled a public expectation that social workers should be able to protect children and, if a child dies from abuse, social workers have done something wrong. The problem for social workers is how to distinguish between good and bad mistakes. Which errors of judgement are due to our limited knowledge and which to inadequate investigation and woolly thinking?

The issue is important because social workers need, for their own peace of mind, to have realistic, achievable standards of good practice. And also, I shall argue, they need to

work in a culture that recognises that good practitioners make mistakes, that new facts or ideas make them review and often revise their judgements, and that acknowledging such errors is a sign of strength not of weakness.

I start by examining the complexity of making judgements in child protection work, highlighting their tentative nature and the inevitability of some degree of error. Analysis of the many public inquiries into child abuse tragedies reveals that inquiries understand the distinction between reasonable misjudgements and errors that deserve to be censured. However closer study of these reports shows how resistant social workers are to changing their minds and how powerful an influence this has on the conduct of a case. This reluctance to abandon beliefs should not be seen as a particular fault of social workers but as a general weakness of intuitive reasoning. A large body of research in psychology suggests that people's beliefs 'are remarkably resilient in the face of empirical challenges that seem logically devastating' (Kahneman, 1990, p.144). However, while mistakes due to our limited knowledge are unavoidable, the errors arising from the biasses inherent in intuitive reasoning can be reduced by social workers' adopting a more critical approach to their judgements.

The jigsaw puzzle of assessment

Child abuse can rarely be decisively established or dismissed on the basis of one item of information. Even serious physical injuries, though arousing strong suspicion, may be due to accident or illness, or there may be dispute about the perpetrator. Identifying child abuse and assessing risk are more akin to making up a jigsaw puzzle than to any simple process of observation. Social workers need to gather together the little bits of information known to relatives, neighbours, and professionals. They then have to try to fit the pieces together to arrive at a picture of the family. The task is far more complex than a typical jigsaw puzzle game. Social workers do not know in advance what the underlying picture is; they do not know if they have got all the pieces; and they are not sure if a particular piece belongs to this picture. To add to the complexity, they cannot be certain of the shape and colour of each piece: these are not made up of 'hard facts' but of information of varying degrees of reliability. Sometimes, we are uncertain whether the 'fact' is true or false. Imagine the difficulty of trying to make a jigsaw when we do not know if a particular piece is black or white or possibly some shade of grey.

Despite the limited knowledge base, social workers have to make decisions and act. They have to guess at the underlying picture and make judgements about the safety of the children involved. The reality of their statutory responsibilities means they are not allowed the luxury of unlimited time and resources to investigate and reflect. The 'dilemma of liberalism', as Dingwall (1983, p.220) calls it, is that society wants children protected from parental abuse while keeping the family as a bastion of liberty. The law therefore gives social workers only limited powers of investigation. The need for speed is another constraint. A quick response is desirable, particularly in deciding whether the child may be at such grave risk that urgent action is needed to protect them. Swift assessments also seem a common aspect of human nature. Within a short time of meeting someone, we all form intuitive judgements about them. Social workers following up a child abuse allegation will quickly form an opinion, a 'gut reaction', about the parents. It is therefore both necessary and inevitable that initial assessments and judgements will be based on very limited evidence about the family.

Judgements made on such slender grounds should, rationally, be regarded as very tentative and open to revision. Consider how many sources of new information or ideas there

are to challenge them.

First, checks on the accuracy of the initial information may disprove or cast strong doubt on some parts of it. Child abuse is an emotive area notorious for the unreliability of people's assertions. Neighbours and relatives may make false or exaggerated allegations from malice or as part of a quarrel. Parents accused of abusing their children have good reason to lie if the claim is true. Children often find it hard to tell outsiders the truth about being abused and so may confirm their parents' false explanations of their injuries. The social worker may have made swift judgements about the honesty of the various people involved but these can and should be checked later in a more detailed investigation.

Secondly, later investigation may produce more pieces of the jigsaw puzzle. When the procedures are followed and checks made with other agencies, the police, for instance, may provide details of a violent criminal record or the health visitor may report previous injuries that made her slightly worried.

A third source of causes for revision comes from reflecting upon how the pieces fit together. With time, emotional distance from the family, and help from a supervisor, social workers can consider new ways of putting the pieces together and sometimes this produces a radically different picture. During an interview, a social worker might find parents' anger at being accused of abusing their child a reasonable response from an innocent couple. In supervision, however, it might be suggested that they had used anger to control the direction of the interview and distract the social worker away from important issues.

In the difficult area of child protection work, social workers are fallible. They cannot make the 'right' decision in any absolute sense. Judgements and decisions can only be the 'best' on the available evidence. As the case progresses and new information and ideas are received, judgements have to be reviewed and sometimes changed. Social workers therefore often have to recognise their former views were wrong - although reasonable at the time they were made. In this sense, 'mistakes' are an inevitable part of practice and recognising them is an essential element of good practice.

Inquiry reports

A study of inquiry reports shows how they have different standards than the public and do not expect social workers to be infallible. When Liam Johnson died there was widespread outrage and a Member of Parliament demanded a public inquiry, asserting that 'something went very wrong'. The inquiry report however firmly rejects this and states that the death was unpredictable and that 'nothing went wrong' (London Borough of Islington, 1989). Analysis of the reports shows interesting differences between cases that were censured and those where social workers were not blamed for the tragedy.

As part of a study funded by the Economic and Social Research Council, I have examined 45 publicly available reports of inquiries into child abuse deaths, from the Graham Bagnall report of 1973 (Salop County Council, 1973) to the recent Leanne White report (Nottinghamshire, 1994). The inquiries aim to examine what happened and see if there are lessons for professionals to learn from the tragedy. This inevitably involves making judgements about the competence of the workers involved. This has to be done in the context of the policies and practice of the time. A social worker's or doctor's actions might be deemed reasonable practice by the standards of that time but the inquiry recommends changing procedures so that future workers should avoid similar conduct. Therefore actions that are criticised in later reports might not have been censured in earlier ones.

Some reports have a straightforward judgemental statement - Jasmine Beckford's

death 'was both a predictable and preventible homicide' (London Borough of Brent, 1985) - but others are so politely worded that, although the tenor of their views is apparent, there is no simple quotation to extract. I have classified reports as not critical of statutory social workers only when there is a clear statement to that effect, such as: 'we consider that high standards of professional care and skill were demonstrated by those who worked with the baby and his family (Cheshire, 1982), 'all concerned implemented policies properly and acted reasonably' (Cambridgeshire County Council, 1982), or the more subdued conclusion that no professional judgements were made 'carelessly or recklessly' (Salop County Council, 1973.)

To compare critical and non-critical reports, it proved illuminating to classify the reports further according to the stage of social work intervention at which the child's death occurred.The first category consists of cases where social workers had received referrals alleging actual or risk of abuse but had concluded that the child was not in danger. The second group comprises reports where some degree of risk to the child was identified but there was insufficient evidence to justify removing the child.The third stage of social work intervention examined by inquiries is after children have been received into care because of abuse and the decision is made to send them home on trial.The final group involves foster and adoptive families who abused the children in their care. The Cleveland and Orkney reports are discussed separately since they deal with groups of cases not an individual one.

The first stage - of preliminary investigation - applied to twelve reports. All these reports were critical of professionals. Social workers themselves were not criticised in three cases since their misjudgement arose from the failure of other professionals to give them significant information. In these three cases, the main agency involved was faulted - in one case the NSPCC, in another the general practitioner, and, in the third, the hospital paediatric unit.

All the cases show a failure either to collect all the relevant, available information or to put the known pieces of the jigsaw together and see the picture of abuse. Reuben Carthy's doctor saw injuries that he believed were due to abuse but he did not judge them serious and failed to tell anyone. If his information had been added to other professionals' worries about the family, the level of concern would have risen sharply and Reuben would probably have been seen to be at considerable risk (Nottinghamshire, 1985).

Twelve reports fell into the second category where some risk had been identified but it had been deemed insufficient to warrant the child's removal. In these cases, social workers were monitoring the family and offering some help to those parents who were cooperative. This type of case can be very stressful to the workers involved who feel concern for the child's safety but have to work within their legal powers and make difficult judgements about the level of risk.The complexity of this work is recognised by the inquiries which only faulted social workers in three cases (25%). One inquiry produced two reports with conflicting judgements. Of the other eight, one was critical of the health visitors and another concluded that poor resources prevented professionals, particularly social workers, from providing an adequate service. Six reports (50%) however concluded that no-one was to blame; the child's death had not been predictable from the available evidence and workers had investigated and monitored the families well so that they were making their judgements on a reasonable body of evidence.

Thirteen reports dealt with cases where a child was home on trial after being in care because of abuse. Eight of these reports were critical of social workers' monitoring of the family. Of the other five, two criticised the courts for, in one case, refusing and, in another, revoking a care order despite a good case being put by the Social Services Department. In one early case the Children's Department had only a marginal role since most of the work

was done by the NSPCC and the paediatric unit. Two reports faulted no-one acknowledging that the decision to return the child had been reasonable on the evidence available at the time and only with hindsight can we see that it was disastrously wrong.

Of the six reports dealing with foster or adoptive families, half were critical. Two of the three critical cases involved a private fostering arrangement, where in one case relatives and, in the other, neighbours offered help during a crisis to a family already known to Social Services. The three non-critical reports concerned one adoptive family and two local authority foster homes. In each case, they concluded that the social work assessments of the families' suitability had been carried out well and the placements had been reasonably supervised.

Inquiry reports illustrate the fallibility of professionals in child protection work. In all the cases the child was not adequately protected from harm so professionals' judgements were clearly wrong. But the reports also demonstrate the important distinction between avoidable and unavoidable mistakes. Some mistakes involve a judgement or decision that is later shown to be wrong but that were reasonable given the information at the time it was made. Social workers were criticised for avoidable mistakes when they failed to make reasonable efforts to collect information - like the social worker who failed to read the file and so did not notice that the children were on the at risk register - or to interpret the evidence they had - as in the case where known abuse to an elder sibling was ignored when assessing current risk.

Changing your mind

Since judgements in child protection work have to be made on the basis of imperfect knowledge, later developments in a case will often require a review and a revision of one's views. But the most striking lesson to be learned from inquiry reports, whether critical or not, is how resistant people are to altering their beliefs. Inquiry reports repeatedly comment on the workers' reluctance to alter their views: 'the overall attitude that comes through to the inquiry is one of fixed attitudes' (Northern Regional Health Authority, 1989.) Whether suspicious or optimistic about a family, social workers tended to be biassed in their attitude to new information.

Social workers are not unusual in being slow to change their minds. Francis Bacon, the sixteenth century philosopher of science, noted that we all tend to pay more attention to evidence that supports our beliefs than to evidence that challenges it:

> the human understanding when it has once adopted an opinion (either as being the received opinion or as being agreeable to itself) draws all things else to support and agree with it. And though there be a greater number and weight of instances to be found on the other side, yet these it either neglects or despises, or else by some distinction sets aside and rejects (1620.)

There is now a wealth of research in psychology that endorses this view of human nature: 'once formulated or adopted, theories and beliefs tend to persist, despite an array of evidence that should invalidate or even reverse them (Nisbett and Ross, 1980, p.10). Kahneman (1990, p.149), summarising the research evidence, explains that: 'our beliefs influence the processes by which we seek out, store, and interpret relevant information'. We selectively remember information that endorses our beliefs (Kahneman, 1990, p.150). We look for evidence to confirm not disprove our views (Wason, 1960). We adopt different

critical standards for evidence depending on whether it confirms or challenges our beliefs: supportive information tends to be taken at face value while potentially disconfirmatory evidence is subjected to highly sceptical scrutiny (Lord *et al*, 1979). As a consequence of all these biasses, there is 'the tendency to perceive more support for those beliefs than actually exists in the evidence at hand' Kahneman, 1990, p.149).

This tendency is apparent throughout the inquiry reports. To return to the jigsaw analogy, it is as if once the workers have decided that the underlying picture is of, say, a happy family they will then find it easy to notice or remember any pieces that fit this image. Memories of seeing the child playing happily with his mother will readily spring to mind. Pieces that do not fit though are less easily recollected.Times when the child was crying or looking scared will not come so spontaneously to mind. Even if someone reminds you of them, the tendency will be to think of a benign explanation - that the child was poorly at the time perhaps - so that they are reshaped into an acceptable form to fit the puzzle.

The imagery of a puzzle is valuable, I think, in highlighting the repercussions of doubting your current assessment. The social worker does not just face altering his or her belief about one item of information but has to consider changing the whole picture of the case. All the known evidence then needs to be reappraised and found a place in the new emerging picture. The human tendency to avoid critical reappraisals of their beliefs may in part be due to a reluctance to undertake such a challenging and arduous intellectual task.

Reder *et al* analysed thirty-five inquiry reports and, in considering how faulty assessments of families are achieved, identified four recurrent themes (1994, p.83). They found workers could mis-interpret available evidence by treating information discretely so that the overall pattern is not seen, making selective interpretations and not considering alternatives, having pervasive belief systems, and focussing on concrete solutions at the expense of asessing complex relationships issues. These factors, however, do not operate randomly. My analysis indicates that social workers' appraisal of a family strongly influences the quality of investigations and assessments.

In the cases examined by the inquiries, social workers' actions were clearly linked to their existing view of the family.The extent to which information was checked, for instance, related to whether it supported existing views or not. Social workers tended to accept information unquestioningly when it fitted their current opinion. Therefore John Aukland's social worker who had a positive view of John accepted his benign version of his first daughter's death and failed to check the records that would have told him John had been convicted of manslaughter and sent to prison for killing his six week old baby. Once optimism had set in, the social worker in the Jasmine Beckford case 'was, fatally, much too willing to believe everything 'her clients' (the Beckford parents) told her' (London Borough of Brent, 1985.)

Conversely, social workers showed much more scepticism when information conflicted with their views. This is particularly apparent in their readiness to dismiss allegations of abuse from relatives and neighbours as malicious and unfounded. Maria Colwell's neighbours tried hard to get help for her as she led a life of drudgery, losing weight and looking 'listless, tired, and unkempt', but they were unsuccessful. The social worker accepted the parents' claim that her injuries were due to accidents and suspected that the neighbours' allegations stemmed not from a concern for Maria but from hostility to the parents (HMSO, 1974). She did not accept their claims of deterioration in Maria's health or check them with available sources such as the school (who had the same anxieties as the neighbours but did not volunteer them).

Conflicting evidence is often not discounted but apparently just ignored. A case

conference on Stephanie Fox (Wandsworth, 1989) when she was home on trial was told in a letter from the paediatrician that injuries he had seen on Stephanie's ears and back recently were unlikely to be accidental. At the conference her parent denied causing them but offered no alternative explanation for them.They had also denied the injuries that had been the grounds for the care order. This time, their denial was not challenged nor alternative explanations sought. The injuries seem simply to have disappeared from people's awareness. The conclusion of the conference was optimistic and the Chairman later wrote to the parents saying: 'your daughters are continuing to progress steadily, and there have been no injuries to cause concern'.

New, alternative interpretations of the known information also seem to fare badly. In the reports, conflicting views rarely led to a productive, rational discussion of the rival pictures of the family. In fact conflict often appears to occur in the context of a battlefield rather than a debating chamber with the loser left feeling bitter and resentful, still convinced that his or her opinion is right but that it has not been taken seriously by the others. This is particularly so with relatives and neighbours who have failed to convince social workers that children were in danger. But even high status does not guarantee having your views listened to. In the case of Carly Taylor, her childminder wrote directly to the Director of Social Services, having failed to persuade the senior social worker that Carly was in danger. He examined the file and 'formed the opinion that it was fairly clearly a classic case that might become one of non-accidental injury' (Leicestershire County Council, 1980.) A memo was sent to the senior listing the risk factors and telling him to put the child on the at risk register. The inquiry found that this failed to change the senior's benign opinion of the family. He responded to the instruction in a desultory manner so that Carly's name was finally put on the register on the day she died.

If we compare the reports where social workers were criticised with the non-critical ones, the influence of the existing view of the family on workers' responses to new information or ideas is apparent.

In my analysis of reports, all the reports in the first group where the risk was not recognised are critical, (although, in three cases, not of the social workers) whereas, in the next group, where abuse or risk was identified, the large majority (eight out of twelve) do not fault the social workers. In the cases where the risk was not seen, inquiries do not criticise the initial judgements of social workers but their failure to test these judgements by further investigation and to revise their opinions when given more information. Leanne White's social worker responded to the first allegation from a neighbour by visiting the family to investigate. She then judged that there was no cause for concern. She was not faulted for this judgement but for rejecting further allegations from other neighbours out of hand, without investigating them or reviewing her opinion of the case.

Social workers escape censure in 75% of the cases in the second category where risk was identified. By definition, this means that they had a picture of the family that included the possibility of abuse but in the three cases where they were criticised the social workers directly involved with the families had taken a more optimistic line than their colleagues. In the cases where their concern was high so that new evidence of abuse confirmed rather than challenged their existing opinion, the quality of their investigations and monitoring was good, but it dropped in line with their concern.

One striking difference between the two categories is the source of referral. In the first category where risk was not identified, ten of the twelve cases were initiated by relatives or neighbours expressing concern about the safety of the child. In the second group, all the referrals came from professionals - seven came from medical personnel, two from midwives,

one from the police, one from a probation officer, and one involved a family already known to Social Services so that there was concern about the child's safety as soon as they knew of the pregnancy. Referral from a professional seems to be treated more seriously and, with an initial expectation that it might be true, leads more often to a thorough investigation. In the second category, case conferences were held in all but one case - and that was a very early one before the conference procedure was established. In the first group however, conferences were only held in three cases (two of them on siblings, not the child who later died), each time at the instigation of the hospital, not in response to a complaint from a member of the public.

It may be that social workers are right to place little credence in referrals from neighbours and relatives while having confidence in their fellow professionals. The reports themselves do not answer this issue since the sample is selective. We need to know how many referrals are received from both groups and how many of each, in the long term, are deemed to have been accurate. But whatever the reliability of allegations from members of the public, it seems that, if a referral arouses initial scepticism, social workers are ready to discount it and make less efforts to investigate and check it. However, this response is misguided when we remember that identifying abuse and assessing risk usually requires a careful and extensive gathering and interpretation of information. Just as abuse can rarely be recognised on the basis of a single item of information so can it rarely be discounted on such slender grounds. One of the main aims of current guidelines in child protection work is to discourage social workers from resting content with their initial intuitive appraisal of a referral and to encourage a more thorough investigation even when their first reaction is sceptical.

A similar picture of the influence of existing opinions is found in the third group where the children were home on trial. In the two cases where social workers believed the child should be removed from their parents but had been overruled by the courts, their monitoring was praised by the inquiries. In all the cases where they were criticised, they had believed the family were making good progress and this seems to have contributed to their not noticing or not recognising the significance of signs of abuse.

In the cases involving foster and adoptive families, social workers, understandably for the most part, had an optimistic view of the family and a low expectation of abuse. In two of the three cases where social workers were criticised however, there were significant differences of opinion between professionals. In one case the area social worker saw no problems while the fostering section felt very worried about how the foster mother was coping. In the other, virtually everyone except the social workers thought the children were at risk staying with private foster parents who had served a prison sentence for ill-treating and neglecting their own children.

The lesson to take from these findings is not that social workers should always suspect abuse. Since these reports were all triggered by the death or serious injury of a child, they only refer to families that were abusers. The nature of the sample means that it reveals cases where social workers' *positive* view of the families adversely influenced their investigations and monitoring. Dingwall's research suggests that this type of error is, in general, more likely in social work than a bias against the parents. He argues that, because of the structural and cultural context in which child protection services operate, staff operate under a 'rule of optimism': 'staff are required, if possible, to think the best of parents' (1983, p.79.) Current beliefs about a case, however, distort and bias workers' subsequent thinking whether positive or negative. The Cleveland (HMSO, 1988) and Orkney (HMSO, 1992) reports illustrate the pervasive influence of a negative opinion of the family. In both cases,

staff developed strong suspicions that the children were being sexually abused. The inquiries criticised them for subsequently acting on these suspicions without testing or reviewing them. The Cleveland report criticised some workers for not considering the possibility that the diagnosis of sexual abuse could be wrong. The diagnosis was treated as infallible, especially by the doctors making the diagnosis, and all other information adapted to fit this view.The paediatricians were criticised 'for the certainty and overconfidence with which they pursued the detection of sexual abuse.' In Orkney, the Social Work department 'failed to keep an open mind' about the allegations of abuse; 'all agencies failed to differentiate between taking the allegations seriously and believing them'.

Time to think

Social workers have to act urgently, making assessments and decisions based on sketchy information. If the tragedy unfolds fast, there may be no time for checking out this initial appraisal and seeking further information. However, in all the cases covered by reports, there was sufficient time. The only instance of a child dying on the day of referral to the Social Services was the case of Malcolm Page, who was referred by the health visitor to the general practitioner and social worker because of neglect. Hospital admission was arranged for the following day but he died that night in an accident. His death was unpredictable and more time would not have produced information that made it predictable.The decision to delay admission to the next day was considered quite reasonable.

In all other cases, there were repeated allegations of abuse or evidence available to suggest the risk to the child. Families were known for months and, in many cases for years, before the child died. In the cases where members of the public failed to convince social workers of the risk to the child, they made persistent efforts to do so. The shortest case was that of Darren Clarke (HMSO, 1979) whose happy childhood ended when his mother moved in with a violent boyfriend. His relatives became very anxious about him and, besides making strenuous efforts themselves to find his new address, in three weeks, visited and phoned the police (who passed the referral on to the Social Services), phoned the NSPCC four times (they also passed the case on to Social Services) and phoned the Social Services once. This final phonecall was successful in communicating their concern. The relative who made the call told the inquiry he deliberately exaggerated the situation and threatened to inform the press if no official action was taken to check the safety of Darren. This triggered a thorough investigation, finding the information that had been available throughout the three weeks but, sadly, Darren died that evening before being found.

The time restrictions for social workers came not from the cases but from their work conditions. Heavy caseloads and little supervision made it hard for social workers to reflect on their work and to carry out further investigations and checks. The worker responsible for Kimberley Carlile's care was a newly appointed team manager who, due to staff shortages, had been unable to allocate the case to a social worker. He received no supervision and so no help in taking a more objective view of the case or examining his judgements (London Borough of Greenwich, 1987.)

A more critical approach to child protection work requires time. Time to check information, not just when you are highly suspicious of it, time to read files and phone other agencies to get more information, time for detailed supervision, but most of all time to think. In a management culture increasingly concerned with financial accountability, the accountant may be suspicious of the social worker sitting at her desk gazing into space but she may be doing the most valuable thing to help the family by thinking long and hard about the case and

reappraising the evidence for her judgements and decisions. Senior management needs to ensure that time for thinking and supervision is valued and protected from competing demands.

Conclusion

This article is arguing, paradoxically, that, in child protection work, making mistakes can be a sign of good practice insofar as a recognition of one's fallibility is part of a general approach involving a willingness to be self-critical and to change one's mind. All social workers make many misjudgements because of the complexity of the work but skilled social workers recognise their fallibility and are open to rethinking their assessments and decisions. Therefore they will more often decide their previous view was misguided.

Both the general public and social workers need a clear understanding of the distinction between avoidable and unavoidable errors. The public quite rightly has high expectations of social workers responsible for protecting vulnerable children. People are understandably distressed by the deaths and the suffering some children and families endure and they are right to demand public inquiries to investigate whether whether any professional was incompetent. Inquiries that then blame social workers tend to capture the limelight and are reported by the media in vivid detail. But although the death of a child is proof that the services failed to protect him or her, it is not proof that anyone acted improperly. The inquiries reviewed in this article have understood this. Many have indeed been highly critical of social workers and other professionals but a substantial minority (42%) concluded that social workers' judgements, though clearly wrong with hindsight, were reasonable given the evidence they had at the time.

The main purpose of inquiries is not to allocate blame but to see if any valuable lessons can be drawn from the tragedy to improve services in the future. The lesson drawn in this article is that social workers are slow to be critical of their own assessments and judgements. Therefore inaccurate judgements that were unavoidable in that they were reasonable on the evidence available at the time they were made become avoidable errors when they are not critically reviewed and revised as more information becomes available. The reports demonstrate the common human failing of tending to notice evidence that supports one's beliefs while overlooking or dismissing evidence that challenges them. When social workers believed the child was at risk, they displayed a good standard of investigation and monitoring.When they became optimistic about a family's progress, they were slower to notice and recognise evidence of problems that challenged their optimism. To reduce errors in child protection work, social workers need to regard their opinion of a family as tentative and open to revision. They can feel confident that they are making 'the best' decision insofar as they have made reasonable efforts to collect and check the evidence on which it is based but they should not base their confidence on an inner conviction that they are 'right'. Although some errors are unavoidable in relation to our knowledge at that time, the knowledge base alters. As new information is found or reflection produces new ways of looking at the case, previous conclusions should be reexamined and sometimes revised. The old view is seen to be mistaken but recognising this type of error should be encouraged, a sign of good practice, not something to be defensive about.

Taking a more critical attitude to one's work is not simple. It takes time, intelligence and effort. Realising your first judgements are wrong can be an unpleasant experience and social workers need to be supported and encouraged in subjecting their work to more rigorous scrutiny. Changing your mind when you receive new information or when a

supervisor suggests a new way of interpreting the evidence is not a sign of weakness but of a rational, intelligent approach.

References

Bacon F (1620) *Novum Organum*, reprinted in J.Spedding, R.Ellis, and D. Heath (eds) (1857) *The works of Francis Bacon.*

Cambridgeshire County Council (1982) *Report by the Social Services Committee on the involvement of the Social Services Department in the events preceding the death of Jason Caesar*, Cambridgeshire County Council.

Cheshire Central Review Committee for Child Abuse (1982) *The report of an Inquiry Panel into the examination of the implications of the death of a child*, Cheshire County Council.

Dingwall R., Eekelar J., and Murray T. (1983) *The Protection of Children: State Intervention and Family Life*, Oxford: Blackwell.

HMSO (1974) *Report of the Committee of Inquiry into the Care and Supervision Provided in Relation to Maria Colwell*, London, HMSO.

HMSO (1979) *The Report of the Committee of Inquiry into the Actions of the Authorities and Agencies relating to Darryn James Clarke,* London, HMSO.

HMSO (1988) *Report of the Inquiry into Child Abuse in Cleveland* 1987, London, HMSO.

HMSO (1992) *The Report of the Inquiry into the Removal of Children from Orkney in February 1991*, Edinburgh, HMSO.

Kahneman D., Slovic P., and Tversky A. (1990) *Judgement under uncertainty: Heuristics and biases*, Cambridge University Press.

Leicestershire County Council (1980) *Carly Taylor: Report of an Independent Inquiry*, Leicestershire County Council.

London Borough of Brent (1985) *A Child in Trust: the report of the panel of inquiry into the circumstances surrounding the death of Jasmine Beckford*, London, Brent.

London Borough of Greenwich (1987) *A Child in MInd: Protection of Children in a Responsible Society*, London Borough of Greenwich.

London Borough of Islington (1989) *Liam Johnson Review*, London, Islington.

Lord C., Lepper M., and Ross L. (1979) 'Biased assimilation and attitude polarization: The effects of prior theories on subsequently considered evidence', *Journal of* Personality and Social Psychology, 37, 2098-2110.

Northern Regional Health Authority (1989) *Report of the Independent Inquiry Team's Review of the Care of Karl John McGoldrick*, Northern Regional Health Authority.

Nottinghamshire Area Review Committee (1985) *Report of the inquiry into the case of Reuben Carthy (d.o.b. 7.4.82.)* Nottinghamshire County Council.

Nottinghamshire Area Child Protection Committee (1994) *Report of Overview Group into the Circumstances Surrounding the Death of Leanne White*, Nottinghamshire County Council.

Nisbett R. and Ross L. (1980) *Human Inference: strategies and shortcomings of social judgement*, Prentice-Hall.

Reder P., Duncan S., and Gray M. (1993) *Beyond Blame: Child Abuse Tragedies Revisited*, London: Routledge and Kegan Paul.

Salop County Council (1973) *Report of the Inquiry into the Circumstances surrounding the death of Graham Bagnall (d.o.b. 20.5.70) and the Role of the County Council's Social Services,* Salop County Council.

Wandsworth Area Child Protection Committee (1989) *The Report of the Stephanie Fox*

Practice Review, London Borough of Wandsworth.
Wason P. (1960) 'On the failure to eliminate hypotheses in a conceptual task' *Quarterly Journal of Experimental Psychology*, 12, 129-140.