

The Failure of Organizational Learning from Crisis – A Matter of Life and Death?

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The continuing failure of organizations to learn from crisis has many costs, social, political, financial and individual and may be attributable to a misunderstanding of learning processes. This paper maps out contributions to learning from crisis from a number of fields. Central to the paper's argument is that the separation of policy development from practice, in theory and action, has contributed to a failure to learn. The paper considers two cases where the failure of child protection services resulted in the deaths of the children concerned. These two cases, separated by seven years, were connected by the failure of the same local authorities and agencies. The paper concludes with a number of observations concerning the public inquiry process.

1. Introduction

How often are the same mistakes repeated and do we, as organizations or individuals, fail to learn lessons in spite of hindsight? Efforts to identify lessons from failure, to avoid their repetition, are institutionalized in the form of the public inquiry. Inquiries and hearings, conducted in public, have been identified as important aspects of 'the life history of many organizationally based crisis, and sense making about technological risks and crises is an important feature of inquiry discourse and documents' (Gephart, 2007, p. 123). This paper takes as a starting point evidence of flaws in the processes of organizational learning from crisis, from knowledge acquisition and policy development through to the translation of newly acquired understandings into operating norms and practices (Turner, 1976; Elliott & Smith, 2006; Elliott, 2008). Central to these failings is a lack of integration, which has been identified as a key barrier to a comprehensive approach to crisis management research in general (Pearson & Clair, 1998) and, it is argued in this paper, particularly with regard to the processes by which organizations may learn from crisis.

This lack of integration is also mirrored in the practice of organizational learning from crisis; this weakness separates policy makers from practitioners. Policy learning should not be confused with organizational learning and while, as Birkland (2006) asserted, regulations may provide tangible evidence of potentially enduring learning outcomes it does not follow that these flow through into changed practices and behaviour at the levels of the organization and individual. A tragic illustration of the material impact of this confusion concerns the deaths of two children, Victoria Climbié and 'Baby P', both under the care of London's Borough of Haringey's Children Services.

In the case of 8-year-old Victoria:

The food would be cold and would be given to her on a piece of plastic while she was tied up in the bath. She would eat it like a dog, pushing her face to the plate. Except, of course that a dog is not usually tied up in a plastic bag full of its excrement. To say that Kouao and Manning treated Victoria like a dog would be wholly unfair; she was treated worse than a dog (Laming, 2003).

On 25 February 2000, Victoria died in hospital; a pathologist described Victoria's condition:

in terms of the nature and extent of the injury, and the almost systematic nature of the inflicted injury, I certainly regard this as the worst I have ever dealt with, and it is just about the worst I have ever heard of (Carey cited in Laming, 2003, p. 2).

Laming (2003) reported that during the 11 months before her death, Victoria's case was well known to various public agencies including social services departments and medics who saw repeated evidence that she had been deliberately harmed. Acknowledging the difficulties of working in child protection, Laming (2003) identified 12 separate occasions when authorities missed clear opportunities to successfully intervene.

Sometimes it needed nothing more than a manager doing their job by asking pertinent questions or taking the trouble to look in a case file (3).

Some 6 years later, three blocks away, 'cared for' by the same London Borough, including a substantial number of the same professionals, managers and elected representatives in post or promoted after Victoria's death, 18-month-old 'Baby P' died:

Baby P was sullen and shaven-headed and covered in bruises and scabs when he died in the dirty, flea-ridden house in August last year. His fingernails and the tips of his fingers had been torn off and he had been hit so hard in the face that one of his teeth was found in his stomach (Bennett & Fresco, 2008).

The official inquiry into Baby P's death found a similar catalogue of errors, malpractice and opportunities to intervene as in the case of Victoria. Despite this, Lord Laming, chair of the public inquiry that had investigated the circumstances around Victoria's death, stated:

The Government deserves credit for a robust response to the report into Victoria Climbié's death and for producing an outstanding policy document in *Every Child Matters*. The legislation that followed in the Children Act 2004 places clear duties on each agency. They now know the questions that they ought to be asking in order to promote the health, development and safety of children. We have a sound framework in place (Laming, 2008).

Acknowledging the gap separating policy from practice, he continued:

However, what still needs to be done is implementation to ensure good practice is standard practice in every agency (Laming, 2008).

These failures of practice, it is argued in this paper, reflect the absence of an all-embracing framework of organizational learning from crisis (see Elliott, 2008, for a fuller discussion). Policy may be developed with only a limited understanding of the mechanisms through which lessons learnt may be disseminated and the facilitators and barriers to learning through which knowledge flows into practice at the organizational level. Hence, although learning from crisis (or disaster) has been considered from various perspectives including policy (May, 1992; Birkland, 1997, 2006), human behaviour (Carroll, Rudolph, & Hatakenaka, 2000), crisis management (Smith & Elliott, 2007) to organizational learning (Reger, Mullane, Gustafson, & DeMarie, 2002), this paper suggests that a framework incorporating knowledge acquisition, transfer and assimilation offers an opportunity to enhance successful organizational learning from crisis. In the case that provides a focus for this study, a tragic incident was investigated, lessons were identified and new policy was created. Four years later, a similar tragedy occurred, within the same organization, and the subsequent review, which identified many similar failings, provides an opportunity to consider the efficacy of the efforts to learn.

Our understanding of organizational learning from crisis has developed in a piecemeal way since Turner's (1976, 1978) seminal study of 'man-made' disasters. Turner (1976) identified a sequence of events associated with failures of foresight including the incubation of the potential for crisis within an organization itself through to cultural readjustment. For the purpose of this paper, we are concerned with Turner's notion of cultural readjustment, which would be characterized by the emergence of new operating norms and practices, a definition that has much in common with many definitions of organizational learning (see, e.g., Argyris & Schön, 1978; Levitt & March, 1988; Elliott & Smith, 2006).

However, a gap in Turner's (1976, 1978) work was a consideration of the processes by which cultural readjustment might take place (Elliott & Smith, 2006), which, although implicit in Turner's work, was never fully developed. Elliott (2008) attempted to map out the processes of organizational learning from crisis, from knowledge acquisition to knowledge assimilation and creation. It identified the limited attention given to the processes of knowledge transfer, a vital link between knowledge acquisition, assimilation and creation. The contribution of this paper is towards the exploration of knowledge transfer, following a public inquiry and a repeat failure, within one sector. Although approximately 35 children die at the hands of their families in

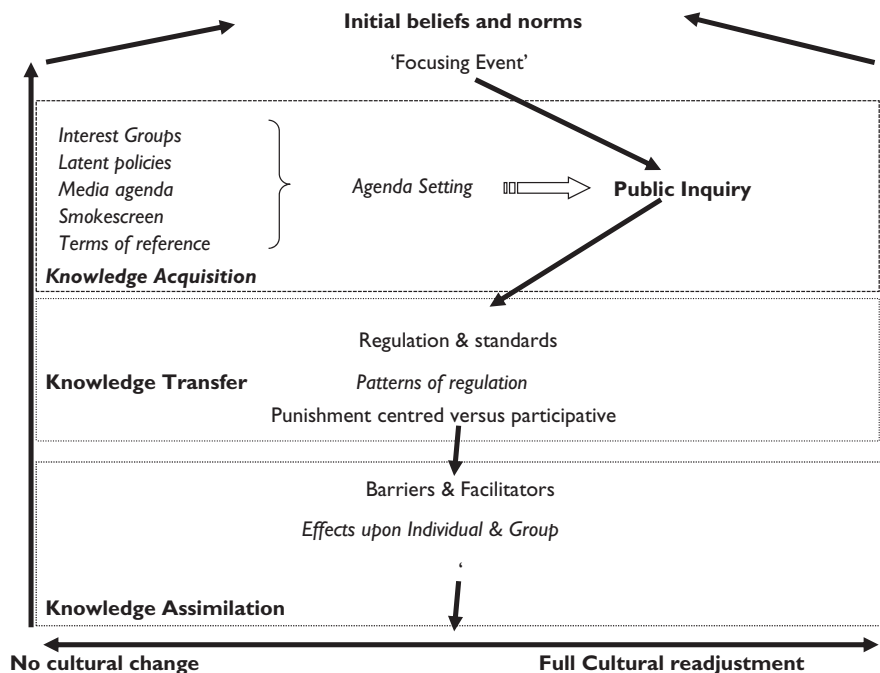


Figure 1. Mapping the process of Organizational Learning from Crisis. Source: Adapted from Elliott (2008).

the United Kingdom each year, this case was unusual in that child victims are usually unknown to child protection services. Both Victoria and Baby P were well known to a variety of child protection agencies and had been identified on an 'at-risk register'.

Drawing from the case of Victoria and Baby P, we argue that policy emerging from the processes around the public inquiry is only one part of the organizational learning from crisis process and that the gap between policy and practice is one that has received insufficient attention to date. The paper is organized as follows: First, a summary of the literature is presented as Figure 1, with a brief discussion of knowledge acquisition, transfer and assimilation. Drawing from a public inquiry and media reports this paper considers the case of Victoria Climbié and Baby P, arguing that it was the failure to bridge the gap between policy and practice that contributed to the death of the second child. It recommends the inclusion of organizational and change management specialists on inquiry panels as a means of ensuring that issues around implementation are considered alongside policy development.

2. Organizational learning from crisis

An idealized and simplified map of the processes of organizational learning from crisis is shown in Figure 1. From Turner (1976), our notional starting point of initial beliefs and norms is during the period before the 'focusing event'. At this stage, organizations and individuals are able to survive through a set of normative

prescriptions consonant with the dominant assumptions and beliefs about the threats facing an organization. For Turner (1976), a cultural collapse follows when such prescriptions are deemed to be inaccurate. This rarely happens instantaneously but occurs as a series of happenings challenge existing norms and beliefs. Although Turner's (1976) terminology referred to a trigger event, the label focusing event applies equally well. Public inquiries are an official response to focusing events (Birkland, 1998), which cry out for investigation as they are:

'sudden; relatively uncommon; can be reasonably defined as harmful or revealing the possibility of potentially greater future harms; has harms that are concentrated in a particular geographical area or community of interest; and that is known to policy makers and the public simultaneously' [54].

A 'focusing event' refers to an episode that is recognized as revealing the inadequacy of what Turner (1976) revealed as an organization's normative prescriptions. In other words, focusing events indicate 'cultural collapse' and provide a motive for identifying lessons to be learned. Birkland's (1998) description of focusing events shares many of the characteristics of crises as they are typically sudden, uncommon, harmful or indicative of future threat within a particular region or community of interest.

In Figure 1, the process of organizational learning from crisis is depicted as a linear process. Once an event is recognized as posing a significant challenge to

norms and beliefs, the process of investigation and knowledge acquisition, in the form of a public inquiry, commences. A widely accepted view is that crises may be distinguished from other events by the challenge they present to established assumptions (see Pauchant & Mitroff, 1988, 1992; Billings, Milburn, & Schaalman, 1980, for example). Thus, the term crisis would incorporate the three types of focusing event identified in Birkland's (2006) adaptation of Faulkner (2001), namely crisis, disaster and catastrophe, because a crisis comes to symbolize the inadequacy or organizational beliefs and practices. This, it is assumed, prepares fertile ground for the establishment of new operating norms and practices as the need for change is deemed to be apparent to both policy makers and practitioners. Typically, inquiries result in codified outputs in the form of regulations and guidelines, which form the heart of knowledge transfer, as shown in Figure 1. From this point, organizations, and the individuals within them, may engage with these outputs. Put simply, this engagement may take the form of acceptance or resistance. The literature concerned with what we have labelled knowledge assimilation in Figure 1 may take the form of either barriers to or facilitators of organizational learning. This has provided the focus of a number of studies (see, e.g., Cox, Jones, & Rycraft, 2004; Elliott & Smith, 2007). The positive and negative influence of crises on learning potential is well established (see, e.g., Stern & Sundelius, 1997).

Figure 1 is also informed by Toft and Reynolds (1992) and incorporates insights from a range of literatures including organizational learning (Crossan, Lane, & White, 1999), public policy (May, 1992; Birkland, 1997, 2006) and from crisis management (Hynes & Prasad, 1997; Wicks, 2001; Elliott & Smith, 2006). Although the 'Systems Failure and Cultural Readjustment Model' (SFCRM) developed by Toft and Reynolds (1992) represented an effort to map out how organizations might learn from crisis, it predated the rapid growth of the organizational learning literature and the emergence of neo institutional theory.

Although we suggest that such a model is implicit in many studies, there have been few attempts to map out the entire process and individual studies tend to be focused on one phase. For example, Turner's (1976) seminal study uses the term cultural readjustment as a proxy for the entire learning process. What have emerged are studies focused on either knowledge acquisition (e.g., Brown, 2000; Gephart, 2007), knowledge transfer (Elliott & Smith, 2006) or organizational-level learning (Jones & Cox, 2005). Without an overarching framework of learning from crisis, what exists to date, largely, is an uncoordinated approach to the study of these processes that has been conducted by researchers working within distinct academic disciplines.

2.1. Knowledge acquisition

A key means of acquiring knowledge in the aftermath of crisis is the public inquiry, which may be seen as an indicator of cultural collapse. The focus of much research has been at the level of public policy, with much interest focused around agenda setting, advocacy coalitions and sense-making, with limited consideration given to how the knowledge acquired might be translated into new operating norms and beliefs. From a study in which the focus was on natural disasters, oil spills and nuclear accidents, Birkland (1997) identified the degree to which a community is organized as a vital factor in determining its ability to 'improve' policy and implicitly, to learn. Further, focusing events may offer opportunities to weaker advocacy coalitions, by providing a powerful symbol of an underlying problem, and to the more powerful, the opportunity to exploit the chance to put forward a latent agenda. For example:

Before September 11 homeland security was a 'policy without a public' (Birkland, 2006, p. 41).

Expressed in another way, although Birkland (2006) noted the rapid pace of policy change after 11 September he argued that there was little evidence of policy innovation; the majority of policy ideas had already been put forward. A key stream of work has dealt with 'political learning' (May, 1992) and inquiry sense-making (Brown, 2000; Gephart, 2007), whereby advocacy coalitions exploit particular social construction and rhetorical devices to express their point of view most effectively. Boin (2008) emphasized the less rational nature of crisis-induced learning in a context dominated by political processes involving many stakeholders. Others, including Hutter (1992), focused on the role of coalitions that seek to influence the terms of reference. Public and media perceptions around risk may be highlighted (Birkland, 2006; Gephart, 2007) or efforts to shape findings by lobbying for a principal investigator drawn from a particular professional background (McClean & Johnes, 2000; Brown & Jones, 2000).

Emerging from this narrative is a challenge to the view of public inquiries as necessarily impartial. They are political in nature and some authors have argued that an underlying purpose might be to protect vested interests (Elliott & McGuinness, 2002) and there seems to be an agreement that scapegoating is a frequent outcome (Brown & Jones, 2000; Scraton, 1999).

Another approach to investigating knowledge acquisition from public inquiries is grounded in a systems perspective. Focusing on the practice of inquiries, Turner and Toft (1988) identified that >80% of recommendations were concerned with organizational and procedural affairs and the remaining 20% with technical and physical improvements. Given our earlier

example from Laming (2008), who identified the difficulties of implementation this raises the question of how useful these organizational and procedural recommendations are in practice. However, they also found that inquiry recommendations dealt only with some of the causal factors identified and that the difficulties of marshalling extensive evidence made it difficult for investigators to fully appreciate the interrelationships resulting in 'blind spots' in the lessons drawn from them. The SFCRM represented an attempt to overcome this weakness and provided a rare example of a practical tool developed as an aid for the public inquiry process.

In summary, this brief overview indicates that those studies concerned with politics and policy processes and the role of the public inquiry pay little attention to how lessons learned might be translated into organizational practice. This separation between policy and practice has been acknowledged within the field of strategic management, which has challenged the view of strategy as the plan and the processes creating it, defining it, alternatively, as a pattern amidst a stream of organizational actions over time (Mintzberg & Waters, 1985). A key task of the strategist, it may be inferred, is not the production of a plan but the creation of the enabling conditions that will steer the organization in the desired direction. Put simply, strategy is about managing practice. Although Turner and Toft (1988) do make reference to knowledge transfer this merits no more than two paragraphs of their paper.

2.2. Knowledge transfer

As argued above, the emphasis of studies of learning from crisis at the policy or the organization level has seen little attention given to the processes of knowledge transfer. Implicitly, it is assumed that new guidelines or regulation emerge from a public inquiry and flow into practice. The case of 'Baby P' points to the inadequacy of this view. The limited attention given to the processes of knowledge transfer includes studies by Wicks (2001) and Elliott and Smith (2006), which dealt briefly with the possible contribution of institutional theory to organizational learning from crisis. Elliott and Smith's (2006) paper, however, was primarily concerned with regulation in a longitudinal study of the UK soccer industry. This used Gouldner's (1954) patterns of industrial bureaucracy and identified that punishment-centred enforcement tended to result in compliance only. In contrast, they identified that participative forms of regulation encouraged deeper learning. This study, from 1946 through to 2000, included four stadium disasters investigated through public inquiries. Despite some eight inquiries in this period, how could, Lord Justice Taylor reflected as chair of a ninth, 95 people be crushed to death in front of those managing the event?

Elliott and Smith (2006) concluded that there was significant evidence of a persistent indulgency pattern of behaviour within the industry regardless of extensive legislation and regulation from 1946. It appears that the problem lies not with policy but with how it may feed through to shape practice. Laming's (2008) observations, following the death of Baby P, that the problem lay with the implementation of policy, repeated his own finding some 5 years earlier in the Victoria Climbié Report (Laming, 2003, p. 6).

Despite this body of evidence, the processes around knowledge transfer have received limited attention within the academic literature and even less within public inquiries, which appear to make specific recommendations without fully comprehending how these should be implemented. The spirit of implementation, it may be argued, is more difficult to codify than the letter. Elliott and Smith (2006) explored the network of actors and agencies within the institutional field of British Soccer; this network, they suggested, was a key unit for learning from crisis encompassing all those who shaped and influenced practice from regulators and educators through to soccer clubs and their personnel. Recommendations from a public inquiry and resulting policy, guidance, laws and regulation feed through to individual organizations through a variety of field-level actors and mechanisms. Within Institutional Theory, a recent special issue edited by Lampel and Meyer (2008) was devoted to the role of a variety of field configuring events as mechanisms of institutionalism. This would provide a fruitful avenue for future research within organizational learning from crisis.

In summary, it is surprising that this phase has received the least attention from researchers despite its pivotal place between policy change and organizational and individual behaviours, which we will now consider.

3. Knowledge assimilation

Significant degree of attention has been given to those mechanisms facilitating or inhibiting organizational learning in the context of crisis. It may be argued that as a field of inquiry it too has suffered from a lack of integration with contributions from organizational learning (Crossan et al., 1999, for example), psychology (Cox et al., 2004) organizational behaviour (Smith & Elliott, 2007) and high-reliability/hazard organizations (Jones & Cox, 2005; Carroll, Rudolph, & Hatakeneka, 2002). Not surprisingly, given the interests of these researchers, this attention has dealt with the levels of the individual and organization.

Mirroring Pauchant and Mitroff's (1988, 1992) Onion Model of Crisis Management, Jones and Cox (2005) identified 'formal systems and practices', 'objectives, priorities and resources', 'organizational culture and

climate' and 'Individual attitudes' as facilitators of organizational learning. Where Pauchant and Mitroff (1992) placed assumptions as the starting point, Jones and Cox (2005) advocated changes to behaviour as a step towards cultural readjustment within the nuclear power industry (see also Cox et al., 2004). Changes in attitude following new behaviour contrast with the logic of Figure 1; this suggests changed beliefs flowing through into new practices. Both approaches share the view that changes in performance require changes in both behaviour and attitudes if they are to be sustained.

More attention within crisis management studies has been placed on barriers to organizational learning than on facilitators. From the organizational learning literature, Berthoin Antal, Lenhardt, and Rosenbrock (2001) identified two clusters of barriers: 'psychological and cultural' and 'organizational structures and leadership,' respectively. Argyris (1990) and Pauchant and Mitroff's (1992) work fits the first of these clusters with barriers at the level of the organization and individual identified. Their concerns were especially with the individual defence mechanisms and routines. A consequence of using these routines was that they constrained processes of problem definition and resolution, especially by limiting opportunities for considering alternative ways of seeing things (Argyris, 1990).

In the second cluster, put forward by Berthoin Antal et al. (2001), structure may reinforce the continuation of current norms and practices and hamper the development of new ones. For example, the limitations of Mintzberg's (1985) 'machine bureaucracy' as a structure for crisis response were noted by Elliott and Smith (1993, 2007). From Smith and Elliott (2007), a third cluster of barriers may be seen, focused on single-loop learning (see also, Kletz, 2001; Carroll et al., 2002; Boin, 2008).

Finally, while there may be many barriers, Hedberg (1981) identified 'slow unlearning' as a critical weakness of many organizations. The resilience of existing operating norms and practices to change suggest that a sustained approach to change management is required. Buchanan and Fitzgerald (2007) advocated a processual perspective as a useful starting point for exploring and understanding the interplay between the many factors that shape the organizational context of change. Such a perspective recognizes the importance of context and may be used to explain how similar initiatives may prosper or founder within different settings.

4. The failure of organizational learning from crisis

From the preceding discussion a number of key points may be identified. First, that research around learning from crisis has concentrated at the levels of policy and organizations, respectively. Brief overviews of the literatures

pertaining to these two areas have been provided. It has been argued that the processes of knowledge acquisition may be shaped by deliberate misrepresentation, opportunistic interest groups or by the emergence of dominant social constructions of problem and context. Within the context of public inquiries, it has been asserted that findings emerge as codified knowledge, often in the form of specific recommendations dealing with explicit issues. The translation of such codified or explicit knowledge into tacit forms has received little attention, which leads to our second point.

Second, we have identified the paucity of attention dedicated to examining the processes of knowledge transfer. It has been argued that the fragmentation of research from processes of knowledge acquisition, through transfer to assimilation, has acted as a barrier to conceptualizing the process in its entirety. Further, we have argued that not only is this separation reflected in the practice of public inquiries, but that this has had material effects in limiting the likelihood of translating new understandings into changed norms and behaviours within organizations.

Third, although the paper has identified the limited literature dealing with processes of knowledge transfer, and the more substantial literature focusing on barriers and facilitators of learning, it is argued that little use of this empirical research has been made in formulating recommendations and plans for implementation following public inquiries. Findings from organizational studies are strangers to the inquiry process. Central, within knowledge transfer, is the notion of spirit, whether it refers to the particular patterns of regulation as Elliott and Smith (2006) asserted, or to the changed beliefs and assumptions that underpin sustained changes in behaviour as Pauchant and Mitroff (1988, 1992) and Jones and Cox (2005) advocated from their different starting points. The paper now turns to consider the learning from the case of Victoria Climbié to that of Baby P.

4.1. Victoria and baby P – the first report, Laming (2003)

The long-term abuse and death of a child under any circumstances would deserve the label tragic, particularly when there were so many missed opportunities to intervene. Laming's own background lay in social service practice from a front-line position through to a strategic one as the director of social services for a local authority. Evidence for Laming's Inquiry was collected from education, social, health, housing and police services professionals, a range of personally interested parties, elected members and senior managers and a small number of individuals from related social care positions. Following phase 1 of the inquiry, five seminars were held on themes related to the inquiry. These

involved members from the key professions identified above as well as a small number of academics with interests in social policy, psychiatry and childhood studies. This gives some indications of the key influences on the direction of the inquiry and its findings. Laming's inquiry team also drew from a small number of personnel from either social care or legal backgrounds.

Without a detailed analysis of the inquiry proceedings and related media, it is beyond the scope of this paper to make firm assertions about the roles of advocacy coalitions and sense making here. What is evident, however, is the involvement of a narrow range of professional groups and the political appointment of a chair to lead the inquiry into the circumstances of an incident that had been the subject of highly critical media coverage. What can be asserted is that the inquiry published a report, including many recommendations, which were enacted and that fed through into regulatory and inspection regimes. Reflecting on the circumstances of Baby P's death and the enactment of proper procedure, the then Director of Children Services at Haringey observed that they were operating a rule of optimism, believing that Baby P's mother was working with them. In defence of her colleagues she stated that following a serious case review of Baby P's death, no one was found guilty of gross misconduct.

However, among the criticisms emerging from Laming's (2003) inquiry into the circumstances surrounding the death of Victoria were major weaknesses in management and with senior members of the various authorities; these resulted in a low priority being given to the child protection service, an attitude reflected in underfunding, inadequate staffing and poor leadership. Laming found that senior managers sought to evade responsibility, arguing that their roles were strategic and not concerned with practice. Elected representatives failed to play an effective role in scrutinizing either strategies, policies or practices. At the practitioner professional level, the final report indicated that the standard of work of those in direct contact with Victoria was poor. For example, there was an absence of proper systems for tracking cases (39), or allocating formal responsibility for a case (41), poor induction training (42), professional incompetence (67), poor record keeping (100) and failure to act on referrals (106). Additionally, the report identified the poor literacy of some case workers, an overload of different policies and procedures and resources so dated that copies of the Children Act 1989 were not available. Practice, management and leadership were all seriously deficient.

Laming's (2003) Report concluded that, following previous inquiries, the legislative framework around child protection was sound and that difficulties were with how it had been implemented. Arising from the report, a number of recommendations were made,

which sought to ensure that those responsible for managing services for children and families were held personally accountable. Put simply, Laming's (2003) intention was to bridge the gap between policy and practice, a critical weakness we have argued of previous attempts to learn from crisis. For example local authority chief executives were identified as personally responsible for ensuring that a solitary database, the Common Assessment Framework, be provided for professionals working with children and families (Laming, 2003), that directors of social services be personally responsible for ensuring that their senior managers inspect a random sample of cases at a minimum of 3-month intervals (Laming, 2003, p. 375). The purpose of these recommendations was to compel senior managers to play an active part in the supervision and management of practice. Thus, while Laming (2003) made many recommendations concerning the detailed practice of social care, from guidance on social worker preparation for visits to record keeping, the responsibility for performance would lie with local authority elected members, chief executives and departmental directors. What emerged from the 41 recommendations, specifically for social care, was not only the identification of what might be considered good practice but a supervisory regime to ensure that an auditable trail be created in order that it could be monitored, and, if necessary, corrected. For example, in responding to the referrals of children from other professions, social workers should reply in writing within 48 hours to confirm receipt (Laming, 2003, p. 374).

The regime envisaged by Laming (2003) included inspection by external bodies to ensure that standards were adequate and sustained, a responsibility given to the Government Office for Standards in Education (Ofsted), whose remit included inspection and regulation to achieve excellence in the care of children (Ofsted, 2008a). This may have been viewed as an end point, lessons identified, policy changed, and a regulatory regime established with clear lines of accountability and responsibility; to put it colloquially, there is a sense of perceptions of a job well done, sighs of relief and self-congratulation on this success.

The paper now moves from 2003 and the Laming (2003) Report to the consider practice as seen from a 2008 perspective, following the death of Baby P. In creating a picture of practice in 2008, we also draw upon inspection reports published in the period 2003–2008.

4.2. Victoria and baby P – practice in haringey from 2003 to 2008

By 2008, a more complex picture emerged of social workers' recommendations not being followed through.

One anonymous social worker from Haringey (Anon, 2008) reported:

we are over ruled all the time, we give our social work opinion, our professional opinion to our managers, together we make a decision and hopefully that will be followed through, but if the financial means aren't there or if the service isn't available, if it's going to cost too much for the local authority it doesn't happen

Anon (2008) reported that following the Laming Report (2003), there was a sharp increase in workload, which placed the service under strain. This meant that social workers might have excessive workloads and once again a statistical sleight of hand could distort the truth; Haringey reported that the social worker responsible for Baby P's case had only seven families to deal with, but failed to report that this included 18 children, at least six more than the recommended case load for an individual (Anon, 2008; Laming, 2003). Further Anon (2008) reported devoting 60–80% of her time to the maintenance of records and completion of paperwork, to the detriment of visiting families.

The quality of the external inspection regime also came to be questioned. In 2006, Ofsted visited Haringey to inspect its children services. Ten inspectors spoke to children, relevant professionals from a variety of agencies, parents, elected members, reviewed reports and internal monitoring documents and visited a variety of services. Among its findings was the observation that in Haringey:

Effective multi-agency working reduces the risks for many children on the child protection register, though there are delays in addressing some children's needs, including potential child protection concerns (Ofsted, 2006, p. 4).

Arrangements for the social care of children were found to be adequate with good prospects for further improvements. In 2007, a follow-up Ofsted inspection rated Haringey as good. However, in a subsequent review (Ofsted, 2008b) triggered by the conviction of those who allowed Baby P to die, Ofsted identified that:

This inspection has identified a number of serious concerns in relation to safeguarding of children and young people in Haringey. The contribution of local services to improving outcomes for children and young people at risk or requiring safeguarding is inadequate and needs urgent and sustained attention (Ofsted, 2008b, p. 3).

Specifically, Ofsted (2008b) identified:

- Inadequate management and leadership, including 'insufficient strategic leadership and management

oversight by elected members, senior officers and others within the strategic partnership'.

- A managerial failure to ensure full compliance with some requirements of the inquiry into the death of Victoria Climbié.
- Poor interagency communications.
- Failure of assessments of children to identify those at immediate risk of harm.
- Inconsistent front-line practice across all agencies and not effectively monitored by line managers.
- Child protection plans are generally poor.
- Arrangements for scrutinizing performance across the council and the partnership are insufficiently developed and fail to provide systematic support and appropriate challenge to both managers and practitioners.
- Poor standards of record keeping on case files across all agencies.
- Too much reliance on quantitative data to measure social care, health and police performance, without sufficient robust analysis of the underlying quality of service provision and practice.

Despite this turnaround in Ofsted's findings, Christine Gilbert, Ofsted's chief inspector, declared Haringey's failings as 'exceptional' and suggested that standards had declined steeply. Weeks later, Gilbert admitted to flaws in Ofsted's supervision and review, conceding that officials had been able to 'hide behind' false data and achieve a rating of good from inspectors only a few weeks after Baby P's death (Curtis, 2008). As Butler (2008) asserted, perhaps:

The key truths about our child protection system are not told through number flows and bar charts but through narrative: in the personal accounts of frontline social workers. These tell of impossible workloads and 'paperwork mountains', of the corrosion of professional judgment and confidence by budget constraints and electronic data recording systems. . . . It suggests . . . that the deeper problems in child protection are not so easily captured in an Ofsted report (Butler, 2008).

Responding to the growing debate around Ofsted's approach, Gilbert (2008) appeared to shift her position in giving evidence to a parliamentary select committee in mid December 2008:

I know there is growing debate about the extent to which inspections use data and frontline observation . . . I have been particularly concerned that we get that balance right, and that we can judge the impact of services on those who use them

I have no time for a 'tick box' approach. Statistics are no substitute for inspections. As inspectors, we are far more interested in outcomes and how they

are achieved than whether people are dotting the i's and crossing the T's in their self-evaluation forms. . . . we want our inspectors to see more of what is happening on the ground, whether through more lesson observation or talking to social workers. But data matter too. And given recent concerns, I have asked council chief executives to assure me of the accuracy of any data provided by their authorities (Gilbert, 2008).

Gilbert's call for inspectors to utilize data supported by a 'gut feeling' or a 'judgement call' superficially appears worthy. However, are these positions compatible, particularly if these data come from the 60–80% of time spent on paperwork rather than in the field? Although there are limited data around the failures in the case of Baby P in the public domain at the time of writing, there is evidence of the persistence of that organizational malaise at the heart of the various authorities tasked with child protection. This may be seen in the low priority given to funding child protection services, the absence of a culture in which elected members and senior managers properly oversaw the operations for which they were responsible and reports of financial considerations overriding professional opinions. As Pauchant and Mitroff (1988, 1992) argued, the structures, plans and practices reflect the core beliefs and assumptions of an organization.

5. Observations and conclusions

In summary, a number of observations may be made. The first relates to the public inquiry process itself. Although those involved in Laming's public inquiry had either relevant legal expertise or experience of the caring professions, there was no evidence of individuals with expertise of successful change management, either from practice or from academic research. Given the failure of previous legal frameworks to effect change within the area of childcare, input from professionals with expertise in effecting change might have provided a valuable contribution. This links to our preceding discussion, which identified how members and coalitions may shape public inquiry investigations and recommendations. Given the persistent failure to translate knowledge into new behaviours, those who initiate such inquiries might extend the range of experts consulted to include individuals with an understanding of how to develop and sustain a context for change at both field and organization levels.

Our second point is specifically concerned with the problem of regulation, oversight and field-level mechanisms for change. Elliott and Smith (2006) described within the UK Soccer Industry a similar, repetitive pattern, of inquiry, lessons identified and a subsequent

failure to translate these into new practices. The central problem is that inquiries identify lessons to be learned, make recommendations and prepare guidelines and regulators regulate, but often to little avail or impact. For example, Ofsted's inspections of child care services, which resulted in flawed assessments about Haringey Council's performance, are indicative of the presence of what Gouldner (1955) described as a mock bureaucracy; a regulatory regime existed but was neither effectively implemented nor properly complied with. Regulator and regulated appear to have hidden behind the statistical illusion of compliance. The surprise expressed that officials from Haringey misled Ofsted inspectors suggests naivety. The role of regulator is a key one in ensuring compliance but also in encouraging better practice, and in this way regulation should form only one element of encouraging and developing new norms and behaviours.

A third, and related point, is that although Laming (2003) made many recommendations for practice, supervision and accountability, he paid little attention to the institutional field forces that may block or diffuse changed norms and behaviours. This reflects the piecemeal approach to organizational learning and the confusion between identifying lessons and learning as new practice. Accordingly, we suggest that a greater emphasis on what Lampel and Meyer (2008) describe as field configuring events and mechanisms including conferences, standards, professional associations, education, guidelines and the myriad means by which professional norms are created and sustained might result in recommendations better attuned to the subtleties of daily organizational life. The idealized model of the organizational system into which recommendations flow is naive. Parallels might be drawn with scientific laboratory knowledge, valid within tightly controlled environments, but inappropriate beyond their confines. What limited evidence has been provided within this paper is far from the ideals of a laboratory-like office. For example, the observations of Curtis (2008) and Butler (2008), supported by the former Haringey social worker Anon (2008), are suggestive, at one extreme, of wilful manipulation and distortion of evidence to portray the impression that child care arrangements were adequate. At the other extreme, a picture is drawn of heavy workloads, bureaucracy, underresourcing, poor organizational and support systems, all underpinned by fear of a blame culture. This untidy context is where organizational learning from crisis must be realized. The sensitivities and complexities of child care would seem to be better served by a regulatory approach focused on the spirit of the law supported by a variety of field-sustaining mechanisms. Ofsted's (2008b) later report was highly critical of Haringey's arrangements for child protection services and marked a turnaround from previous

reports by including its final finding, a criticism of an overreliance on quantitative data, which may have reflected Chief Executive Gilbert's own changed position. With limited evidence it is difficult to be certain, but an alternative reading might reiterate the failings identified but also ask whether the measures and practices recommended, and supervisory safeguards introduced, may be fully workable. Evidence of heavy workloads, poor systems, persistent poor communications and poor supervision is indeed suggestive of what Laming (2008) described as a widespread organizational malaise, and indicates the potential value of exploiting expertise in the field of managing and sustaining change.

Our fourth point concerns the limited attention given to the organizational barriers to, and facilitators of, organizational learning within public inquiries. Ensuring appropriate enabling conditions is a key step in sustaining changes to beliefs, norms and practices. In his analysis of the 'Great Crash of 1929', Galbraith (1954) identified the structural weaknesses that might be seen as the enabling conditions for it to occur but identified the speculative mood or spirit as the vital ingredient of that and future crashes. The spirit or culture of Haringey is revealed in its manipulation of inspection data. This is suggestive of, what might be seen at best, weak senior management supervision or worse a flawed culture of management. More specifically, there is little consideration of the means by which interagency communications might be developed, other than a focus on the highly tangible shared database. It is possible that where a shared database is introduced, each professional partner retains its own system as well, leading to duplication. Little attention is given to the development of the spirit or culture of communication, with emphasis placed on the more tangible technical system. As much crisis management research has shown, it is the culture of informal communications that plays a key role in achieving organizational effectiveness. Tangible elements, such as an information system, lie at the outer layers of Pauchant and Mitroff's (1988, 1992) Onion Model and new structures and plans that do not reflect organizational values and beliefs are likely to be circumvented, as appeared to be in the case at Haringey.

In summary, we have argued that the deficiency in developing new and appropriate practice following a public inquiry reflects the all too frequent lack of attention placed on the processes of knowledge transfer and assimilation. The separation of policy from practice, as reflected in the academic literature, continues to constrain opportunities for learning from crisis. Figure 1 highlights the limitation of thinking of the process in this way. Alternatively, a processual perspective acknowledging the interplay between policy and practice, between bottom-up and top-down forces, is more likely to lead to effective change. Such a

perspective emphasizes a systemic view of the process, one in which the acquisition, translation and assimilation of knowledge are equally important. A fuller understanding of political learning and processes of sense-making around knowledge acquisition should help us be more certain of the validity of inquiry findings, but greater attention to the processes by which knowledge is transferred will ensure that communications are as effective as possible. Our focus has been largely on regulation in this regard, although Elliott (2008) has identified the important role played by a variety of field-level mechanisms, which may be exploited to promote translation of the spirit of learning from the public inquiry process. We have alluded to the extensive work conducted by psychologists and organizational theorists to better understand the barriers to and facilitators of learning at a micro level. We suggest that a better understanding of these at the point of policy development may raise the probability of new knowledge and understanding feeding into new behaviours. If organizational learning includes appropriate changes in norms, behaviours and beliefs then policy must be developed in a way that is grounded in practice. After all, it really can be a matter of life and death.

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