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How Can Research and Theory Enhance Understanding of Professional Decision-Making in Reviews of Cases of Child Death and Serious Injury?

Philip Gillingham [1,*] and Andrew Whittaker [2]

[1]*School of Social Science, University of Queensland, Brisbane, Queensland, Australia*
[2]*Social Work Research, London Southbank University, London SE1 0AA, UK*

*Correspondence to Dr Philip Gillingham, Hon A/Professor, School of Social Science, University of Queensland, Brisbane, Queensland, Australia. E-mail: p.gillingham@uq.edu.au

Abstract

In most child protection jurisdictions, a case of child death or serious injury through the actions or inaction of a parent or carer is responded to with an inquiry into the circumstances that led to the death of the child. A key objective of such inquiries is to discern what may have been done by public agencies to prevent the child's death or serious injury and this may, in turn, lead to changes in existing policies or the development of new policies. Such changes have, at times, been criticised as 'knee jerk' reactions and can lead to well-meaning but possibly counter-productive initiatives. A general observation is that, in some inquiry reports, there is little, if any, reference to research and theory about child protection practice and policy. In this article, an anonymised case study of a child death inquiry is used to analyse the decision-making processes of child protection practitioners using a range of theory and research. The aim is to demonstrate how the use of insights from theory and research can lead to an enhanced understanding of the circumstances that led to a child death or serious injury, one which is grounded in current knowledge and evidence.

Keywords: child death, child death inquiry, child safeguarding, theory and research

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Introduction

The death of a child through the actions or inaction of a parent or caregiver (hereafter referred to as child death) is rare. Child deaths by 'assault or undetermined intent' averaged sixty-eight per year over the years 2015–2019 (NSPCC, 2021) in the UK. Data from forty-one countries provide rates of 1.6 per 100,000 worldwide, 0.5 in Europe and 3 in the Americas (Vazsonyi *et al.*, 2014). The phenomenon is, of course, a tragedy and there may be responses to it in the popular media, the judicial system and in the social and health systems. There may be a criminal case to answer in relation to the perpetrator(s), a case in the Coroner's court and both internal and external investigations of the actions by public and non-government agencies which led up to the death. Research about the reporting of such deaths in the popular media has shown how journalists tend to sensationalise and try to find someone, or an organisation, to blame (Warner, 2013). Internal and external reviews may be focused more on identifying processes that could have been different and which could have prevented the death, though there may be an implicit agenda about apportioning blame (Gillingham and Bromfield, 2008).

A child death confronts us with what Bauman calls the 'ultimate humiliation of reason' (1992), which can provoke understandable anger and fuel unrealistic demands that 'this must never happen again'. Internal and external reviews can lead to changes in policy and practice, but these changes have sometimes been criticised as a 'knee-jerk' reaction (Axford and Bullock, 2005). Changes in policy and practice that stem from a consideration of a single incident may even undermine day-to-day practice through, for example, the implementation of new information technology and an increased amount of administration (Gillingham, 2011; Munro, 2011; Parton, 2011). Research has shown that the way in which internal and external reviews are conducted and responded to by public service agencies, specifically those responsible for the protection of children, may also be guided by ideologies. In the UK, the two dominant approaches within child death inquiries have been a legalistic ideology (Louis Blom-Cooper in the 1980s) and technical–rational managerialist ideology (Laming, 2003; Gillingham, 2014). For example, a legalistic ideology would lead to the perception of the problem being a lack of, or gaps in, legislation with the obvious response being more legislation and practice procedures. Instrumental ideology would characterise the problem as a lack of tools, such as risk assessment and other decision-making tools (Lonne and Thomson, 2005; Tilbury, 2005). Additionally, many reports contain little, if any, explicit reference to either theory or research. A key example in the UK is the report prepared by Lord Laming about the death of Victoria Climbie

(Laming, 2003) which led to some important changes in child protection services (Pritchard and Williams, 2010). Research is referenced only in relation to the job titles of some of the witnesses. Other examples in England include the reports into the deaths of Tyra Henry (Lambeth, 1987) and Heidi Koseda (Hillingdon, 1986) and, in Canada, an unnamed child (Ombudsman, 2014). The Munro review of child protection services (Munro, 2011) was unusual both for employing theory and not being in response to the death of a child (Cooper and Whittaker, 2014).

In this article, it is proposed that one strategy that mitigates against perceived pressure from media reporting, the influence of ideology and the proposal of changes with unintended consequences is the use of theory and research to analyse accounts of the circumstances that led up to a child death. The aim is to demonstrate how the use of insights from research and theory can lead to an enhanced understanding of these circumstances, one which is grounded in current knowledge and evidence.

Using an anonymised case of an actual child death, in which the second author was asked to analyse the professional decision-making in the lead up to the child's death, it demonstrates how insights from research and theory were applied in this case. More specifically, the discussion focuses on cognitive biases and other psychological aspects of professional decision-making and the organisational and environmental context for decision-making. The limitations and potential criticisms of such an approach are outlined in the 'Discussion' section.

Background

The authors are mindful of the sensitivities involved in this case and would not want to add to the burden of grief being experienced by the child's family. Consequently, little detail and contextual information is provided in this article. Rather than referring to 'the child', he has been given the name 'Jack'. Jack was three months shy of his second birthday when he died from injuries inflicted by his mother's partner. The local child protection office was involved with Jack's family in relation to allegations of domestic violence and concerns about Jack's health.

Jack's death has been the subject of a coronial inquiry and criminal court proceedings. Recommendations have been made for changes in child protection practice. In this article, there is no intention to apportion blame or exonerate those involved in Jack's life. As stated, the aim of the article is to demonstrate how theory and research can help in understanding how decisions were made and what may have influenced these decisions. The workers involved in the case are, in this article, referred to as 'child protection practitioners' as the jurisdiction in question does not insist on a social work qualification, for reasons that are not pertinent to this article (Gillingham, 2016).

Methods

The study provided to the court was a documentary analysis of over 2,400 pages of documents provided by the court, which included transcripts of interviews with the individual practitioners and managers involved in the case (1,570 pages), evidence statements provided to the court by the same practitioners and managers (533 pages), previous internal investigation and review documents including file case records (312 pages).

The interview transcripts and court statements were analysed as qualitative research data using a thematic analysis approach (Braun and Clarke, 2006, 2013). It involved coding data extracts to analyse patterns in the data and to identify key themes and sub-themes that emerged. The data were coded in two stages: first, the analysis used an inductive approach to establish the broad themes, Secondly, the data were analysed using theoretical coding using a framework developed in a previous study of decision-making in child protection (Whittaker, 2014, 2018) that drew widely upon the field of heuristics and bias in decision-making and the study of decision-making and organisational culture.

As this task was undertaken as an expert witness in a court process rather than an empirical research project, it was not appropriate to seek research ethics approval. The court subsequently made a redacted version of the report available as a public document (Whittaker, 2019).

Understanding the decision environment

The analysis began by contextualising the actual decision-making within the literature about the influence of decision environments. The decision researcher Herbert Simon argued that in order to understand human decision-making, it is necessary to examine both the individual decision-maker and their decision environment. He used the metaphor of a pair of scissors, in which the individual and the decision environment are like the two blades of the scissors, each of which cannot be understood separately from the other (Simon, 1956; Taylor and Whittaker, 2018). Providing this context enables the non-specialist reader to gain an understanding of what it is like to be a worker within a child protection service.

Workers in child protection services operate within a decision environment that is inherently complex and stressful. They are expected to perform a variety of competing tasks, including establishing and managing relationships with children, care-givers and other professionals and processing considerable amounts of complex information within the context of time pressures and powerful emotions. Workers can find themselves

in situations where they face intimidation and physical violence (Stanley and Goddard, 2002; Littlechild, 2003; Ferguson *et al.*, 2021).

Managers and workers can easily experience cognitive depletion in a decision environment of information overload and decision fatigue arising from making many sequential decisions through the course of a single day (Kirkman and Melrose, 2014). The information that workers have to analyse is often substantial, contradictory, incomplete and of variable quality (Kirkman and Melrose, 2014).

The complexity of the decision environment was highlighted by one child protection worker who had previously worked in the police service where 'everything had to be viewed as black and white'. The worker described working in child protection where the work was more nuanced:

> But for departmental clients, their lives are anything but [black and white] and we have to learn to work in the grey area around the issues they face. Having seen both sides, I can see how very difficult it is for anyone outside the department to understand the complexities involved with working with our families. (Child protection worker, Whittaker, 2019)

Themes and theories

The original report prepared by the first author about the professional decision-making was forty-six pages long and so what is presented in the following are examples of how theory was applied with respect to decision-making processes, rather than a detailed account of an analysis of the child's circumstances. Almost all of the quotations from practitioners included in the original report were redacted from the publicly available version so cannot be included for legal reasons that are aimed to protect the identity of workers.

A key part of the decision environment in this case was the perceptions held by practitioners of the child, the mother and the mother's partner.

The invisible child

'Jack' was to a large extent 'hidden from view' in the work with the family. There was very little information about the child in the case file and trying to find any was like searching for a 'needle in a haystack' (Whittaker, 2019). The child appeared to be periphery of practitioners' attention rather than at the centre, and this was a common theme across all who visited the family. In their case recordings, workers found it easier to recall the presence of adults than 'Jack' and his siblings, and there appeared to be a lack of curiosity. For example, there was no evidence to suggest that any practitioners had gone beyond the main living areas

of the child's home and the assumption made appeared to have been was that if these areas were acceptable then the rest would be too.

This may appear to be surprising given that the legislation, policy and procedures in this jurisdiction, or decision environment, all very clearly place the welfare of children as the central and the most important consideration. Consequently, an analysis from a purely legalistic perspective would be likely to conclude that the individual practitioners were shockingly negligent in failing to apply the legislation.

However, the relative invisibility of children in the information collated by child protection practitioners during an investigation is a commonly identified problem in previous research about child protection practice and child death reviews (Cooper, 2005; Thomas and Holland, 2010; Ferguson, 2011, 2017; Witt and Diaz, 2019). The tendency to focus upon adults rather than children is not specific to the practitioners in this case, or to a specific time or place but endemic in child protection practice. There have been long-standing criticisms that, when investigating allegations of abuse and neglect, 'child protection agencies are obsessed with parental actions and motives rather than what the child is experiencing' (Elliott, 1998, p. 7). Information about a case emerges therefore as adult rather than child focused, with children at the periphery of the practitioner's attention. As Ferguson (2017) notes, practitioners need to be helped to keep children at the centre of their attention rather than at the periphery and relate to them in the close, intimate ways that are required to keep them safe.

Professionals' perceptions of the mother

It was clear from the evidence that workers had a clear understanding about the importance of maintaining a focus upon the child but found it difficult to achieve in practice. One of the main reasons was that the mother disproportionally secured the attention of the professionals involved. Indeed, the ways in which the professionals viewed the mother shaped their judgements and decision-making in powerful ways.

Workers' perception of mother as engaging well with services

The mother was regarded by professionals as engaging well with services and being open and honest. However, in reality, there was a history of inconsistent and ambivalent engagement; for example, she cancelled appointments over a period of months, giving plausible excuses such as child illness. When she did meet with practitioners after this period, she mentioned a 'friend' who was in a violent relationship, though she

readily agreed when questioned that she was referring to herself. This was interpreted by the practitioners as 'openness'.

In a study of how child protection social workers in the UK made professional judgements in relation to families, Cook (2017) found that parental openness was highly valued: 'When making sense of the information presented by the parent, child and family, social workers drew on their perception of "openness" as an indicator of risk …. Where child and family social workers perceived parents as open they tended to come away from the visit feeling more reassured' (Cook, 2017, pp. 437–38).

In contrast, social workers were likely to experience lack of openness as concerning: 'Workers were less reassured where they perceived the parent to be "closed". This was taken as a sign that matters were more complex or concerning. Openness acted as the worker's first-pass in relation to the parent and was often treated as predictive of future parental cooperation' (Cook, 2017, p. 438). Other studies have found that parental cooperativeness is used by child protection practitioners to gauge risk (Regehr *et al.*, 2010; Hackett and Taylor, 2014). While this belief can be quite functional in many situations, there is a danger that practitioners can miss instances of parents or care-givers who present as open and cooperative but who are hiding key information about the risks that the child is facing.

Workers' perception of mother as a 'victim'

The mother was perceived as a 'victim' by professionals in a number of ways. As a child, she had experienced abuse and had been looked after within the care system for some years. As an adult she had been the victim of domestic violence perpetrated by a series of partners. She was a young woman who was viewed by professionals as vulnerable, largely bringing her children up as a single parent. She did not have a strong system of family or community support around her. She was also perceived to be a victim of negative judgements by health professionals when the child was in hospital.

Professionals are often reluctant to make negative judgements about a parent, particularly if they regard the family as disadvantaged and socially excluded (Tuck, 2013, p. 7). In their daily work, practitioners are likely to work with adults who have experienced childhood abuse, poverty and discrimination. In the face of this, practitioners can experience genuine empathy with parents and want to build a good relationship with them. However, this can become problematic when this leads to practitioners feeling hesitant to challenge parents sufficiently. This is not to deny the reality of the mother's experiences of abuse, which appeared to have been all too real. The point is the effect this had on the workers' perceptions, as their focus upon her as a victim had the effect of drawing the attention of the practitioners away from her child and towards her, particularly in relation

to safety. Professionals were quick to take what the mother said at face value and reluctant to probe further because of her apparent openness and her identity as someone who had experienced adversity. For some practitioners, her response to this adversity was framed as her being a 'survivor', which also contributed towards practitioners overestimating her capacity to assess and manage risk to her children.

Jack's father

As research has shown consistently, the natural fathers of children involved with child protection services seem to be routinely 'left out' of investigations and ongoing statutory involvement (D'Cruz, 2002; Philip *et al.*, 2019). However, Jack's father was not known to child protection practitioners and had no role in Jack's life.

Cognitive biases and other psychological aspects of professional decision-making

In this section, the influence of cognitive biases and other psychological aspects will be discussed. Cognitive biases are patterns in perception, interpretation or judgement that consistently lead us to make errors (Kahneman *et al.*, 1982). They are relatively common in our everyday thinking and, while these patterns of thinking are often unproblematic, there are certain situations where they make us vulnerable to predictable errors. This is particularly the case in child protection work where cognitive biases and other psychological vulnerabilities in professional decision-making have been identified in UK inquiries and serious case reviews (Munro, 1999; Brandon *et al.*, 2009). It is important to recognise that, although cognitive biases can have a significant influence on decision-making, it would be too simplistic to focus exclusively upon them to explain real life situations. It is rare that they explain errors in isolation, and there is usually a combination of psychological, organisational and environmental factors at play that can interact. When discussing professional decision-making, traditional views have focused upon models drawn from economics that assume that we are social actors who act in a completely rational way at all times. This has been challenged by the work of researchers such as Kahneman *et al.* (1982), which has identified how we are subject to biases and heuristics. These are ways of thinking that can often feel intuitively correct but lead to predictable errors (Kahneman *et al.*, 1982; Kahneman, 2011).

In everyday life, attention is a scarce resource and cognitive overload can be experienced when trying to process information to make decisions. In order to avoid this, people often use heuristics, which are

shortcuts or rules of thumb that are often functional, if imperfect, ways of guiding our thinking. In the same way, child protection practitioners are more likely to be vulnerable to over-relying upon heuristic ways of thinking when they are tired, cognitively overwhelmed or when they have significant time and workload pressures (Kirkman and Melrose, 2014). There was evidence of a number of cognitive biases that appeared to influence the professional decision-making of the professionals involved with Jack and his family.

The halo effect

The 'halo effect' refers to the positive bias experienced when evaluating another person. People can find it difficult to separate out different aspects of a personality in isolation and instead substitute a global evaluation of that person (Nisbett and Wilson, 1977). For example, people are more likely to regard a person they like as trustworthy, even when there is insufficient information to make such a judgement. The 'halo effect' refers to the positive version of the bias while the 'horns effect' refers to the negative version. In this case, two specific aspects of the mother's interactions with professionals promoted the halo effect. First, as discussed above, the mother appeared to be open about her situation as a victim of domestic violence and to be willing to engage with professionals. Secondly, professionals also observed warm interactions between her and her children.

Since child protection practitioners often work with adults who are hostile and resistant, it is understandable that they would be relieved to find that the mother appeared to be cooperative and engaged with them even when she occasionally expressed frustration with child protection services being involved in her life (Ferguson *et al.*, 2021). This is an important context that is rarely known or understood by those outside the profession, especially in the harsh light of a public inquiry. Studies have found that parental cooperativeness is a factor in the process of risk assessment (Regehr *et al.*, 2010; Hackett and Taylor, 2014) which tends to lower the level of risk perceived by professionals. This is, though, highly problematic when parents and other adults are engaging in deceptive behaviour.

Overly optimistic judgements and the 'rule of optimism'

Another bias present in the minds of the professionals in this case is the 'rule of optimism', which is a term that was developed in the 1980s to describe how child protection services had an implicit expectation that staff members should think the best of parents (Dingwall *et al.*, 1983).

This operated through two mechanisms that enabled child protection professionals to neutralise parental 'deviance'. First, parental behaviour can be justified with reference to cultural relativism, by which a particular behaviour is permitted because it is part of a wider cultural or geographical context and therefore it would be unacceptable for the agency to impose dominant societal values (Dingwall *et al.*, 1983, p. 82). Secondly, there was the excuse of 'natural love', which acknowledged parental deviance but worked on the belief that all parents love their children as a 'fact' of nature.

The rule of optimism has endured as a concept to explain decision-making errors in child protection over more than thirty years and continues to be cited in child death inquiries and serious case reviews (Kettle and Jackson, 2017). For example, the serious case review of Daniel Pelka in England concluded that:

> In this case, professionals needed to 'think the unthinkable' and to believe and act upon what they saw in front of them, rather than accept parental versions of what was happening at home without robust challenge. (CLSCB, 2013, p. 6)

An analysis of serious case reviews (Wood, 2016) produced the same finding, identifying that an overly optimistic view of parental behaviour and insufficient professional curiosity led to interventions that were insufficiently authoritative and protective of children. There is an ongoing academic debate about whether the rule of optimism should be viewed as a psychological explanation for the behaviour of individual professionals or whether it is a sociological explanation for how organisations shape the decision-making of its staff according to political priorities (Dingwall *et al.*, 1983; Whittaker, 2014; Kettle and Jackson, 2017). At a practical level, it is most likely that they are both equally important perspectives which cannot be understood in isolation from each other. As Kettle and Jackson (2017) states, 'professional actions do not take place within a vacuum' (p. 1628) and both psychological and organisational factors are important.

Risk assessment

The first aspect of overoptimistic thinking was that the mother was trusted to assess and manage risks to her and her children's safety, despite historical evidence that suggested that she had significant difficulties in being able to do this. From the transcripts of the interviews with the professionals undertaken as part of an internal investigation into this case, it appears that the halo effect promoted overly optimistic thinking. The mother was acknowledged as a 'survivor' of abuse both in her childhood and as an adult and was perceived to have survived these

experiences relatively successfully. The implication of this perception was that the mother was considered to be competent in assessing and managing threats to safety. Another aspect of overly optimistic thinking related to cultural relativism (Dingwall *et al.*, 1983), where concern was initially expressed that the mother had been associating with people who were considered to be 'inappropriate', but this was normalised as a 'lifestyle' that she was accustomed to within the local community.

Accepting information at face value

A second aspect of the rule of optimism that manifested in this case was that professionals accepted information provided by the mother at face value, for example, her denials about substance abuse and mental illness. Professionals acknowledged that she was unable to provide accurate or complete information about the child's daily care and medical appointments, but this was framed as the mother trying her best to be cooperative rather than deceptive. The mother did not follow-up with some medical appointments for Jack, but it was noted by professionals that her explanation for not doing so was consistent when she was challenged at different times. This consistency was mistaken for veracity.

This aligns with Cook's (2017) research with child protection social workers in the UK, which found that workers valued coherence in parental accounts. In the second author's research (Whittaker, 2014), this tendency was identified particularly in less experienced workers, but, in this case, it was observed across a range of professionals. There are two possible explanations. First, as discussed above, the seemingly cooperative and open relationship between the mother and professionals mitigates against questioning and checking what she said. Secondly, there may have been constraints in the organisational context that prevented professionals from questioning the information provided by the mother. For example, the professionals in this case described the time pressures of large caseloads that existed at the time they were dealing with the case in question. This is not to excuse omissions in practice but rather to acknowledge that a lack of fact-checking can be associated with organisational as well as psychological factors.

Parental deception and disguised compliance

Most child protection practitioners are aware that adults who are subject to an investigation are likely to be presenting themselves in the best possible light, recognising that this is what people tend to do when being scrutinised (Whittaker, 2014). However, parents and carers engaged with child protection services, and especially those who have a history of

involvement with those services, may behave in ways that are more deceptive, including using disguised compliance (Whittaker, 2014). Disguised compliance is defined as 'a parent or carer giving the appearance of cooperating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention' (NSPCC, 2017). It is a form of deception that is subtler and occurs when a parent or carer presents a different scenario to the reality of a situation, to 'cover up' information or actions that they know will be seen as worrying or may illicit disapproval. In this case, both the mother and her partner misled practitioners in a number of ways. Initially they hid the fact that they were in a relationship and this is not unusual, and it may be for reasons not related to child protection, such as eligibility for public welfare payments and housing. Over time, they both downplayed the nature of their relationship and the role that the partner had in the daily lives of the children.

Child protection professionals may be vulnerable to being deceived by parents and other carers for a number of reasons. It is more difficult to detect deception in others, and people tend to overestimate their ability to detect it. Studies to gauge the accuracy in detecting when someone is lying have varied from 27 to 70 per cent (Vrij, 2008). The average accuracy rate was 48 per cent, which is slightly less accurate than a random guess (Vrij, 2008). However, most people tend to feel an unwarranted sense of confidence in their ability to tell whether someone is lying or not. In the inquiry report following the death of Victoria Climbié in the UK, Lord Laming recommended that practitioners should have a 'respectful uncertainty' towards information received. He argued that practitioners should critically evaluate information received and keep an open mind, rather than simply being 'passive recipients' of information (Laming, 2003, p. 205). Additionally, in the second author's research (Whittaker, 2011), it was found that many practitioners found very difficult and stressful to challenge parents, particularly when parents responded with defensiveness or aggressive behaviour. Practitioners may also be perceived as having been deceived after the event, especially when more information has come to light which makes the deception seem much more pertinent that it was at the time.

The organisational and environmental context for decision-making

In the interviews, practitioners described their office as being very busy and they felt the pressure of investigating one case after another. As research in the UK has shown, time pressures and weak organisational systems can lead to practitioners engaging in 'speed practices' as a means of completing assessments within timescales that were vulnerable to error (Broadhurst

et al., 2010). They may also experience 'decision fatigue' (Kirkman and Melrose, 2014) as they make many decisions each day.

Another vulnerability in a reactive service is that practitioners may not have sufficient time to prepare for home visits or other interviews. In this case, there was a pattern of practitioners not tending to read background information sufficiently or prepare more generally for interventions with children and families. For example, one practitioner who went to visit the child recalled having only read key documents.

Lastly, a lack of professional support for frontline practitioners can also lead to errors in decision-making (Saltiel, 2016). Though the office was trialling a new system of case management in an attempt to increase support for practitioners, it appeared to have not made a significant difference at the time during which the office was involved with the child.

Discussion

In the previous sections, the ways in which decision-making by child protection practitioners might be adversely affected has been analysed through the application of theory and research findings. This demonstration supports the contention that an approach to analysing practice that is grounded in theory and research is more constructive than one based on an atheoretical legalistic or technical–rational managerialist ideology as outlined in the introduction. There are, though, a number of potential criticisms and limitations that need to be considered.

Both the process and outcomes of applying theory and research findings about decision-making can be criticised and reacted to in different ways. First, it could be objected that it is not a description of ordinary or day-to-day practice in a child protection jurisdiction because a child died. Given this awful outcome, any analytical account of what practitioners did or did not do in this situation carries with it the implicit suggestion that they did something wrong. As alluded to in the introduction, popular media reported Jack's death as being a failure of child protection services to fulfil their basic function. From this perspective, the above account of the influences on decision-making can be read as a damning critique that demands urgent and possibly far-reaching changes to policy and practice and perhaps censure of those involved. From a different perspective, the application of theory and research findings might be considered as an attempt to exonerate practitioners. Reference to research and theory about, in this case, decision-making, implies that what might be considered as mistakes in Jack's case are features of child protection practice that have occurred in other situations and jurisdictions. This can be read as an attempt to normalise and therefore justify what can be considered as 'bad practice'.

The account might also be criticised for generating a series of hypothetical scenarios in which it is conjected that Jack's death could have been prevented. For example, what if the practitioners had made sighting Jack a priority? Would that then have led to the identification of actual or perceived risk of harm to Jack and to an application before court to remove him and his siblings from the care of their mother? This is what Munro (2005) describes as the 'charm of the counterfactual', the simple narratives that suggest that the world is a safer and more predictable place and that the systems to protect children all work well if only fallible humans can avoid making mistakes. However, such reasoning is specious and does not lead to constructive suggestions for improving practice.

An analysis informed by theory and research which highlights some improvements in practice has to be realistic in terms of its potential to prevent child deaths for two main reasons. First, as mentioned in the introduction, filicide is an extremely rare event from a statistical perspective, and, as such, it is extremely difficult to predict at the level of individual children. It is a classic 'low probability-high consequence' event that poses profound political and policy dilemmas. Research that has aimed to identify the unique characteristics and factors in scenarios in which children have been killed have struggled to find any that are not shared by many families and indeed, given the very low numbers of cases involved, a caveat limiting the extent to which any findings can be generalised is frequently included (Dawson, 2018). It is also unlikely that most child protection practitioners will ever be involved in a case in which a child dies from an assault by a parent or care-giver, and so there is little, if any, practice wisdom to draw from. Secondly, and at a more practical level, the authors considered what was known by protective practitioners about Jack's circumstances in the lead up to his death and concluded that there did not appear to be any factors that would set Jack, his siblings and his mother apart from other families that protective practitioners deal with every day.

Lastly, a demonstration of how theory and research can be used to analyse practice invokes the question of how they might be more effectively used in practice. There is, though, a world of difference between applying theory and research some time after events have unfolded and applying them in fast-moving and unpredictable circumstances. The use of theory and research in social work practice is complex (Gordon *et al.*, 2009; Treater, 2017), as evidenced by debates within the profession about evidence-based practice (see, for example, Thyer, 2002; Gray *et al.*, 2009; DePanfilis, 2014), and is beyond the scope of this article.

Conclusion

Using theory and research in child death inquiries is a rare but valuable approach that can offer insights that may be overlooked within a

legalistic framework. One of the limitations of a purely legalistic or technical–rational approach to child death inquiries is that they tend to focus upon individuals and their decisions without a fuller understanding of the decision environment and its influences. Using the example of an analysis conducted for a child death inquiry, this article has argued that it is necessary to understand both the psychological aspect of individual decision-makers and the influence of the decision environment.

To finish on a positive note, it has been acknowledged that protective practitioners work in the complex and messy environment of everyday practice characterised by considerable uncertainty, incomplete information and with adults who can go to considerable lengths to hide the abuse of children. While it may serve the interests of media outlets to sell more copy, inferring the deficits of a child protection agency and its practitioners from a single case obscures a self-evident fact about child protection services that is difficult to quantify and qualify. The fact is that child protection services do intervene in families, and they do prevent maltreatment and possibly death every day.

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