Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE)

Learning Together systems model: lessons from the pilots

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INTRODUCTION

The Munro Review of Child Protection: Final Report. A Child Centred System suggested that:

> *in moving to a system that promotes the exercise of professional judgment, local multi-agency systems will need to be better at monitoring, learning and adapting their practice...[and recommended] that the 'systems approach' used in the health sector is adopted and applied, in particular, to Serious Case Reviews*[1]*. This will enable deeper learning to overcome obstacles to good practice* (Cm 8062, 2011, p.9).

The systems approach looks for *causal explanations* and aims to explain not simply *what* happened but *why* it happened and how systems and organisational cultures influenced the decisions and actions taken by individuals at the time (Fish, Munro and Bairstow, 2009). Further details concerning the basics of the approach are outlined in Box 1, below.

Box 1: The basics of the approach

The goal of a systems case review is not limited to understanding why specific cases developed in the way they did, for better or for worse. Instead, a case is made to act 'as a "window" on the system' (Vincent, 2004, p. 242)*. It provides the opportunity to study the whole system, learning not just of flaws but also about what is working well.*

The cornerstone of the approach is that individuals are not totally free to choose between good and problematic practice. The standard of their performance is influenced by the nature of:

– the tasks they perform;
– the available tools designed to support them;
– the environment in which they operate.

The approach, therefore, looks at why particular routines of thought and action take root in multi-agency professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice. Ideas can then be generated about ways of re-designing

[1] When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the Local Safeguarding Children Board (LSCB) should **always** conduct a Serious Case Review (SCR) into the involvement of organisations and professionals in the lives of the child and family. An SCR should also be conducted if a child is seriously harmed and abuse or neglect is known or suspected and there are concerns about how organisations worked together to safeguard the child.The prime purpose of a SCR is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children (HM Government, 2010, paragraphs 8.1, 8.9 and 8.11).

the system at all levels to make it safer. The aim is to 'make it harder for people to do something wrong and easier for them to do it right' (Institute of Medicine, 1999, p. 2, cited in Fish *et al*., 2009, p.2).

The Social Care Institute for Excellence (SCIE) has developed a Learning Together model for case reviews which uses a systems approach (Fish *et al*., 2009). The Childhood Wellbeing Research Centre was commissioned by the Department for Education (DfE) to undertake a rapid response study between January and July 2012 to independently review the strengths and limitations of using the SCIE Learning Together model to conduct SCRs and to compare this with traditional SCR processes. It is important to note that this research ran in parallel with the pilots and the majority of professionals involved had limited experience of using the SCIE Learning Together model. In this context the findings illuminate training, support and implementation issues that may not reflect the effectiveness of the model itself (see also, Fish, 2011). It should also be acknowledged that the emotive nature of SCRs may influence participants' recollections of the process and their interpretations of events. These factors should be taken into consideration in reading and assessing the evidence presented in the report.

AIMS, OBJECTIVES AND METHODS

The overarching aim of the evaluation was to review the strengths and limitations of the SCIE Learning Together model for the conduct of SCRs compared to traditional SCR processes[2].

Since October 2011 three LSCBs have been granted dispensation to set aside the requirements outlined in Chapter 8 of Working Together to Safeguard Children (HM Government, 2010) in order to pilot the SCIE Learning Together model for the conduct of SCRs. The timetable for completion of the study meant that it was possible to undertake in-depth work in two of these LSCBs (see below for further details) and in the third an interview was conducted to capture learning from this pilot, including detailed information concerning issues arising from running a SCIE Learning Together SCR in parallel with criminal proceedings.

[2] As outlined in Chapter 8 of *Working Together to Safeguard Children* (HM Government, 2010).

The overarching aims were to:

- Systematically map the approach that the LSCBs adopted[3], the rationale for the strategy employed, any unintended consequences and adaptations implemented to try and address these.
- Examine different professional perspectives (including health, police and children's social care) on the strengths and limitations of the SCIE Learning Together model (compared to traditional SCRs). Areas for exploration included:
    - experiences of the review process (including individual conversations and analysis meetings);
    - factors facilitating or inhibiting active participation;
    - the interface between the SCR and other types of process (criminal proceedings, inquests);
    - engagement with children and families.
- Explore the approaches adopted to disseminate findings and maximise lesson learning.
- Highlight any perceived limitations of the SCIE Learning Together model when applied to SCRs and explore recommendations for resolving such issues.

A mixed methods approach was employed. An online survey was administered to all members of the review teams (25) and case groups (58) to explore the issues outlined above. Surveys were returned by nine members of the review teams (36%) and 24 (41%) of the case groups. Semi-structured interviews (a combination of face to face and telephone) were also undertaken with 26 professionals involved in the pilots[4] to explore their experiences of participating in a SCR using the SCIE Learning Together model. Table 1 outlines the professional backgrounds and roles of the interview sample.

[3] For example, expectations concerning Independent Management Reviews, documentary evidence, reporting.
[4] Some survey respondents did also participate in the interviews.

Table 1: Background and role of interviewees

Agency	Review teams[5]	Case groups[6]	Other	Total
Lead reviewers and legal	5	n/a	0	**5**
LSCB business managers	2	0	0	**2**
Education	1	0	0	**1**
Health	1	2	0	**3**
Police	1	1	2	**4**
Probation	1	1	0	**2**
Social care	3	1	0	**4**
Voluntary sector	1	3	1	**5**
Total	**15**	**8**	**3**	**26**

In addition, focus groups were held with Chairs and members of the two LSCBs that commissioned the SCRs, to explore their perspectives on the strengths and limitations of the final output and their plans for dissemination of the findings[7].

Interviews were recorded and extensive notes taken (given time and resource constraints interviews were not transcribed). A coding matrix was developed to facilitate thematic analysis of the data and to explore similarities and differences in perspectives according to participant's roles and professional backgrounds. There was no evidence that views or experiences were particular to one pilot area or individuals from specific agencies. In order to protect the anonymity of those involved direct quotes have not been attributed but they do illustrate the views of a range of participants from different professional backgrounds.

[5] In the SCIE Learning Together model a team are involved in reviewing the case. The team should reflect the key professions involved in the case under review (see Fish *et al*., 2009, p.15).
[6] Case group meetings are attended by practitioners and managers from agencies who were involved with the family of the child that died (see Fish *et al*., 2009, p.15).
[7] The majority of the fieldwork was conducted between March and April 2012. Follow up interviews with lead reviewers and business managers and focus groups with LSCBs were undertaken from late May to mid-July 2012.

FINDINGS

Implementing the SCIE Learning Together systems model in practice

SCIE's Learning Together model (Fish *et al*., 2009) provides a structured process for conducting SCRs using the systems approach. Table 2, below, maps the activities undertaken by both pilot LSCBs against this framework.

Table 2: An overview of the SCIE Learning Together systems model and its implementation in the pilot areas

SCIE/ systems model	SCIE process	Pilot 1	Pilot 2
PREPARATION			
Identifying a case for review			
Select review team		Review team meeting - introduction to the SCIE model	Review team meeting - introduction to the SCIE model
Identifying who should be involved		Review team planning meeting	Review team planning meeting x 2
Preparing participants	A face-to-face introductory meeting with the case group [*recommended by SCIE*]		Case group meeting - introduction to the SCIE model
DATA COLLECTION			
Selecting documentation	Selecting documentation	Collation of documentary evidence	Collation of documentary evidence
One-to-one conversations	One-to-one conversations	16[8] one-to-one conversations	36 one-to-one conversations (plus 6 follow-ups)
ORGANISING AND ANALYSING DATA			
Producing a narrative of multi-agency perspectives [practitioners' story]	Review team analysis meeting(s)	Review team meeting to review relevant documentation and undertake analysis x 4	Review team meeting to review relevant documentation and undertake analysis x 3
Identifying and recording key practice episodes and their contributory factors	Case group meeting x 2	Case group meeting x 2	Case group meeting x 2
Reviewing data analysis			
Identifying and prioritising generic patterns	Review team finishing meeting		Review team debrief meeting x 2

[8] Based on case group number.

Making recommendations	Review team briefing meeting		
ADAPTATIONS			
	Not applicable	Independent Management Reviews [9]	Meeting with agency senior managers

Preparation

Identifying who should be involved

In pilot 1 Independent Management Reviews (IMRs) were commissioned before the LSCB was granted permission from the DfE to undertake an SCR using the SCIE Learning Together model. This assisted the lead reviewers to identify those professionals it would be appropriate to hold conversations with; conversations and the subsequent case groups involved approximately 17 people.

In pilot 2 far more conversations were held because the case was more complex and a greater number of practitioners were invited to participate. Thirty six conversations were held and during the process it became clear that there were considerable variations in levels of involvement in the case and what professionals were able to contribute. This was reflected in the relatively short duration of some conversations. One interviewee queried the approach that had been employed and suggested that it would be worthwhile to have a preliminary discussion with people to:

> *see whether this line of enquiry is worth pursuing...Nobody ever had that discussion with me in sufficient detail. I was just asked to come and discuss it… if they'd said to me we want to know about [a specific meeting], how effective it was, how do you think it might change, what was good and bad about the process? I would have said ok I can tell you some of that but I can also tell you the person you need to speak to about it.*

However, a member of one of the review teams identified that a conversation with a professional who had had peripheral involvement in the case had served to illuminate critical information which provided new insight. A balance needs to be

[9] IMRs were commissioned prior to DfE granting permission for the SCIE Learning Together model to be piloted. This increased the data available but increased the time required for the analysis. The timescale for completion of the SCR had to be extended beyond six months.

struck, taking into account the importance of securing sufficient data to assess events, but also considering the resource and capacity implications and impact on group dynamics of involving a large number of professionals in the process.

Preparing participants

SCIE recommends holding a face-to-face introductory meeting with the case group to prepare them for the SCR and introduce them to SCIE Learning Together model to ensure that professionals understand the aims of the approach, what it entails and their level of involvement (Fish *et al*., 2009). Pilot 1 did not convene an introductory meeting and opinions were mixed amongst the case group as to whether such a meeting would have been beneficial. Instead a letter was sent to professionals outlining the Learning Together model and how they would be involved. Two members of the case group felt that this was satisfactory but two indicated that they did not feel sufficiently prepared for their involvement in the SCR.

In pilot 2 a meeting was held for all practitioners and managers that there were plans to conduct conversations with. The small number of interviewees who had attended this meeting reported that it was informative. One participant highlighted it was a 'massive meeting' which included a large number of managers who had limited contact with the family; 'what were they all doing there?' They also suggested that there was not sufficient acknowledgement of what an 'upsetting time' it was for those practitioners that worked directly with the family. In recognition of the sensitivities involved in SCRs a lead reviewer suggested that additional pre-meetings with the staff most heavily involved in the case would be beneficial; these practitioners and managers are likely to feel the most vulnerable about the process. Interviewees from both pilot sites also drew attention to the value and importance of providing clear and robust written information about the SCR process and SCIE Learning Together model in recognition that: not everyone involved in the case will be identified straight away; not everyone will be able to attend the introductory meeting; and not everyone will recall everything they are told at the meeting, particularly if they are anxious or upset.

Data collection

'*Local rationality' and conversations*

> *A key assumption in a systems approach is that human behaviour is fundamentally understandable: even actions or decisions that later turned out to be mistaken or to lead to unwanted outcomes, at the time seemed sensible...[A] key task is to reconstruct how people were making sense of an evolving situation. This is referred to as their 'local rationality': how the situation looked to someone at the time* (Fish *et al*., 2009, p.9)*.*

In the systems approach, conversations with the practitioners and managers involved are important to obtain an insight into 'local rationality'. Fish and colleagues (2009) emphasise that the approach employed should not be 'pseudo-legalistic' and instead should aim to 'identify, respectfully, the approach taken by the person' and understand 'how the world looked through their eyes' (p.9). Every one of the review team who completed the survey strongly agreed that those who participated in conversations were able to provide valuable accounts of how the situation looked at the time and factors that influenced the decisions that were taken; six out of nine also agreed that the conversations provided a better insight into cases than Independent Management Reviews (IMRs). The majority also perceived that participants had not found the experience intimidating. Interview data also suggested that on the whole conversations secured high quality data, moving beyond identification of procedural non-compliance and illuminating issues that would not necessarily be revealed in IMRs. For example, one professional reflected that conversations provide:

> *a lot more information than IMRs would tell us or documentation would tell us – some of the nuances and the inter-agency issues, for example that isn't documented. You don't get the nuances of what was going on for that worker that day... The complexity and severity of those other cases pitted against this case on that given day and the decision making that took place depending on who was there at the time.*

Another reported that the conversations:

brought to the fore a lot of information that doesn't come from IMRs in terms of how things actually work...an early draft of the social care IMR described that CAFs were working very successfully and when you looked at the records they were successful CAFs in that they were minuted properly...they had actions clearly written at the end for people to go away and do but talking to the workers involved they didn't feel that they were successful. They found the CAF arrangements complicated and there was confusion about roles. And at times quite a lot of practical difficulty in terms of engaging the family who was a little bit resistant or didn't see the CAF as important as the professionals. And I don't think we would have got that without having the conversations.

The development of a timeline or skeleton chronology is a feature of the Learning Together model. The majority of members of the review teams reported that this was an important tool to assist them in undertaking effective conversations to secure the data required to understand action or inaction by different individuals or agencies. As one of the review team explained:

the panel, or review group, needs to develop a chronology...[In conversations] there's a bit of free narrative a bit of people telling you what it was like for them but I think you need to have a sense/a map in your head of what was going on in the case and if people don't mention things that were significant then you need say 'well what about the second CAF meeting?' and they go 'oh yeah that's right'. It's perfectly understandable that people need prompts and I think the chronology is the most neutral way of getting those kinds of prompts.

There were mixed perspectives as to whether it was desirable to ensure that conversations were conducted by two members of the review team who were from a different agency to the participant (independent model); or whether it was advantageous for one of the review team to be from the same agency as the participant (mixed model). The key advantages of the independent model were reported to be that: it is potentially less intimidating for the participant, thus maximising the likelihood that they will feel able to speak freely; and that it means the case is viewed with 'a fresh pair of eyes' thereby reducing the risk of pre-judging the actions of a participant.

> *I suppose doing some multi-agency working you've got some knowledge of issues across the board but equally you won't have a level of detail about the agency. So I suppose you can come at it with a fresh pair of eyes in terms of your line of questioning because you're not necessarily constrained by that kind of knowledge and those assumptions you almost take as read sometimes*.

However, others viewed the mixed model to be advantageous because they perceived that it was important for at least one of the review team conducting the conversation to have some understanding of policies and procedures and the organisational context in which participants were operating. Without this certain key lines of enquiry may not be pursued. For example:

> *health is so complex that even some of our closest agencies like children's services and police still do not understand and I think you could actually just spend a whole conversation trying to explain how health works...I do think there needs to be someone from health sitting in to explain how health works… that has a big impact on how conversations can actually go*.

Participants' perspectives

Research on traditional SCRs highlights:

> *the value of a more participative approach to conducting SCRs, rather than focusing on documentary review and one way transfer of information through practitioner interviews* (Sidebotham *et al*., 2010, p.3).

Survey data from those who participated in conversations revealed that all but two (16 out of 18) agreed that they had been able to explain how the situation had looked to them at the time and that the conversations had provided them with a welcome opportunity to express their views and explain why they took the decisions they did. Two thirds (12 out of 18) also indicated that they had not found the experience intimidating. However, interview data revealed a more mixed picture with considerable variation in how conversations were experienced by participants. Four interviewees were generally positive about their participation in conversations; two of these practitioners identified that they had had minimal direct contact with the family in the months leading up to the child's death and were not anxious about taking part.

The remaining two found the process more ‘nerve racking’ and felt ‘under scrutiny’ but the approach adopted was perceived to be ‘supportive and enabling’. In both these cases the practitioners also identified that the conversations had allowed them to reflect on their practice and identify what they might do differently in similar situations in the future.

> *It was relaxed. It was nerve racking to think you’re going to be asked of your involvement but for me personally I think everything we did was accurately recorded and if things did go wrong that was recorded as well and they did make you feel very comfortable. Obviously there were lots of things they were interested in which we could go into more detail and it was kind of like a session where you also learnt a little bit as well in terms of ‘well had I thought of that’*.

However, three participants indicated that framing what they considered to be formal interviews as informal conversations was misleading.

> *I object strenuously to the word conversation. Serious case reviews are a rigorous formal process and people should stop pretending that they’re conversations – they’re not conversations, they’re interviews. So what’s the game there? It’s disingenuous*.

One manager indicated that she had received an email reassuring her not to worry and that the process was about learning rather than blame but felt that she was ‘lured into a false sense of security’ and she was ‘interrogated’ during the conversation. Others also suggested that certain members of the review team had adopted an adversarial rather than inquisitorial style of questioning:

> *the tone of it was not particularly nice. It was quite aggressive. They were occasionally grimacing and pulling faces like they weren’t happy with the responses*.

Criticisms were also directed at the SCIE conversation structure summary. Firstly, all the interviewees in pilot 1 were supplied with a copy of the framework in advance of their conversation to provide an insight into the sort of information that the LSCB were interested in eliciting. Two practitioners suggested that this did not serve to reassure them and instead heightened their anxieties. Secondly, a small minority of

participants suggested that the questions were ‘nebulous’, ‘too vague’ and ‘leading’. It was noteworthy that although the systems approach is intended to ‘establish not a single story but a set of multiple and differing perspectives’ (Fish *et al.*, 2009, p. 10) a small number of participants perceived that those leading the conversation had a pre-determined view of the case and were biased towards particular agencies. Such issues have the potential to undermine the quality of the data collected and reinforce the importance of ensuring that those conducting conversations are trained and confident in conducting conversations and have the appropriate skills to fulfil this role.

Organising and analysing data

Case group meetings

Case group meetings are attended by practitioners and senior managers from agencies who were involved with the family of the child that died. In general three meetings are held; the first is an introductory meeting and the second and third are both ‘follow on’ meetings that involve discussing the information obtained through conversations and other key documents and are used to develop the ‘practitioner’s story’, the ‘key practice episodes’ and the ‘overview report’. Meetings are also attended by some or all of the review team to facilitate the process and support those involved.

Survey data revealed that the majority of respondents were positive about their experiences of the case group meetings as a forum to discuss key events that shaped the outcome of the case and that they were able to comment on what they thought were the KPEs and contributory factors. Interviewees who were positive about these meetings generally perceived that agencies were ‘not defensive’ and the approach adopted was ‘non-judgemental and respectful’ and ‘practitioners worked well together’. They also valued the opportunity to explore different perspectives on the case and identified that this helped enhance their understanding of the roles and responsibilities of other agencies and gave an insight into the ‘bigger picture’. However, it was also identified that attendance at meetings was variable and that non-attendance by key individuals or agencies could limit meaningful discussion of critical issues. Some practitioners did not have the chance to verify the accuracy of the review team’s interpretation of events or benefit from the inter-agency learning

opportunity because they were unable to attend all the meetings. In one of the pilot sites the draft working papers were circulated to the case group to make sure that they were given the opportunity to comment.

Securing the attendance of staff at each case group meeting proved to be problematic due to staff availability and capacity issues[10]. Senior managers highlighted that releasing staff to participate in the process has wider organisational implications:

> *Our experience has been massively time and labour intensive. In the current financial climate it's not sustainable. I cannot afford for a social worker to be [involved for so long] because they have got a case load and all the rest of their cases might be suffering.*

It is also important to acknowledge that not everyone who attended the case groups found the experience a positive one. Being involved in a process involving appraisal is undoubtedly challenging. One pilot site highlighted that case groups were organised as sensitively as possible and 'delicate matters' were not discussed in plenary sessions. However, a small number of participants reported that 'practitioners at the meetings were scared', that meetings were 'not supportive' and 'were about blame', even if they had not experienced the meeting in this way. In one pilot site six interviewees concluded that the experience of children's social care professionals was 'not good' and it was reported that a 'social worker was lambasted in public'. Questions were also raised about whether it was appropriate to expect frontline practitioners to speak honestly and openly in a group setting with senior managers from their own agency. It was also highlighted that even if information is framed in terms of 'good and problematic' practice rather in terms of 'errors and mistakes' that individual's actions are exposed to scrutiny and it is often clear whose actions (or inaction) are deemed to have contributed to the outcome of the case.

As one survey respondent reflected:

[10] Interviewees in our research highlighted that a much higher proportion of the work involved in traditional SCRs can be undertaken outside working hours and so this has less impact upon the provision of frontline services. However, it should be noted that drawing valid comparisons between the time spent on traditional SCRs and Learning Together SCRs is challenging and the overall time spent on the pilots may be artificially high because those involved are in learning mode. SCIE identify potential time savings from adopting the Learning Together model, for example, a comprehensive chronology and Individual Management Reviews are not required (see Fish, Munro and Bairstow, 2010, p.17-18). SCIE have now developed a sliding scale of review options.

sometimes the issues being appraised are so delicate or devastating for individuals that one has to manage these meetings with great care. There are natural justice issues in sharing A's challenges, even mistakes, with B-Z; contributory factors do not wash that away.

These accounts highlight the complexities of applying the systems approach in the context of SCRs and the need to ensure that effective strategies are in place to support staff through the process and empower them to 'tell their story' without causing them harm and distress.

Review team meetings and KPEs

A SCIE Learning Together SCR is conducted by a team of people as 'critical dialogue between team members is vital to the quality of the analysis and learning' (Fish, Munro and Bairstow, 2009, p.15). In the pilot sites the review teams were comprised of 12-13 professionals from the key agencies involved in the case.

The identified benefits of convening the review team were consistent with those in respect of case group meetings, including the multi-agency and collaborative approach adopted to explore KPEs and contributory factors and the opportunity to reflect upon good and problematic practice. Interview data revealed that professionals perceived that holding analysis meetings was a useful exercise. The range of professionals involved and their knowledge and expertise were deemed to have assisted in clarifying issues and identifying KPEs and contributory factors. Having a range of practitioners on the review team:

led to more insight… they can explain a little bit more about their own agency.

Another member reflected that:

the overview author in a traditional serious case review, although they come to all the meetings and listen to what's discussed often they present a report that is theirs rather than – [for] this report...the review team have identified the key practice episodes...discussed those and what they might mean so it does feel more of a collaborative report I think.

Interview data suggested that it was not difficult for the review team to reach consensus with regards to the KPEs or the contributory factors. However, those that were identified and put forward were discussed at great length before any final decisions were made.

> *There is challenge and there needs to be challenge – you know that's where consensus comes from really and it's reassuring that things don't just go through on the nod*.

However, it is noteworthy that the KPEs which are explored in-depth in the course of the review will not necessarily have been critical to the outcome of the case (i.e. to the death or serious injury of the child who is the subject of the SCR). Furthermore, the issues that become the central focus of the SCR may be at the exclusion of other important issues.

> *You go in deep - you get a lot more information…[and] you find out more. But it leads you down certain paths. It leads you down key practice episodes and you identify one thing as big and everyone starts focusing on that. So you learn about that episode in loads more details than you would have learned under a traditional part 8 SCR but you're isolated to that incident.*

Furthermore, although the Learning Together systems model does include an explicit methodology (see Appendix 1) for moving from case specific issues to general underlying patterns, questions were raised about whether KPEs simply reflect the practice of one team operating at a given time, or, whether the findings are generalisable and reflect issues that are relevant to the current operation of one or more agencies. In the absence of sufficient additional data to triangulate the findings this is not always clear and there are dangers in extrapolating from one case and applying the learning more broadly[11]. As one LSCB member reflected:

> *There is an issue of the methodology and the outcomes in terms of generalising from a single case to the whole geographical areas or everything that happens and every transaction….There are some things at a certain level*

[11] One of the pilots was undertaken in a large county.

that you can generalise but I think there are some risks and some dangers from the one particular case.

The final SCR report in one pilot site included an acknowledgement that it should not be automatically assumed that findings from one District apply across the County. It also signalled the need for the LSCB to critically appraise whether findings might apply more broadly. In the context of high levels of organisational change it is also possible that the issues highlighted may not be relevant to current operational systems and processes and this limits learning to inform safeguarding policy and practice. This is particularly concerning given the time commitment that is needed to undertake SCRs. A number of members of the review teams perceived that there were 'too many meetings'. Some also questioned whether the SCIE Learning Together model served to provide additional insight into the case or illuminated issues that would not have been apparent through the conduct of a traditional SCR.

We don't all need to be there to put the story together. There must be a better way?

[In] child protection, we're all doing more...[so the issue is] do you want to safeguard the children out there who need [safeguarding] or do you want to get [everyone] sitting down and writing this report? If we could find out something new rather than the usual chestnuts that tend to be in the majority of serious case review findings now one might feel a little bit more enthused but it is that competition of workload to safeguard children and [doing] a lot of extra work to find something else out.

Systemic factors influencing practice and the report

Learning Together (Fish *et al*., 2009, p.45) presents a typology of patterns or interaction in child welfare that may create unsafe conditions in which poor practice is more likely, or may serve to support good practice. This includes patterns in: human-tool operation; human-management system operation; communication and collaboration in multi-agency working in response to incidents/crises; communication and collaboration in multi-agency working in assessment and longer-term work; family and professional interactions; human judgement/reasoning. This typology is

also adopted in the report and is intended to assist professionals to escape 'deeply entrenched frameworks for thinking and understanding practice' (see for example, Haringey LSCB, 2012).

Those involved in the pilot acknowledged the importance of adopting a methodologically robust approach to the conduct of systems reviews but raised concerns about the rigid application of the SCIE typology. For example, one reviewer indicated that:

> *You almost have to suspend your own analytical skills in order to apply [a] rigid [analytical] framework.*

It was also suggested that the approach fails to build on professionals' pre-existing skills and abilities in favour of a counter-intuitive approach. Interviewees acknowledged that SCIE's report structure may be intended to protect the fidelity of the model but, in practice, a number of people said that this had not facilitated lesson learning and had been at the expense of delivery of accessible outputs for the pilot LSCBs. The structure, language and the presentation of the report were criticised:

> *The prescribed structure was almost text book academic…the language and terminology need some further refinement…engagement and getting ownership is good, but in terms of the presentation of the information sometimes you couldn't see the wood for the trees…It was like this reflection around the evidence and what that tells us rather than the facts that relate to this case in their context.*

It was also suggested that information had to be 'shoe horned' in to specific sections of the report at the expense of a narrative that assists the reader to understand the case and the inter-relationship between issues[12]. Differences of opinion and interpretation meant that a number of amendments were made to the reports to satisfy SCIE that the systems approach had been applied in the way that they

[12] This could be likened to local authorities requiring social workers to complete every section of an assessment record rather than supporting them to use the *Framework for the Assessment for the Children in Need and their Families* (Department of Health *et al*., 2000) as an underpinning framework and then allowing them to exercise their professional judgement on how to present the findings. Research also demonstrates that separating information under a series of headings can disrupt the narrative and mean that the information supplied is disjointed thus placing 'interpretive demands' on the reader (White, Hall and Peckover, 2008; see also Munro and Lushey, 2012).

perceive it should be and to respond to issues raised by the LSCB. Such oversight may be legitimate as a quality assurance mechanism and play a key part in the reviewers' training and supervision; however, tensions did arise as a result, as the following quote illustrates:

> *There was quite heavy intervention from SCIE in the form of amendments…I found there was a tendency for SCIE's input to go beyond the evidence base…some of the comments over emphasise the issues that were found.*

This reveals different perspectives concerning the evidential claims and conclusions that can be drawn from using one case as a 'window on the system'. It also raises issues concerning lines of accountability.

Recommendations and lesson learning

Brandon and colleagues (2011) study concludes that:

> *[SCR] recommendations have become more 'specific, measureable, achievable, relevant and timely' [SMART] but this has resulted in the proliferation of tasks to be followed through. Adding new layers of prescriptive activity appears to leave little room for professional judgement…Where recommendations need to be made there is still value in this structured, methodical model but LSCBs should free themselves to construct a proportion of recommendations that are not easy to audit or make SMART that might encourage deeper learning and take longer to embed* (p. 5).

SCIE suggests that it is helpful to make a distinction between the following kinds of recommendations:

- *issues with clear cut solutions that can be addressed locally and by all relevant agencies;*
- *issues where solutions cannot be so precise because competing priorities and inevitable resource constraints mean there are no easy answers;*
- *issues that require further research and development in order to find solutions, including those that would need to be addressed at a national level* (Fish *et al*., 2009, p.24).

There were mixed views amongst LSCB members about whether findings from SCIE Learning Together SCRs reveal matters that would not have been identified during a traditional SCR. There were also differences of perspective on whether LSCBs would be able to affect change to address issues that were identified during the course of the SCR.

One LSCB member reflected:

> *I'm not convinced that we got something out of it that we wouldn't have got though the old serious case reviews. It's very resource intensive and I'm not convinced about the learning. If you're constantly changing as a service the question to ask is 'Ok, but would that happen again?' The system doesn't resemble the system it was then.*

However, others were more positive. A member of the review team suggested that they could:

> *see the case group discussions feeding into other change processes...practitioners and managers are taking their learning and beginning to apply it in service design and strategic planning*.

It was also suggested that the in-depth insight secured through the SCIE Learning Together model means that:

> *Actions will be smarter because we understand what the issues are a bit better.*

There was an acknowledgement that some of the SCIE Learning Together SCR findings are 'quite far reaching' and 'far more challenging for Boards'. Another professional highlighted that there tends to be comfort in SMART recommendations but responding to systemic issues is more challenging and will require a shift in thinking. It was suggested that it takes time to move from a system characterised by high levels of prescription to adopt an approach that requires LSCBs to be stronger and more dynamic in leading and action planning. The scale of the implementation task was also noted:

> *We're talking about moving juggernauts…*

Other issues

Criminal proceedings

In some cases, criminal proceedings may follow the death or serious injury of a child. In these circumstances *Working Together to Safeguard Children* (HM Government, 2010) states that:

> *The Chair of the SCR Panel should discuss with the relevant criminal justice agencies such as the police and the CPS, at an early stage, how the review process should take account of such proceedings. For example, how does this affect timing and the way in which the SCR is conducted (including any interviews of relevant personnel), what is its potential impact on criminal investigations, and who should contribute at what stage?...Much useful work to understand and learn from the case can often proceed without risk of contamination of witnesses in criminal proceedings* (paragraph 8.25).

However, the systems approach poses new challenges in respect of conducting SCRs in parallel to criminal investigations because the professionals involved in the case are brought together in a multi-agency forum. This raises potential issues concerning the integrity of witnesses. To date, one LSCB has undertaken a Learning Together SCR while criminal investigations have been underway. This was facilitated through a close working relationship between the lead reviewers and a detective inspector who had had no direct involvement in the criminal investigation, and who in turn liaised with the Crown Prosecution Service (CPS) and the senior investigating officer leading the case.

The detective inspector played an active role in advising on communication between the lead reviewers and other professionals, as well as attending case group and review team meetings to ensure that SCR process did not jeopardise the criminal investigation. On police advice it was agreed that the lead reviewers would not ask questions about practice and decision making in the handling of the specific case. Rather, the review team drew on documentary evidence to identify relevant agency processes and conversations focused upon how these influence the way professionals act. From the review team's perspective this proved to be effective as

a means of identifying obstacles to best practice and in analysing organisational factors relevant to the reoccurrence of similar incidents.

Family participation

In determining the nature and scope of traditional SCRs LSCBs are required to consider how surviving siblings, parents and other family members might contribute to the SCR, how they will be involved and who will facilitate this (HM Government, 2010, paragraph 8.20). However, as Fish and colleagues (2009) acknowledge facilitating the involvement of families in SCRs adopting a systems approach is underdeveloped. In one of the pilots 'the family were approached to take part but were not interested' but in the other the family were engaged in the process and were pleased to have the opportunity to be involved. The police family liaison officer and review officer visited family members to explain the purpose of the SCR and to outline the approach that was being employed; it was made clear (and reiterated as necessary) that the aim was to 'learn lessons and help stop similar things happening in the future' rather than 'pointing the finger' at particular professionals or agencies. As one might expect, attitudes towards participation were reportedly mixed with some 'keen to have their say' and others 'angry' and 'wanting to put it behind them'. Accounts suggest that those who did participate provided valuable information and illuminated how the situation was understood by the family at the time and provided their views on the adequacy of service responses[13]. Key members of the review teams highlighted that family participation in reviews is challenging and complex, irrespective of the methodological approach being employed. The following were identified as important:

- transparency about the process and the approach being employed;
- flexibility concerning the timing and venue of conversations;
- regular up-dates about the progress of the review;
- providing an opportunity to discuss the findings in advance of publication and/or opportunity to comment on the report before it is made public.

[13] In the pilot involving a parallel criminal investigation it did not prove possible to involve the family because the CPS had not taken a decision about whether one or more parties would be charged.

Training in the SCIE Learning Together Systems model and implementation issues

Traditional SCRs have been:

> *much maligned but part of the problem is that a number of people who were conducting them didn't have the necessary skills and experience.*

Irrespective of the methodological approach employed to undertake SCRs it is essential that those involved are equipped to undertake them effectively. Interviewees noted that use of and training in the use of the SCIE Learning Together model is still in its 'infancy' as such the training that was delivered involved an element of 'trial and error'. However, they were positive about the on-going support and guidance offered by key personnel throughout the pilot process. This was deemed to have been beneficial particularly given reports that there were some gaps in the initial training. However, aspects of the content and delivery were thought to need further refinement, particularly those relating to the format and writing of the report and management of the politics and sensitivities surrounding SCRs[14]. Findings also suggest critical consideration needs to be given to the accreditation of reviewers.

SCIE reportedly envisage implementing a Learning Together reviewer accreditation process. Their proposals include an expectation that reviewers will adhere to SCIE's supervision and quality assurance arrangements and that 'independent' reviewers will agree to amend their reports, where SCIE deems this to be necessary, to protect the fidelity of the Learning Together model. The experiences of those involved in the pilots reveal that this may lead to situations where lead reviewers and/or the LSCB are being asked by SCIE to make changes that they do not necessarily agree with. As outlined above, reviewers and members of LSCBs have had different perspectives from SCIE on the evidential claims that can be drawn from SCRs adopting a systems approach and on how findings should be written up so that they are accessible to the key audiences. These issues warrant further consideration as new SCR processes are being implemented.

[14] SCIE and the reviewers were engaged in an iterative process of learning from and refining the approach during the course of the pilots.

CONCLUSION

There are strengths and limitation of both traditional SCR processes and the SCIE Learning Together model. In interpreting the findings from the research it is important to acknowledge that it was undertaken in the early stages of implementing the latter and an iterative process of feedback, learning and refinement was underway in parallel with the study. Throughout there was evidence of a high level of commitment to piloting the SICE Learning Together model to maximise lesson learning. The collaborative approach and orientation towards 'moving beyond looking at whether procedures were followed' and exploring the impact of systemic issues on decision-making were welcomed. Conversations were found to illuminate issues that would not necessarily have been identified through IMRs; the greater level of practitioner involvement in the process was also seen to provide new insights into the case and embed learning in the process. The majority of survey respondents who participated in conversations revealed that this had provided them with an opportunity to express their views and explain why they took the decisions they did. Case group meetings were also perceived to be valuable forum for exploring difference in professional perspectives and promoting improved understanding of respective roles and responsibilities. However, interviews revealed that not all professionals experienced conversations or cases groups as empowering. Some questioned the appropriateness of exposing the problematic practice of one or more individuals in a group setting. It was also suggested that the model:

> *underplays the sensitivity of a SCR and how difficult this is to manage in a group setting...SCIE thinks you can talk about everything but you can't.*

Others questioned whether findings from SCIE Learning Together SCRs were generalisable and the knowledge gains from adopting the approach were sufficient to justify the time spent on the process. It was highlighted that there is an opportunity cost because frontline practitioners and managers are diverted from their core business thus placing additional pressures on those seeking to provide an effective service response to meet the needs of children and families in a difficult economic climate. It was also identified that the 'academic' analytical framework and report structure would benefit from further development to make them more intuitive and accessible. Some professionals also indicated that they would favour adapting the

model or developing a 'hybrid approach' bringing together elements of the traditional review process and the SCIE Learning Together model.

> *SCIE do not believe in a partial model and part of me can see why because you could lose the intellectual rigour but on the other hand let's think back to why we do these things [to learn and develop practice]…If there was a licence to adapt it to suit the case and suit the authority as well then I think we'd feel a bit more easy about going into this again.*

There was a feeling amongst some others that the traditional SCR approach can deliver and that the additional time spent in adopting the systems approach was not justifiable as the lessons learned were not dissimilar to those identified in the course of traditional SCRs. It was identified that it takes time to embed policy and practice and replacing one approach with another may serve to divert attention from learning from reviews and acting upon the findings and towards 'learning a new methodology'.

> *It took years to get everyone to understand the traditional model...Can we make the traditional model better rather than throwing it out and starting [again with] a new one?*

Eight out of ten of the review team who completed a survey agreed or strongly agreed that LSCBs should be able to decide which SCR methodology to use. This reflected recognition of some of the advantages of the traditional model, including: familiarity and confidence in this approach at a senior level[15]; and that there are sufficient Chairs and authors with the skills to undertake these reviews in prescribed timeframes. A Delphi policy evaluation in Northern Ireland also concluded that the traditional approach can deliver if 'greater attention is given to the operation of the process, its findings, recommendations and dissemination' (Devaney *et al*., 2011, p.257). Furthermore, key stakeholders involved in the evaluation, including Chairs of Area Child Protection Committee, Chairs and panel members of completed reviews, Directors of Children's Services and frontline professionals from a range of backgrounds, supported the retention and refinement of the traditional process rather than implementation of a new model (Devaney *et al*., 2011).

[15] It was identified that without IMRs agency management do not necessarily have a clear idea about matters for which they are accountable until reports are produced.

One of the pilot LSCBs took the decision to initiate a traditional SCR rather than a SCIE Learning Together SCR in response to a more recent child death; they perceived that matters were 'too raw' and the conversations would be too emotionally distressing for the practitioners involved. This highlights the significance of timing in facilitating or inhibiting realisation of the benefits of the systems approach. Professionals involved in both the pilots also highlighted that there were certain circumstances, for example, in cases involving a number of authorities or in cases concerning inter-generational abuse, it may be challenging to use the method. It is also important to acknowledge that irrespective of the model a critical foundation for the effective conduct of SCRs is that those involved have the necessary training, skills and competencies to fulfil their role.

MESSAGES FOR POLICY AND PRACTICE

The effectiveness of SCRs (irrespective of model) is dependent on the training and skills of those leading the process and on the commitment, engagement and organisational capacity of those involved. This rapid response study was small scale and explored *very early implementation* of the SCIE Learning Together model. The messages from those involved suggest that the approach has the potential to contribute to deeper learning. Strengths include:

- The use of skeleton chronologies to enable the review team to elicit information on the actions taken by individuals and/ or agencies;
- Conversations, which were judged to secure high quality data, moving beyond identification of procedural non-compliance and exploring matters that would not necessarily have been illuminated in Independent Management Reviews;
- The opportunity for those involved to express their views and explain their actions and factors influencing the decision-making process;
- The multi-disciplinary perspectives obtained from case groups and review team meetings. These forums can enhance understanding of key practice episodes, contributory factors and promote understanding of the roles and responsibilities of different agencies;

- In-depth insight into why a small number of key practice episodes (KPEs) were handled in the way they were.

However, it was also identified that further consideration needs to be given to:

- How the SCIE Learning Together model is experienced by those who are traumatised by the case and may be experiencing feelings of guilt and worthlessness; the potential damage of exposure to criticism in a group setting; and how the emotional support needs of staff are being met both during the process and afterwards (see also Horwath,1995; King, 2003);

- The number of practitioners and managers involved in full SCIE Learning Together SCRs and the impact this will have upon the breadth and depth of data obtained through conversations, as well as implications in terms of group dynamics, attendance and active participation in case group meetings and on wider service delivery;

- Exploring the application of SCIE's explicit methodology for moving from case specific findings to determining underlying patterns and examining whether findings from the reviews are generalisable;

- Determining whether SCIE's analytical framework and report structure could be refined so that they are more accessible for a wider audience without undermining lesson learning;

- Identifying circumstances in which the SCIE Learning Together model may not be practical (for example, when SCRs involve a number of authorities or in cases concerning inter-generational abuse);

- Ascertaining whether in the context of high levels of organisational change issues illuminated in systems SCRs are relevant to current operational systems and processes;

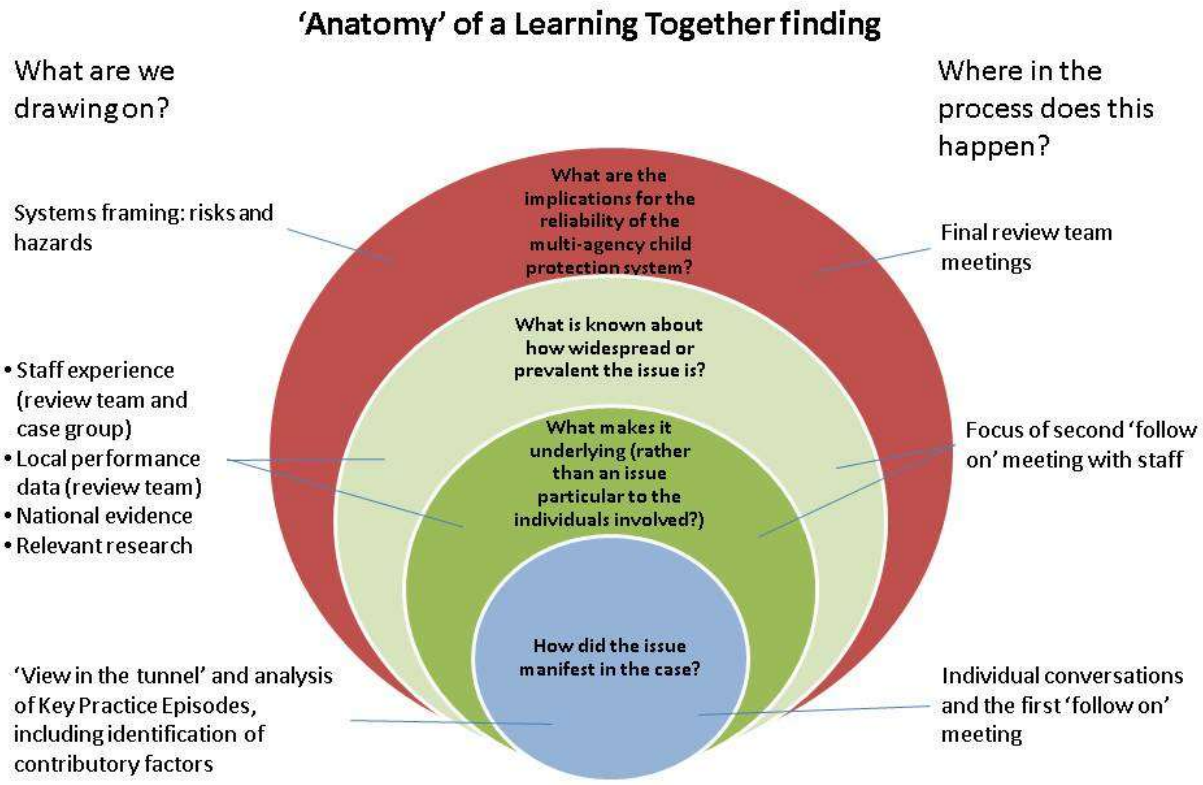
- Exploring the strengths and limitations of developing a 'hybrid approach' bringing together elements of the traditional SCR process and SCIE Learning Together model because replacing one approach with another may serve to

divert attention from learning from SCRs and acting on findings and towards ‘learning a new methodology’.

- Determining the viability of implementing the SCIE Learning Together Model nationwide in the short to medium term given that a relatively small number of professionals are trained in applying this approach.

Appendix 1: SCIE's Anatomy of a Learning Together finding

Anatomy of a Learning Together finding



An illustration

A false assumption of stable populations of CP Conferences and Core Groups means their functioning will be less than optimal.

Perhaps the most startling finding of this case review has been that there is far more change in the participants at Child Protection (CP) Conferences and Core Groups in relation to any particular case than anyone assumes there to be. In this case, the 'population' of those who attended formal CP meetings shifted throughout the period of the case review. The most striking example was the lack of continuity between Initial Child Protection Conference (ICPC) and the first Review Conference: the professionals who attended the first Review Conference were entirely different

(including a new Chair and minute-taker), apart from the social worker. The same was true of the important Core Group meeting (held just before the summer holidays): only Mother and the social worker had been part of the group before. At the final Core Group, just before the death of the child, 2/5 were new members of the group.

In the context of other vulnerabilities in the system, described below, the Review Team was persuaded that this loss of continuity (and knowledge and understanding) was highly significant for the effective working of the case, both within and across agencies. In particular, the newness of the group each time made it very difficult to

a) understand previous history/context and concerns
b) appropriately review the CP Plan, and
c) present a robust and consistent response to Mother.

The challenges posed by the changing population were exacerbated by the fact that this changing attendance was not recognised at the time or subsequently. It came as a shock to those participating in the Workshop Day, including, perhaps most surprisingly, the Chair. This meant that there was no chance that the significance of the lack of consistency could be ascertained or responded to at the time.

As part of this case review process we discussed this issue with the staff directly involved. Did professionals think it was a common phenomenon? How often would CP Conferences and CGs experience such a degree of changing professionals? The Review Team and Case Group concluded that this was commonplace. They also highlighted that it is something which is unlikely to change – for the following reasons:

- Parents and children move between services over time – from nursery to school, changing schools, changing GPs, moving house, etc. When this happens, new workers are assigned to them.
- Some services have a number of possible, different attendees. Our GP said there are nine doctors in her practice, any one of whom may be called upon to attend a CP Conference for a family.
- Professionals experience reorganisations and other changes which move workers around. There are currently reductions in some services – which we were told may lead to less ability to attend meetings by individuals. And workers retire or leave their jobs.
- There are fewer internal CP Chairs in the locality now (2 instead of 3), so more agency Chairs are used – leading to less consistency at Review Conferences.
- A minor but important point: the invitation lists to Conferences may contain inaccuracies, resulting in the wrong people being invited. In our case, the critical involvement of Mother's GP was lost because of this.

As such, the assumption that there is continuity across these meetings represents a serious vulnerability to the effective operation of these meetings, and therefore the local multi-agency child protection systems.

Finding 1: A false assumption of stable populations of CP Conferences and Core Groups means their functioning will be less than optimal.

CP Conferences and Core Groups play a fundamental role in the way that formal CP systems are designed to operate. The design includes an implicit assumption of continuity and consistency of participants across these meetings. This case review has identified that this is a flawed assumption. Input from participants suggested that a changing group of attendees is in fact the norm. Yet if the change in participants at these meetings goes unnoticed, it poses a serious challenge to their effective functioning, making it much harder for the network to a) understand previous history/context and concerns; b) appropriately review the CP Plan; and c) present a robust and consistent response to parents and carers.

Issues for the Board to consider:

- Is the situation whereby 'core' groups are not core individuals relative to the child acceptable to the Board and member agencies?
- If stability is an unattainable goal, how might Core Groups and Conferences operate effectively in spite of a changing population of professional personnel?
- How could the identification of the degree of change in attendance be supported? Input from staff at the Workshop Day suggested, for example, that all Conferences begin with an indication of those who have attended before and who are new members of the Conference – thus establishing the degree of shared knowledge and understanding.
- What would the cost-benefits be of requiring new attendees to familiarise themselves with the history of the case before attending a Review Conference (including reading reports from the Initial Conference)? Would it be feasible to resend all the original reports to new invitees to Review Conferences using secure email?
- Could the role of the Chair be amended/expanded to compensate?
- Does the LSCB have access to type of information on performance of the system to assess improvement in this area? Is a change needed to the information collected and analysed?

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Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together systems model: lessons from the pilots
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