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# THE DIRTY DOZEN IN CHILD PROTECTION

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Everyone working in child protection will know the sinking feeling when reading Serious Case Review reports and seeing the same familiar themes appearing with dreadful regularity time after time. Former aviation accident investigator Gordon Dupont knew the same frustration. After repeatedly seeing the same patterns leading to tragic outcomes, he decided to try to prevent accidents by pulling together insights into the common factors underlying mistakes.

Aviation and child protection have more in common than may first meet the eye. Both are complex, fast-moving, high-risk systems dependent on people from different professions with different skill sets and cultures working together. In both cases, the cost of failure is high and investigations follow. Can child-protection systems learn from aviation incidents?

In aviation investigations, the aim is to understand not just what went wrong but why people acted as they did, to figure out why their actions 'made sense to them at the time, rather than focusing on what they did wrong'.[1]

The International Civil Aviation Organisation (ICAO) explains:

> *'In hindsight, it is often easy to see how decisions and actions led to an undesired outcome and how it might have been avoided – but at the time the decision was made or the action taken, it seemed appropriate. It made sense. The unintended consequences were unknown and may not have been predictable. People's actions therefore need to be considered in context and understood from the individual's perspective at the time of the action.'*[2]

Thus, critical to understanding why things go wrong are human factors, defined as: 'the application of what we know about human beings, their abilities, characteristics and limitations, to the design of equipment they use, environments in which they function and jobs they perform'.[3]

Over 300 possible precursors to human error have been identified by ICAO,[4] but Gordon Dupont narrowed these down to a much more manageable 12, nicknamed 'the Dirty Dozen'. They are in no order of priority, are often interlinked and rarely exist in isolation. This article considers whether the Dirty Dozen can give insights into child-protection disasters using the report of the *National Review into the murders of Arthur Labinjo-Hughes and Star Hobson* ('the report').[5] The children will be referred to simply as 'Arthur' and 'Star'. Both died in 2020, Arthur aged six and Star aged 16 months. The tragic chronology of what happened to them as well as the catalogue of mistakes and missed opportunities to protect them is examined

in detail in the report and will not be repeated here. Instead, this article will look at the report through the lens of human factors to see if this could be a useful approach towards understanding what happened.

One of the first factors noted in the report is weaknesses in information seeking and sharing. The report notes: 'Time and again we see that different agencies hold pieces of the same puzzle but no one holds all of the pieces or is seeking to put them together.'

In aviation, too, effective communication is key. It is therefore no surprise to see that **lack of communication** features on Dupont's list. Knowledge and information serve no purpose if they are not communicated effectively to the right people at the right time. In Arthur's case, we see that failures to communicate information, which, taken alone, seem minor or even insignificant, have serious consequences. For example, the police omitted to pass photos of bruising to the MASH team, and information about Arthur's father's new partner's mental health problems were not passed on, meaning that Arthur was not offered a school place during Covid. The report finds (para 12.32): 'In Arthur and Star's cases, we see three main information sharing issues: a lack of timely and appropriate information sharing; limited information seeking; and evidence not being pieced together and considered in the round.'

This is nothing new. As the report notes, 'problems with information sharing have been raised by every national child protection review and inquiry – going back as far as the inquiry into the death of Maria Colwell in 1973'.[6]

However, what we don't know is why these communication failures occurred. Did people not appreciate that the information was important? Did they not realise that it needed to be shared? Did they not know who to share it with? Were the channels of communication insufficiently clear? Were they overwhelmed by other tasks that seemed more important at the time?

This suggests that it is high time to consider in detail why and how these

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