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Inquiries into Fatal Child Abuse in the Netherlands: A Source of Improvement?

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Abstract

In some Western societies, inquiries into fatal abuse of children known to agencies are nowadays a common phenomenon. They have been carried out in the UK for many years, but have recently also emerged in the Netherlands. The main aim of these inquiries is to improve child welfare and protection practice in order to reduce the chance of further child deaths. However, there is reason to critically consider the feasibility of this aim, as British research into child death investigations suggests that they have hardly worked and even may have had counter productive consequences. This paper examines for the first time all Dutch public inquiry reports into child abuse fatalities. It is shown that the problems highlighted in the reports are highly similar to those recurring in their British counterparts. Furthermore, there are considerable similarities between Dutch and British investigations regarding the solutions they propose. Like British inquiries and reviews, Dutch inquiries largely focus on changing procedures, introducing decision-making instruments and increasing monitoring. This one-sided emphasis on bureaucratic measures, the paper argues, does not rate the human side of child protection work at its true value, and makes it questionable whether the inquiries will contribute to improving practice.

Keywords: Public inquiries, child abuse deaths, child welfare, child protection, risk

Introduction

In contemporary Western societies, serious and fatal abuse of children tends to cause public outcry, particularly if these children were known to child welfare and protection services. Oftentimes, responsibility for such cases is attributed not only to the actual abusers, but also to agencies and professionals that allegedly failed to prevent a bad outcome. In some countries, this involves holding official inquiries into professional practice after child abuse tragedies (Parton, 1998, 2006; Axford and Bullock, 2005; Lachman and Bernard, 2006). Such inquiries are most common in the UK, where, from the 1970s onwards, they have significantly shaped childcare policy and practice as well as the image of social work with children and families in the public's mind (see, e.g. Munro, 2004c; Parton, 2006).

Recently, inquiries into serious or fatal child abuse have also emerged in the Netherlands. In the last decade, there have been a number of fatal child abuse cases

that shocked the public and provoked investigations into possible professional failure, resulting in public reports. The first notorious case occurred in 2002, when, in Roermond, six children died in a fire started by their father. The family was known to twelve professionals and agencies. In 2004, three-year-old Savanna died after a long period of serious abuse mainly by her mother, despite being under supervision of child protection services. Two years after Savanna's death, new outrage was caused by the discovery of the body parts of a girl in the Meuse near Rotterdam. Eventually, the so-called 'Meuse-girl' (Maasmeisje) turned out to be the teenager Gessica, who had been known to child-care organisations and health care services. The most recent case attracting attention is that of 'baby T.', who died in 2007 after abuse by her parents. A year before, another baby of the same parents had been removed after his birth.

Of these tragedies, the death of Savanna has had most impact on Dutch society. This case has become symbolic of failing childcare and protection and is, as such, comparable to 'Victoria Climbié' and 'Baby Peter' in Britain. 'Savanna' is used to justify several changes in child-care policy and practice, and is thought to have contributed to earlier intervention by child protection workers in families. In this respect, it is spoken about as the 'Savanna effect' (see, e.g. Bruning, 2007). What makes this case particularly unique is that it led to the prosecution of the front line worker charged with supervising Savanna. Though she was eventually acquitted, this first indictment of a child protection worker in Dutch history aroused strong protest among practitioners all over the country, saying that the risk of being prosecuted as a practitioner will negatively influence their work.

In the Savanna case, as well as in the other ones, inquiries appear to have played an important part in attracting public and political attention to problems in child welfare and protection work. The formal purpose of these inquiries is to improve professional practice, with the ultimate aim of reducing the chance of further child abuse fatalities.

However, good reasons exist to scrutinise whether the inquiries are to be expected to contribute to this goal. In Britain, there is a considerable body of research on child abuse inquiries, stating that they have failed in improving practice and even may have had counter productive consequences, partly due to a wrong focus (see, e.g. Hill, 1990; Reder and Duncan, 2004a; Munro, 2005a, 2005b). This raises the question as to whether Dutch inquiries differ so much from their British counterparts that they are more likely to make a positive contribution.

In this paper, for the first time, we critically examine all seven published Dutch inquiries into the role of agencies and practitioners in fatal child abuse cases (Arnhem (2000), Roermond (2002), Savanna (2004), Tolbert (2005), Case D. (2005), Gessica (2006) and Baby T. (2007)). Where relevant, we compare our findings with what is known about child abuse investigations in Britain.

The paper is organised as follows. After briefly describing the role of some key actors in Dutch child protection work, we go into the characteristics of inquiring in the Netherlands. In the next section, we outline the main themes featuring in the inquiry reports, which have, as we subsequently show, significant resemblance to problems highlighted in British investigations. Thereafter, the reports' recommendations are discussed, which, similar to British investigation reports, mainly focus on bureaucratic solutions. The following section provides an analysis of a topic in which Dutch and British inquiries importantly differ: the allocation of blame for child deaths to professionals and agencies. This analysis considers also the wider societal context of the inquiries. Parts of this section, as well as other passages throughout the paper, are based on an investigation of the press coverage of fatal child abuse cases in the

Netherlands since 2000, particularly focusing on the cases considered in this paper. Using the database LexisNexis, we examined the coverage in all national newspapers, some regional newspapers, as well as a few news magazines. That is not to deny that electronic media are important, or, in a way, may be even more important than newspapers (cf. Parton, 2006), but simply because ‘television and radio are fugitive’ (Aldridge, 1999, p. 90) and therefore harder to investigate. Finally, we discuss the likelihood that the inquiries will contribute to improvements in Dutch child welfare and protection practice. It is argued that since there is, just as in the UK, a discrepancy between the bureaucratic solutions the inquiry reports propose and the nature of the identified problems, the inquiries’ contribution is questionable. To make progress, an approach is needed that devotes more attention to the human side of child welfare and protection work.

Youth Care Agencies and supervision of services

One of the key actors in Dutch child welfare and protection work is the Youth Care Agency (Bureau Jeugdzorg), which is located in every province and in three metropolitan areas. (In the Netherlands, the equivalent of the term ‘youth’, viz. ‘jeugd’, is used to indicate children and young people from birth to adulthood.) The Youth Care Agency assesses requests for assistance and, if needed, refers children and parents to specialised (voluntary) care. It is also responsible for carrying out child protection orders issued by the juvenile court, such as supervision orders, which may or may not be supplemented by out-of-home placements (cf. Netherlands Institute for Care and Welfare, 2004; Ministry of Health, Welfare and Sport, 2005). To carry out supervision orders, Youth Care Agencies employ family supervisors, who are a kind of social worker with at least a bachelor’s degree. They are charged with monitoring the child’s development and supporting the child and its parents to solve their problems (cf. Van Nijnatten, 2006, 2008). Youth Care Agencies also host an Advice and Reporting Centre for Child Abuse and Neglect (Advies- en Meldpunt Kindermishandeling), to which suspected child abuse should be reported.

Obviously, besides Youth Care Agencies, many organisations and practitioners play a role in Dutch child welfare and protection work. All of them are supervised by various inspectorates, like the Youth Care Inspectorate (Inspectie jeugdzorg (IJZ)), the Health Care Inspectorate (Inspectie voor de Gezondheidszorg (IGZ)) and the Inspectorate of Education (Inspectie van het Onderwijs (IO)). Of these, the Youth Care Inspectorate has a central position in conducting child death inquiries. Sometimes in collaboration with other inspectorates but mostly alone, it has investigated all cases concerned in this paper. For this reason, we pay most attention to this inspectorate and its working methods.

Inquiring into child abuse fatalities in the Netherlands

Compared to Britain, where child abuse inquiries date back to at least 1945 and have increased considerably since 1973 (Corby et al., 1998, 2001), the Netherlands have a relatively short history of inquiring into practice after child abuse cases. The first inquiry into child protection practice did not concern negligence, but acting overzealously. In 1988, the so-called Bolderkar affair took place, which, similar to the 1987 Cleveland case in Britain, concerned the removal of several children from their homes after suspicions of sexual abuse. While the independent inquiry committee into this case reported professional failure (Baartman et al., 1989), its criticism was rather moderate compared to the way child-care professionals were criticised in the public

and media discourse, depicting parents and children as victims of a witch hunt (Edwards and Soetenhorst-de Savornin Lohman, 1994; Roelofs and Baartman, 1997).

By emphasising the danger of false positives, the Bolderkar affair, along with similar cases, may have contributed to the false negatives at issue in child abuse fatalities coming to the fore only recently (cf. Roelofs and Baartman, 1997). It lasted until the late 1990s before inquiries into child death cases were initiated, as can be deduced from successive annual reports of the Youth Care Inspectorate's predecessors, the Youth Welfare Inspectorate (Inspectie Jeugdhulpverlening (IJHV)) and the Youth Welfare and Youth Protection Inspectorate (Inspectie Jeugdhulpverlening en Jeugdbescherming (IJHVJB)) (IJHV, 1989–94; IJHVJB, 1995–99, 2000a, 2001). In 2000, for the first time, an inquiry report was made public and from 2002 onwards, reports have been published on the internet.

Since inquiry reports have been published in only seven fatal child abuse cases, the question arises as to what determines whether an inquiry is commissioned and, if so, whether a report is published. Obviously, a necessary condition for conducting an inquiry is the involvement of agencies with the child concerned. Until 2005, the Youth Care Inspectorate had to rely largely on media reports for receiving notice of serious or fatal abuse of children known to agencies but, since then, agencies are bound to report such cases to the Inspectorate and to the provincial government responsible for childcare (IJZ, 2006b). When taking notice of a serious case, the Inspectorate normally requests the organisation(s) involved to conduct an internal evaluation addressing the Inspectorate's questions and demands. If the evaluation is deemed insufficient, the Youth Care Inspectorate may decide to conduct its own inquiry. Also, national and provincial (and in some cases local) governments may commission an inquiry (cf. IJZ, 2007a, 2008a). Indeed, most of the inquiries considered here were undertaken at the request of national, provincial or local governments. This applies not only to high-profile cases like 'Savanna' and 'Gessica', but also to a case such as 'Arnhem', which has been much less publicised and turned out to have relatively little impact in the long term.

However, it should be emphasised that the child death inquiries we investigate in this paper are not the only inquiries that have been carried out, but the ones that resulted in public reports. As can be concluded from media reports as well as annual reports of the Youth Care Inspectorate (e.g. IJZ, 2007a), there have also been inquiries that yielded no public report. The decision whether or not to publish a report seems to be taken on a more or less ad hoc basis; clear criteria governing this decision are not known. Yet, a comparison of the inquiries that did and did not result in public reports reveals some interrelated factors that appear to contribute to the likelihood of publication of a report. It should, however, be kept in mind that we know little about unpublished inquiries, so firm conclusions cannot be drawn here.

A first factor that apparently increases the likelihood of a public report is the extent of media coverage. Most of the cases leading to public inquiry reports attracted considerable media attention before publication of the reports, while there were no well publicised cases that yielded no public report. A second factor that seems to be of importance is whether inquiries are conducted at the request of governments. This counts for nearly all published inquiries, while we know of only one inquiry commissioned by a government that did not result in a public report. A third factor is whether inquiries identify certain problems or failures either on behalf of the organisations involved or the responsible governments, and subsequently issue recommendations that are thought to deserve a wider public audience.

Although the inquiries carried out by Dutch inspectorates seem to have a similar function as British public inquiries, there are significant differences in form. Whereas many British inquiries have adopted a quasi-judicial approach, characterised by lawyers as chairs, legal representation for witnesses and cross-examinations (Corby et al., 1998, 2001), Dutch inquiries are conducted in an inquisitorial way, using mainly written documents, often complemented by interviews with practitioners and managers. Unlike British inquiries, which are sometimes held in public and often name professionals (Corby et al., 1998; Burgess, 2008), Dutch inquiries have no public proceedings and keep professionals anonymous. In that respect, Dutch inspectorate inquiries resemble Serious Case Reviews (SCRs) more than public inquiries. Furthermore, Dutch inquiries are of shorter duration and the reports have a more limited size than public inquiries such as that into the death of Victoria Climbié (Lord Laming, 2003). Whereas the Laming report has about 400 pages, none of the Dutch reports runs to 100 pages. This applies even when one adds up the number of pages of the several reports that, in some single cases, have been published due to the engagement of various inspectorates. The fact that inquiries in the Netherlands are carried out by inspectorates, which may be characterised as vested institutions, signifies yet another difference with British inquiries, which are often undertaken by ad hoc committees or panels (cf. Corby et al., 2001; Burgess, 2008).

Main themes in the inquiry reports

The Dutch inquiry reports identify several factors that seem problematic in child welfare and protection work. Below, we outline the main failures and concerns pointed to in the reports.

Co-ordination, collaboration and responsibilities

Most inquiry reports criticise the co-ordination and balancing of services and duties. Problems arise when many professionals are involved with the child and the family, especially when they work for agencies from various sectors, like childcare, health care, education and police. The reports criticise practitioners and agencies for having been insufficiently aware of each other's activities and duties, and having failed to harmonise responsibilities (e.g. IJHVJB, 2002a; IGZ, 2005; IJZ, 2008b). In this respect, they point to lacking or unclear procedures that are believed to have discouraged practitioners from communicating, acting and taking responsibility. In the Gessica case, for instance, according to the joint inspectorates, none of the involved care providers acted like a 'problem owner' (IGZ et al., 2007, p. 13). The Youth Care Inspectorate states that lacking clarity as to who is responsible for establishing and maintaining collaboration between professionals involved puts children growing up in disadvantaged circumstances at 'great risk' (IJZ, 2007c, p. 19). Worth mentioning in this respect is the specific role the inspectorates assign to the family supervisor involved in the Savanna case. They believe that the family supervisor appointed for the girl was 'primarily responsible' for co-ordinating and directing services (IGZ, 2005, p. 5), following their notion of a family supervisor being more of a 'director' of services than a practitioner providing care (IJZ, 2005b, p. 4). The inspectorates believe that in the Savanna case, this function has not been carried out properly. At the same time, the involvement of the family supervisor is said to have inhibited other practitioners in their actions, as they considered the supervisor's presence a 'reassuring fact' (IGZ, 2005, p. 4).

Information exchange

Poor information exchange between practitioners, negatively influencing the assessment of situations and decision making, is a recurring theme in most of the inquiry reports (e.g. IJHVJB, 2002a; IJZ, 2005b; IGZ, 2007; IGZ et al., 2007). According to the reports, practitioners failed to integrate single observations and did not recognise a pattern in signs because of poor information sharing. In the Savanna case, for instance, the Youth Care Inspectorate (IJZ, 2005b, p. 3) states this has had 'huge consequences' for the assessment of the girl's safety. In another case, the Youth Care Inspectorate criticises a Youth Care Agency's separated data systems, which are said to contribute to poor information exchange within the organisation (IJZ, 2005c). Some reports notice a reluctance amongst practitioners to share information because of perceived restrictions resulting from professional confidentiality. In the cases concerned, the inspectorates decline this attitude and criticise professionals for not sufficiently having used available possibilities to share information in the child's interest.

Record-keeping, transparency and accountability

Several reports reveal poor documentation of observations and signs of abuse and neglect, and criticise practitioners' recording of analyses, decisions and activities (e.g. IJZ, 2005b; IGZ, 2007). In the Savanna case, for instance, this is illustrated by the Youth Care Inspectorate's observation that practitioners' considerations and expectations about activities and services needed were insufficiently and not systematically documented. Also, the assistance plans underlying care provision are criticised for lacking explicit goals and not being evaluated properly. According to the Inspectorate, care records should contain the rationale of practitioners' activities, decisions made and its underlying grounds, as well as practitioners' responsibilities resulting from agreements (IJZ, 2005b). At this point, it deserves attention that particularly the Youth Care Inspectorate's Savanna report tends to make no clear distinction between considerations and actions that have not been recorded on the one hand and considerations and actions that have not taken place on the other. So, in a way, it seems to reduce actual practice to what can be seen of it retrospectively.

Noticing child abuse

Apart from the criticism on documenting signs of abuse and neglect, all cases reveal the complexity of noticing and interpreting signs that point towards abuse or neglect. In several cases, practitioners who considered applying for a child protection order repeatedly believed their concerns were not serious or obvious enough to ask the Child Protection Board (Raad voor de Kinderbescherming) to start off the required inquiry into the child and family (e.g. IJZ 2005b, 2008b). In the Savanna case, the inquiry reports show practitioners disagreed on the assessment of risk factors, the situation at home and the assistance needed. According to the Health Care Inspectorate (IGZ, 2005, p. 4), signs have not been rated 'at their true value' and events have not been compiled. However, problems on this matter do not only involve difficulties of interpretation and failures to see alarming events in the context of the case history. Some of the reports also point to an absence of signs indicating serious abuse (e.g. IJZ, 2006a, 2007b).

Dealing with parents and focus on the child

Several inquiry reports highlight practitioners' difficulties in dealing with parents. A concern often shown in the reports is that practitioners have not paid enough attention to family and parental problems and its consequences for the children (e.g. IJHVJB, 2002a; IGZ, 2005, 2007; IJZ, 2008b). In this respect, a lack of risk assessments about the safety of children is criticised. Another, and, in most cases, related, problem is that practitioners and parents differ in their opinion about the assistance needed (e.g. IJHVJB, 2000b, 2002a; IJZ, 2005b). In the Savanna case, the Youth Care Agency is reproached for simply having accepted the mother's initiative to end certain compulsory services and having complied with her request to reduce contact (IJZ, 2005b). Furthermore, practitioners are judged to have been 'insufficiently alert and sensitive' to manipulation by the mother (IGZ, 2005, p. 4); the family supervisor is criticised for having been guided too much by the mother's perspective (IJZ, 2005b). Although the Youth Care Inspectorate recognises the significance of building a good working relationship with parents, it believes the focus on Savanna's mother resulted in not providing the girl the assistance she needed. According to the Inspectorate, a change of attitude is required: the child's interest should be the guiding principle, 'other perspectives' being subordinated to it (IJZ, 2005b, p. 44). In the Gessica case, similar comments are made, saying that practitioners have not focused enough on the child and its safety (e.g. IGZ, 2007).

Monitoring and control in child protection services

Whilst the reports mainly focus on front line practice, management-related issues are not ignored. They are most clearly addressed in the Savanna case, in which the Youth Care Inspectorate points to insufficient support and supervision of front line staff representing the Youth Care Agency and refers to a lacking system of monitoring and control. More specifically, the failures identified relate to making professional assessments and controlling information and assistance plans within the agency. Such a situation is believed to lead to 'unacceptable risks' for children and young people whom child protection services should protect (IJZ, 2005b, p. 3). Also, the Child Protection Board is criticised in this case for not having carried out its legal duty to examine cases of supervision and out-of-home placements that will not be extended (IJZ, 2005b).

Resources and staffing capacity

Slightly different from the previous themes is the problem of availability of care. Some reports point to waiting lists at the Advice and Reporting Centre for Child Abuse and Neglect, resulting in a prioritisation of cases based on perceived urgency. The Youth Care Inspectorate sees a risk in long waiting times and in assigning cases to a waiting pile when urgency has not yet been assessed (e.g. IJZ, 2005c, 2006a, 2007b). Also, other agencies are criticised for long waiting times before starting assistance (e.g. IJHVJB, 2000b; IJZ, 2007c). In the Gessica case, for instance, waiting times are believed to have contributed to the development of behavioural problems of the girl (IJZ, 2007c).

A comparison with key issues in British investigations

The main failures and concerns touched on in the Dutch inquiry reports show many similarities with recurring problems in British reviews and inquiries into child abuse tragedies. Problems of inter-agency co-operation, errors in communication and inadequate sharing of information are, for instance, among the main problems referred

to in British investigations (see, e.g. Hill, 1990; Munro, 1999; Sinclair and Bullock, 2002; DfES et al., 2003; Reder and Duncan, 2004b; Lachman and Bernard, 2006; Brandon et al., 2008; Ofsted, 2008). This is well exemplified in the Victoria Climbié case, where the inquiry report points to the ‘dreadful state of communications which exposed Victoria to danger’ (Lord Laming, 2003, p. 9). Also, the Baby Peter case may serve as an illustration. Quite similar to the Health Care Inspectorate’s criticism on practitioners in the Savanna case, the second SCR into Baby Peter’s death relates that his GP did have concerns but did not alert others, because ‘he assumed that others would have similar concerns and would be in a better position to take action’ (Haringey Local Safeguarding Children Board (LSCB), 2009, p. 21).

Just like Dutch reports, British inquiries and reviews perceive poor record-keeping and quality of child protection plans as problematic, as well as practitioners who did not follow basic procedures (see, e.g. Munro, 1998; Sinclair and Bullock, 2002; Reder and Duncan, 2004b; Ofsted, 2008; Rose and Barnes, 2008). The same applies to the complexity of interpreting signs of abuse, failures to recognise the significance of risk factors, overlooking information concerning the family history and not seeing the overall picture (see, e.g. Hill, 1990; Munro, 1996, 1998, 1999; Sinclair and Bullock, 2002; Reder and Duncan, 2004b; Brandon et al., 2008; Ofsted, 2008; Rose and Barnes, 2008).

In addition, failures to focus on the children and give enough weight to their needs and rights are viewed as a significant and recurring problem in British cases. Munro (2004c, pp. 77–8) refers to the inquiry report on the death of Jasmine Beckford in 1985 that expressed the importance of children being social workers’ primary concern. Interestingly, she notices that this meant ‘a significant shift from the view expressed in the first inquiry (Graham Bagnall 1973) which saw abusers and children equally in need of assessment and help’. In its evaluation study, Ofsted (2008, p. 18) refers to the focus on the child as ‘possibly the single most significant practice failing throughout the majority of the serious case reviews’. This issue is also highlighted in the Baby Peter case (Haringey LSCB, 2009).

Problems and concerns regarding dealing with parents seem not unique either. British reports point to practitioners who appeared to have been guided too much by parents’ views, and — as a consequence — might have accepted lower standards of care (e.g. Brandon et al., 2008; Ofsted, 2008). In the Baby Peter case, for instance, practitioners are believed to have been misled by the boy’s mother. Supported by their own observations, they followed the mother’s explanation for her son’s injuries (Haringey LSCB, 2008). The second review of this case also goes into the complexity of working with parents and concludes that interventions have been ‘insufficiently challenging to the parent’ (Haringey LSCB, 2009, p. 24). Similar to the Savanna case, the review touches the dilemma of striving after protecting a child from harm on the one hand and improving parenting and attachment between the child and his family on the other.

Although the problems highlighted in Dutch inquiry reports and those addressed in British inquiries and reviews are highly similar, some differences appear as well. A main theme emerging from the Dutch reports that seems less reflected in British investigations is the insufficient availability of child welfare services, reflected in long waiting times and delays in providing assistance for children and families. Although problems concerning resources and staffing capacity are recognised in Britain as well (see, e.g. Ofsted, 2008), Dutch reports appear to put more emphasis on this ‘system’s problem’. Another difference relates to the attention paid to the role of universal services, with British reports putting more emphasis on the responsibilities of these

services in safeguarding children compared to Dutch reports. A partial explanation for this difference could be that most of the Dutch cases have exclusively been investigated by the Youth Care Inspectorate, focusing on specialised child welfare and protection services and not so much on the role of universal services.

Recommendations of the inquiry reports

Investigating the failures and problems in Dutch child welfare and protection work after fatal child abuse cases aims at improving practice and ultimately reducing the chance of similar cases recurring (see, e.g. IJZ, 2007b, 2007c; IGZ et al., 2007). As the Youth Care Inspectorate puts it, inquiries are meant to promote ‘the way of thinking and acting that is needed to systematically improve [provided] care’ (IJZ, 2007a, p. 48). It is assumed that the inquiry reports may contribute to the desired improvements (cf. IJHVJB, 2002a), for instance, by exercising a warning function to practitioners and agencies. In the Savanna case, this is expressed by the Health Care Inspectorate’s conclusion that ‘insufficient has been learned from previous situations’, since similar errors are made ‘in spite of the attention paid to the reports [into previous cases]’ (IGZ, 2005, p. 6).

The question of how to remedy the identified errors and problems is addressed in the reports’ recommendations, which are directed to front line practice and agencies as well as to central and provincial governments. Recommendations on practice and institutional level order agencies and professionals to change attitudes and practices, to clarify and improve procedures and to adopt assessment frameworks and tools. Governments are mostly urged to increase the monitoring and control of child welfare services and agencies, improve organisational preconditions for child welfare agencies and develop guidelines and instructions for improving the quality of services. Neither the recommendations directed to professionals and agencies nor those targeted at the governmental level pay explicit attention to extra training of professionals to deal with problematic situations, or to the allocation of sufficient resources in order to reduce waiting lists.

An important set of attitudes and practices that, according to the inquiry reports, should change has to do with the perceived failures to act properly on signs of abuse and to focus on the child. In this respect, the recommendations state that the safety of the child must be the guiding principle for child welfare services and they stress the potential hazards of keeping parents and children together as long as possible. This means a significant shift from the meaning formerly attached to ‘the child’s best interests’, which were thought to be served by maintaining the bond between parents and children as long as possible (Baartman, 2008). Not surprisingly, the solutions presented in the reports take the form of earlier intervention (IJZ, 2005b), ‘recognising the boundaries of voluntary care’ and ‘initiating the care needed in time by providing quasi-coercive assistance’ (IGZ et al., 2007, p. 6). According to the Youth Care Inspectorate, it is about providing care ‘as heavy as needed, not as light as possible’ (IJZ, 2005b, p. 45). With that, the Inspectorate reformulates an important former principle in Dutch childcare policy, stating that child welfare services should ‘last as short as possible, be offered as close to the child as possible, and be as light as possible’.

What is especially striking about the recommendations is their emphasis on bureaucratic measures: designing or changing regulations, improving compliance with procedures, developing and improving guidelines and protocols, and using assessment frameworks and tools. Illustrative is the increasing importance attached to risk

assessment. Though not wholly absent from the previous reports, the need to make risk assessments is for the first time clearly stressed in the Youth Care Inspectorate's Savanna report (IJZ, 2005b). From then onwards, the reports tend to pay more explicit attention to this theme, reflected, for instance, in the distinct sections that several of them devote to the assessment of risks (e.g. IJZ, 2007b, 2007c, 2008b). This trend is also discernible in the annual reports of the Youth Care Inspectorate. Until 2003, 'risk', let alone its assessment, is entirely missing from them (cf. e.g. IJHVJB, 2001, 2002b, 2003; IJZ, 2004). Particularly from 2005 on, risk assessment becomes unmistakably an important theme in the annual reports (cf. IJZ, 2005a, 2006b, 2007a, 2008a, 2009). Characteristic in this respect as well is that the Inspectorate has demanded all Youth Care Agencies by 2009 to prioritise implementing 'systematic and professional risk management' to children under supervision, using a 'standardised instrument', which will be monitored as of 2010 (IJZ, 2008c, p. 1).

Here, again, there are important similarities with British inquiries and reviews. Like Dutch investigations, British ones tend to target their recommendations at a bureaucratic level. They mainly focus on the modification or creation of policies, compliance with procedures, refining technical aids such as assessment forms, and increasing monitoring (Reder and Duncan, 2004a). Thus, they contribute to a growing formalisation of practice, diminishing the scope for professional discretion (Munro, 2005a, 2005b).

Attributing blame

Whilst Dutch and British investigations show many similarities in the problems they reveal and the solutions they offer, they differ considerably with respect to the allocation of responsibility. British inquiry reports tend to name and blame professionals where considered justified, attributing some responsibility to them for the death of the child concerned (Munro, 2004c; Burgess, 2008). This tendency may be related to the quasi-judicial way in which many inquiries are conducted and their formal aim of establishing responsibility where possible (cf. Corby et al., 1998), but it cannot be divorced from the wider societal context either. Child abuse deaths cause public outrage and a desire to hold someone responsible, whose satisfaction seems to require the blaming not only of the actual abusers, but also of professionals considered negligent (Munro, 2005b). A key role in voicing and amplifying public indignation and allocating blame is played by the media, which, in the UK, have a fairly negative coverage of child protection work (Aldridge, 1999; Franklin, 1999; Franklin and Parton, 2001; Hall et al., 2006) and do not hesitate to single out individual professionals (Aldridge, 1994, 1999). This was firmly illustrated in the Baby Peter case, in which The Sun successfully campaigned to sack various practitioners and senior managers. It may be argued that an important function of inquiries, which have often been established only after public and media pressure (Corby et al., 2001; Stanley and Manthorpe, 2004), is to provide authoritative confirmation of the negative public opinion by identifying culprits (cf. Sulitzeanu-Keenan, 2006), thus contributing to the dynamics of blame (cf. Corby et al., 1998; Stanley and Manthorpe, 2004).

However, in comparison with British inquiry reports, Dutch reports are remarkably reluctant in attributing responsibility to individuals. In a way, they even avoid the question of responsibility by abstaining from making a connection between identified problems and the fatal outcome, or denying such a connection. None of the inquiry reports concludes that the death of the children concerned was avoidable by better

practices, which is striking given that they nevertheless do assume that eliminating the identified risks and problems may reduce the chance of similar cases recurring. This paradox is most clearly shown in the Gessica case, in which the Inspectorate of Education asserts 'Identifying risks is ... important to support future policy that focuses on reducing the chance of similar events occurring in the future' (IO, 2007, p. 1).

At the same time, it is stated that 'Identifying risks does not mean that the horrific event concerning Gessica could have been prevented with other procedures or other practices' (IO, 2007, p. 2; IJZ, 2007b, p. 6, 2007c, p. 6).

Another quote from one of the Gessica reports, emphasising that 'presence of risks is not equal to identifying culprits' (IO, 2007, p. 1), makes it plausible that the inspectorates' restraint in establishing causal responsibility for child abuse deaths relates to a conscious attempt to avoid scapegoating individuals.

The foregoing certainly does not mean that the inquiry reports avoid criticising professional failure. However, their criticism is mostly directed to agencies instead of specific professionals. Even in the reports that clearly criticise individual professionals, viz. the ones concerning the cases of Savanna and Gessica, most attention is devoted to organisational and systemic shortcomings and risks. Moreover, as individual professionals are kept anonymous, the reports provide them with a certain degree of protection from blaming practices.

Considering this, it is ironic that the Youth Care Inspectorate's inquiry into the Savanna case seems to have contributed to the prosecution of Savanna's family supervisor. On the same day as the Youth Care Inspectorate published its report, 10 March 2005, the public prosecutor announced a preliminary investigation into the supervisor's practice, in which, among several others, one Youth Care Inspector and two Health Care Inspectors would be heard. In December 2006, it was decided to charge the supervisor with culpable homicide or grievous bodily harm by culpable negligence. Thus, the prosecution assumed a relationship between failing practice and the fatal event, taking the step that the inquiry reports hesitated to take. However, during the court proceedings, only the charge of grievous bodily harm by culpable negligence was maintained, and a suspended community sentence was demanded. The court eventually acquitted the family supervisor on 16 November 2007, judging the fatal maltreatment of Savanna neither predictable nor preventable, and a causal relationship with the supervisor's errors unproved. The prosecution did not appeal the acquittal.

With the indictment of the family supervisor, the trend to responsabilize professionals for preventing child abuse tragedies reached its preliminary climax. Yet, although this attempt to attribute blame in its ultimate form can be seen in a way as a logical sequel to the Youth Care Inspectorate's relatively severe judgement, at the same time, it seems to be a somewhat isolated event. Prosecution was apparently neither intended nor wanted by the Youth Care Inspectorate. In newspaper interviews, the head of the Inspectorate said she was surprised about the prosecutor's decision to single out the supervisor, who was not the sole responsible. She stated moreover that the penal approach would have been unnecessary, and causes child-care workers to feel threatened and under pressure (Trouw, 14 June 2006, 16 December 2006). Also, the explicitness of the above-quoted statements on preventability and culpability in the Gessica reports, appearing during the prosecution of Savanna's supervisor, seems to indicate a wish on behalf of the inspectorates to avoid likewise procedures.

What is perhaps more striking, though, is the scarce public and media support for the trial against Savanna's family supervisor. Child protection work in the Savanna

case was certainly covered in a critical way, particularly after the Youth Care Inspectorate's report was published, but the criticism was mainly directed to certain agencies as well as the child protection system in general. Individual professionals were hardly focused on by the press, and the decision to charge Savanna's supervisor was taken without any public or media demand to do so. Quite contrarily, the media devoted a lot of attention to people voicing concerns over and opposition to the prosecution, giving a stage mainly to child-care professionals and the family supervisor's counsels. The few newspapers that defended the decision to charge the supervisor did so in a rather nuanced manner.

The media's reporting of the Savanna case fits in the general pattern that the coverage of child protection work has followed since the Roermond case. From then onwards, the media have been reporting on child protection services in an increasingly negative way, although mostly indirectly, by quoting people and bodies offering criticism. Negative reporting, however, rarely concerns individuals. Criticism is mostly directed at specific agencies or 'the system' and certain features thereof, such as waiting lists and bureaucracy. This makes the Dutch media climate considerably less hostile towards individual child welfare and protection workers than that in the UK, which could explain at least part of the difference between Dutch and British child death inquiries in their degree of allocating responsibility to individual professionals. Yet, it should be kept in mind that a societal climate in which child protection work faces broad criticism, albeit mainly targeted at agencies and the system in general instead of individuals, nevertheless increases the pressure felt by the professionals working in the system.

Discussion

As we have shown in this paper, Dutch inquiries bear significant resemblance to British investigations regarding both the problems and risks they identify and the solutions they propose. In the Netherlands, as well as in Britain, problems in professional practice relate, for instance, to the difficulty of assessing child abuse signs and dealing with parents, as well as a lack of inter-professional collaboration and information exchange. Both Dutch and British investigation reports try to address these problems mainly by bureaucratic measures, focusing on procedures, protocols and assessment instruments, and on increasing monitoring of professional practice.

However, in Britain, this kind of solution has, to date, been unable to solve the identified problems. Despite numerous inquiries and reviews into child abuse fatalities in the last three decades and the subsequent introduction of more detailed assessment frameworks, new procedures and increased monitoring, professional practice seems to be hardly improved and the same problems still persist (Reder and Duncan, 2004a; Munro, 2005b).

Partly, this may have to do with the 'culture of blame' in British society, which seems to have worsened child protection work by encouraging practitioners and agencies to develop defensive practices that let their own protection dominate over the protection of children (cf. Stanley and Manthorpe, 2004; Munro, 2004c, 2005b; Lachman and Bernard, 2006). At this point, there are significant differences between the UK and the Netherlands and between investigations in both countries, though, as we have seen, the chance of being criticised or blamed for failing to prevent a child abuse death has increased also in the Netherlands.

Yet, the lack of improvement cannot wholly be attributed to fear of blame among practitioners and agencies, but seems also related to the inadequacy of the

bureaucratic solutions to which the investigation reports tend to resort. As British research suggests, these solutions do not fit the identified problems, or at least not all of them. Reder and Duncan (2004a, p. 102) point to the fact that despite the preoccupation with procedures, there is 'little evidence that the problems lay with the procedures themselves'. According to Munro (2005a, 2005b), the inclination to change procedures, issue more detailed protocols and introduce stricter monitoring usually ignores the actual problem of why practitioners omitted crucial steps in the procedure or overlooked signs of abuse.

Given the similarities with British investigations, it is not surprising that the discrepancy between the nature of the problems and the focus of the solutions appears also in the Dutch inquiry reports. Although some of the problems revealed in the reports are mainly at the organisational level and may be tackled by changing policies and procedures, many involve difficulties and errors that relate to human judgement and action. This 'human factor' can by no means be fully addressed by bureaucratic measures. To avoid the problem of manipulation by parents, for instance, one should first and foremost be sufficiently trained and have enough psychological understanding to recognise manipulation. And, to properly assess signs of abuse, protocols and assessment instruments may be helpful, but, in the end, it is humans who have to judge and decide. These basic insights are largely ignored due to the inquiry reports' bureaucratic focus. It is true in a way that the human factor does receive attention in the reports, as there are some non-bureaucratic recommendations that aim at changing certain attitudes and practices of professionals and agencies. However, the recommendations try to bring about this change merely by issuing imperatives (and increased monitoring), and so cannot be taken very seriously. Failures that are made repeatedly seem to be related to some basic ways of human reasoning (cf. Munro, 1999) or to persistent difficulties in practice, and therefore cannot be expected to disappear if they are simply forbidden.

The one-sided focus of the inquiry reports on bureaucratic solutions is not only inadequate, but may even lead to adverse effects. In a context of considerable public pressure, heavy workloads and many inexperienced practitioners, as is the case in the Netherlands, the strong emphasis on following procedures and using assessment tools threatens to create its own rationality, displacing the actual interests at stake in child protection work. The more practice becomes formalised and monitored, the more time practitioners need to spend on administrative paperwork. This leaves little time for contact with clients (cf. Bruning, 2007), which can be considered crucial in making a proper assessment of needs and risks. Furthermore, there is a real risk that growing pressure to follow the correct procedures leads to defensive rule-following, narrowing down the scope of child protection work to meeting bureaucratic requirements, which may easily become an end in itself. The problem is that mere rule-following or tool-applying is not the same as good practice and may even be contrary to it, endangering the actual protection of children (cf. Parton, 1998; Munro, 2004b). This applies even more when procedures or tools are poorly suited for use in practice, as exemplified by Broadhurst et al.'s (2009) findings on the counter productive effects of the initial assessment system in England and Wales.

However, there is a more fundamental problem with the reliance on formalising child protection work. In a climate in which child protection services are increasingly held responsible for preventing fatal child abuse, the unrealistic expectation seems to be fostered that child abuse deaths may be avoided if only the procedures are followed or decision-making tools are applied. Especially, risk assessment tools seem surrounded by a sense of predictability and certainty. To be sure, such tools may

support a systematic assessment of risks, but they surely cannot predict or detect child abuse with certainty (Munro, 1999, 2004a). Not only is the accuracy of risk assessment instruments often grossly over-estimated and difficult to determine (Munro, 1999, 2004a; Littlechild, 2008), but they are moreover not able to provide certainty even if there are concrete signs that may indicate child abuse. Probable signs of child abuse are difficult to interpret and may or may not point to actual abuse (Hoefnagels, 2001). This uncertainty can never be completely resolved, as it is inherently related to the contingent and complex nature of the social world (Littlechild, 2008; Stevens and Cox, 2008). Overlooking these limitations may lead to a tunnel vision and eventually to wrong decisions, based on either false positives or false negatives (cf. Munro, 2004a).

Considering the foregoing, we think the current focus of the Dutch inquiries makes them not very likely to really contribute to improving child protection practice and preventing child abuse deaths. Making progress should start with the recognition that bureaucratic solutions cannot provide a panacea for all problems. Bureaucratic solutions can only work if they are sufficiently attuned to the skills of professionals (cf. Munro, 2005a, 2005b) and if they are applied by professionals that have the skills to do so (cf. Munro, 2004a). Moreover, they may only partially solve the revealed problems, as these relate in large part to human judgement and action, and cannot be fully remedied by procedures and assessment instruments. Therefore, more attention should be given to the human side of child welfare and protection work, and that in a non-blaming manner.

This should also imply that the inquiries do not limit themselves to ascertaining which problems and errors have occurred, but investigate more in depth why and how they have occurred, in order to find the most apt solutions (cf. Munro, 2005a, 2005b). These solutions may include, besides procedural change and the use of decision-making tools, extra training for professionals on specific topics. Last, but certainly not least, sufficient resources are a necessary precondition for improvement in child welfare and protection, and therefore deserve also explicit attention in the recommendations of inquiry reports.

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