The Role of Child Death Reviews in an Integrated System for Enhancing Child Protection Practice

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Overview

• The influence of child death reviews on
  – Policy and practice
  – The international body of child protection practice evidence

• Child Death Reviews and the *National Framework for Protecting Australia’s Children*
Purpose of child death reviews and inquiries

“Child death teams attempt to understand cases of preventable death, rather than assign blame, and to uncover ways that child welfare systems (e.g., child protection, public health, juvenile justice) can be improved to prevent future deaths or injuries.”

Hochstadt (2006) p. 659
Child death reviews can comprise

- Investigation of preventable child deaths and identification of their causes
- Identification of changes necessary to prevent future deaths
- The collection of data to identify trends

Hochstadt (2006)
Child death reviews & inquiries are necessary ...

... Why are they the subject of critique?
Predictable deaths?

If risk to children is considered measurable and manageable. The implication is that harm to children both can and should be prevented – and if it is not, that someone is to blame
Defining threshold

Changes to threshold at which the *public* choose to contact child protection services reflect changing social values.

Changes to thresholds at *internal* decision-making points reflect changing social values *and* factors *internal to the service system*.

Bromfield & Holzer, 2008; Holzer & Bromfield, 2008
Child death reviews & threshold

High-profile child death reviews and the media response to them, tend to create an alarmed community reaction, and have reinforced increasingly risk-averse practice in recent years.

Connolly & Doolan, 2007; Spratt, 2001
Dangers of overloaded child protection services

- Children in serious jeopardy missed
- Children in need not referred
- Parents who feel more isolated
- Children in care receiving less attention
- Strained relationships between child protection and other services
- Staff experiencing high levels of stress

Scott, 2005
Can we make reliable predictions?

*What does the research evidence tell us ...*
Risk assessment tools

- Actuarial based instruments
  - Developed based on empirical analysis of the factors associated with child maltreatment
  - Practitioners score each item. The scores of individual items are summed, and families are assigned to a risk category according to their overall score

Austin et al, 2005; White & Walsh, 2006
Risk assessment tools

- Consensus-based instruments
  - Developed based on relevant theory (e.g., attachment theory) and the opinions of experts
  - Individual items guide practitioners to consider risk factors. However, the final decision as to the overall family risk category is usually left to the practitioner’s (guided) discretion

Austin et al, 2005; White & Walsh, 2006
What are we predicting?

• Risk (high, medium or low) of:
  – re-referral
  – re-investigation
  – re-substantiation
  – re-entry into care
# Making accurate predictions

<table>
<thead>
<tr>
<th>Predicted</th>
<th>Observed</th>
<th>Did not recur</th>
<th>Recurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk of recurrence</td>
<td></td>
<td>✓ True negative</td>
<td>✗ False negative</td>
</tr>
<tr>
<td>(low risk)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk of recurrence*</td>
<td></td>
<td>✗ False positive</td>
<td>✓ True positive</td>
</tr>
<tr>
<td>(high risk)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Assuming no intervention provided to reduce risk
Predictive validity of SDM for re-notifications in Minnesota

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<tr>
<th>Predicted</th>
<th>Observed</th>
<th>Did not recur</th>
<th>Recurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk of recurrence (low risk)</td>
<td></td>
<td>✓ 78%</td>
<td>✗ 22%</td>
</tr>
<tr>
<td>High risk of recurrence* (high risk)</td>
<td></td>
<td>✗ 60%</td>
<td>✓ 40%</td>
</tr>
</tbody>
</table>

Loman & Siegal, 2004
Child death reviews and the practice context

Practitioners must make decisions about case prioritisation for each individual case in light of the other cases they are carrying.
Preventable versus predictable

- Preventable
  - Capable of being prevented
- Predictable
  - It happens in the way that you would expect
Implementing change

- Identification of changes necessary to prevent future deaths
- How are recommendations implemented?
Procedure and training

• Policy or practice standards
  – eg Qld Child Safety Practice Manual

• Mandatory training
  – 12 topics and 93 subtopics were identified as important to educating competent BSW-level child welfare practitioners in the US (Unrau & Wehrn, 2003)
  – Inquiry into child protection services in NSW comprised 9 recommendations that specified a need for training (Wood, 2008)
Memory test 1

seven, review, cat, chair, blade, bus, moon, pencil, blind, key, door, hair, shoe, top, jar, boat
Memory test 1
Human reasoning

“If [people] were perfectly rational, they would carefully consider all evidence before reaching a conclusion ...

Research in psychology has shown that people are not, on the whole, rational thinkers who have occasional lapses”

Munro, 1999
Memory test 2

- Flowers
  - rose, daffodil, alamanda, hibiscus
- Writing Instruments
  - pen, crayon, chalk, pencil
- Transport
  - car, aeroplane, truck, train
- Furniture
  - desk, bed, table, chair
Memory test 2
Common errors of reasoning

• Narrow range of evidence
• Biased towards information readily available to them
• Biased towards the memorable
• Errors in communication
• Lack of appropriate scepticism
• Slow to change views

Munro, 1999
Reframing errors as normative

- **Common errors** of reasoning identified in child death reviews were the **errors you would expect** if we apply our understanding of cognitive psychology to decision-making in child welfare.

Munro, 1999
What message do practitioners receive about error?

• Risk assessment in child protection now involves an additional un-stated dimension—risk to the individual or organisation of making the wrong decision.
Proceduralisation

- It is possible to implement procedure to the letter in a child protection case and still miss the vital clues as to what is happening. Lord Laming’s justified complaint ... [was] that decisions were not pursued, and the procedures were not followed. But the more searching inquiry concerns why they were not pursued and implemented”

Cooper, 2005, p. 4
Proceduralisation

• Winkworth & McArthur (2006) noted
  – increasingly complex and procedurally driven care and protection processes mean that there is a risk that the child’s experiences of these processes become lost
Accept error as inevitable

- A non-judgmental acceptance that errors are an inevitable feature of practice might make it easier for people to point out any errors they spot

Munro, 1999
A systems approach to investigating child abuse deaths

“Public inquiries have “been intelligently conducted, their analyses of practice look accurate, and their recommendations seem very sensible. Yet they are not leading to the desired improvements in outcomes for children and families. It is time to stop, reflect and ask whether there is an alternative way of approaching the problem. Fortunately, there is.”

Munro, 2005
Starting with human error

• Instead of stopping when human error is identified, a systemic investigation takes this as a starting point
  – Why are humans in this circumstance performing badly
  – What demands do the tasks make on operators knowledge and skills?
  – Do individuals have the necessary capabilities?
  – Are the demands realistic given what we know of human reasoning?

Munro, 2005
What do we want practice to look like?

- Informed by guiding values & principles
- Child and family centred
- Passes the ‘reasonable person’ test
- Comprises sound analysis and clinical judgment
- Practitioners are equipped with evidence to inform practice decisions
Child death reviews as research evidence

• Representative samples
• Purposive samples
  – positive case examples
  – negative case examples
Child death review: A negative case example

- *Child death group analysis: Effective responses to chronic neglect.*

Frederico, Jackson, & Jones, 2006
Good practice stories: A positive case example

• Victorian Government National Child Protection Week Good Practice Stories
Client satisfaction surveys: representative sampling

• 2009 Telephone Survey of Former Protection Service Clients

• Method reports
  – how they identified a randomised sample,
  – response rates
  – reasons for refusal and non-completion

• Caution potential for bias

Acknowledgment: Dr Deborah Goodman,
Children’s Aid Society of Toronto
Survey Questions

1. My phone calls were quickly returned
2. Clearly explained why CAS was involved
3. Treated with courtesy and respect
4. Enough time was spent with me providing help
5. Felt listened to and treated fairly
6. Worker knowledgeable about children
7. Involved in decisions about my family
8. Clear about what needed to make child safe
9. Ask me about what I needed to keep my child safe
10. Kept informed about what was happening
11. Overall satisfaction with CAS
How satisfied were you overall with services received from CAST?

2004-2009

How satisfied were you overall with services received from CAST?

2004-2009

Very satisfied  Satisfied  Neutral  Unsatisfied  Very unsatisfied

2009

39%  38%  10%  9%  4%

2008

42%  42%  4%  6%  6%

2007

38%  37%  12%  7%  7%

2006

35%  40%  14%  6%  5%

2005

40%  39%  9%  3%  9%

2004

36%  43%  12%  4.5%  4.5%

Acknowledgment: Dr Deborah Goodman, Children’s Aid Society of Toronto
Service Quality Questions - Respondents Strongly Agree or Agree

<table>
<thead>
<tr>
<th>Question</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>My phone calls were returned quickly</td>
<td>86%</td>
<td>86%</td>
<td>90%</td>
<td>87%</td>
<td>86%</td>
<td>93%</td>
</tr>
<tr>
<td>My worker treated me with courtesy &amp; respect</td>
<td>50%</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>My worker spent enough time with me when providing help</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>I felt listened to and treated fairly</td>
<td>82%</td>
<td>82%</td>
<td>82%</td>
<td>82%</td>
<td>82%</td>
<td>82%</td>
</tr>
<tr>
<td>Worker was knowledgeable about children</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>Clear about what was need to ensure child's safety</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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New Questions - Respondents Strongly Agree or Agree

- Clearly explained why CAS involved: 88% in 2008, 81% in 2009
- Involved in decisions about my family: 83% in 2008, 89% in 2009
- Ask me about what I needed to keep my child safe: 85% in 2008, 84% in 2009
- Kept informed about what was happening: 83% in 2008, 80% in 2009

Acknowledgment: Dr Deborah Goodman, Children’s Aid Society of Toronto
Summary

- Preventable versus predictable
- Practice context
- Prescriptive practice and human reasoning
- Organisational environments that enable the type of practice we want to see
- CDR as research evidence
Memory test 1

seven, review, cat, chair, blade, bus, moon, pencil, blind, key, door, hair, shoe, top, jar, boat
Memory test 2

- **Flowers**
  - rose, daffodil, alamanda, hibiscus

- **Writing Instruments**
  - pen, crayon, chalk, pencil

- **Transport**
  - car, aeroplane, truck, train

- **Furniture**
  - desk, bed, table, chair
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References


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References

• Goodman, D. “2009 Telephone Survey of Former Protection Service Clients: Summary of Results”. Children’s Aid Society Toronto.


References

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