Social Care TV:

Safeguarding Children: A New Approach to Case Reviews

social care institute for excellence

Transcript:

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A New Approach to Case Reviews

Narrator: In child death tragedies, such as the recent case of baby Peter, the public's response is often one of incredulity as to how this could have happened. Faced with this, new methods of investigation are needed to move beyond identifying what went wrong to understanding why it did so, in order that effective lessons may be learned.

This programme explores a new systems model for conducting case reviews that is explicitly designed to address those 'why' questions. As such the systems approach produces organisational learning that is vital to improving the ability of services to keep children safe.

The systems model can be used, not only to learn lessons from tragedies, but for reviewing any kind of case, including those in which things go well.

In the first part of the programme we look at the origins of the systems model and how it works.

Dr. Eileen Munro: That's the basic idea around all of the solutions in systems work; that you make it easier to do the right thing and harder to do the wrong thing.

Narrator: In the second part we look at two local authorities that have tried out the systems model in practice.

Sue Waldbridge: This was a way of capitalising on that, perhaps, more reflective way of looking at, what did we do that we could have done differently, rather than feeling somebody is going to point the finger at me?

Damian Griffiths So we were looking for something more comprehensive, more holistic and more sensitive I guess, to looking back and seeing how things were at the time, rather than being wise with the benefit of hindsight, which is always easy.

Narrator: In the final part, we look at the broader implications of this approach for learning within the children's services sector.

John Harris: The Learning Together study was very important because it was highly attuned to the context of working with children and families. It identifies those different things that will either support good practice, or, if they are absent, will lead to greater risk and ineffectiveness.

Origins of the Systems Approach

Dr. Sheila Fish: At a conference recently, a woman came up to us afterwards and said, as a social worker, people keep asking me "How could this baby Peter case have happened'. And she said she couldn't give a very good answer. All she could say back to people was "There must have been reasons, but it's complicated". And I think, for me, that really gets in a nutshell why we need this new approach to case reviews. As they stand, and as that social worker said, we aren't really providing adequate explanations.

Dr. Eileen Munro: I had done a twenty year study of child abuse enquiries and found the same findings; the same recommendations, same lessons continually being drawn, and yet all that good intention was not showing up in improved outcomes for children. And what's more, the affect of all of the changes had been to demoralise the staff; we had huge problems in keeping social workers in the front line. So there was something seriously wrong with the way that we were looking at the mistakes that happened in child abuse.

Narrator: Traditional approaches to reviewing cases of serious harm, or death, have tended to assume a linear model of causality, 'A' has caused 'B', focussing on individual human error.

Dr. Eileen Munro: The typical child abuse enquiry has looked at the practice, until the point where they get to see that a front line worker made a mistake, and then they stop and they say "It's because this social worker didn't read the medical report". "It's because this doctor didn't do a proper health check". And then the human error is seen as the problem. So you have very this very simplistic idea of causality, as a domino effect; that one mistake led to a whole toppling of the dominoes.

Dr. Sheila Fish: It's a very appealing approach, the person centred one, in some ways you know what the problem is; there's a person, and it's simple to fix it.

We assume that the system is fundamentally safe, and the problem is these erratic people. And the solution is to control the erratic people.

Narrator: Looking for a more holistic perspective on how poor practice occurs, the research team, led by SCIE, turned to research in other industries for inspiration.

Air accident investigations take a different approach to human error. When a plane crashes the first person likely to be killed is the pilot. As such it is unlikely that a pilot will be lazy or negligent in their job, so what else might influence their decisions and lead to a crash?

Dr. Eileen Munro: Well, the big difference in the aviation engineering world was the realisation that the front line worker isn't just a single, autonomous person, who can choose to do it right or do it wrong, but is actually very much shaped by the task and the whole culture of the organisation.

Narrator: An important early model of accident causation that considered factors above and beyond the individual likens organisations to Swiss cheese. The defences and safeguards of an organisation are represented by different slices of cheese. These might be technical, procedural, or rely on people working as individuals or in teams. Mostly these organisational defences are effective, but they all have weaknesses or holes. As long as these weaknesses are protected by other parts of

the organisation, the chance of a bad outcome is minimised. However, when these weaknesses converge, there is a strong chance that accidents will follow. Yet this model has its limitations.

Dr. Sheila Fish: The Swiss cheese model presumes that a weakness is always a weakness, but actually that presumes again, quite a linear model of causality.

Narrator: The systems approach builds on the Swiss cheese model by developing a more complex understanding of how different agencies interact.

It considers the potential for serious unforeseeable outcomes to result from seemingly harmless interactions between agencies.

Dr. Eileen Munro: The weather's a very good image, particularly for multi-agency working, because you can't always predict the weather, notoriously. You might have a policy within the police that on it's own is very rational, very helpful. But actually when the police come into contact with social workers; and with social workers, different policies, that interaction creates a weakness; creates a problem. And the issue about them being emergent properties is that it is very difficult to predict in advance what the outcome of that interaction will be. That reinforces the notion, then, that in thinking in systems terms of needing very strong feedback loops within the organisation.

Narrator: In developing a complex systems approach to case reviews within social care, the research team has drawn on similar developments in the health sector.

Suzette Woodward: In the health service over the last ten years there has been a significant change in how we've looked an incidents and investigations. And now there is expectations from regulation, from standard setters, and for those that assess organisations that certain incidents are investigated at different levels.

A good example of using the systems approach to see what the real problem is, was an investigation that I conducted at a children's hospital. We had a child who died as a result of what is now described as vincristine errors. This is where you inject the wrong drug, and

instead of injecting that drug into their vein, in this instance it went into their spine, and this caused paralysis and then death.

This is extremely tragic and distressing for every single person involved. And what we did was ask ourselves "Why did this happen" rather than "What did that doctor do?" and we looked at every single aspect, from pre-admission to admission, to the decision as to where the injection was going to be taken. We owed this to the little boy who died, and to his mother, to say we want to really make sure this never happens again.

And we got to understand that if, in this instance, you simply packaged these individual drugs in completely different packaging, you kept them completely independently, and you administered them in two different places, then that incident was highly unlikely to ever happen again. So we completely changed the design of the system in which those drugs were delivered.

Narrator: The research team, led by Sheila Fish, at SCIE, took the systems approach developed in other sectors and adapted it for children's services.

Dr. Sheila Fish: SCIE thought that what we needed was some really quite in-depth research and development work, to see how we might need to take the engineering model that had then been taken up in health. How would we need to adapt that so that it would really suit the nature of multi-agency safeguarding and child protection work.

Narrator: This research resulted in the publication of learning together. In the study the systems approach has been developed from earlier models of accident causation, to take into account the complexity of human performance. But how does it operate in practice?

Using the Systems Approach

Narrator: Some of the key features of the systems approach are that it:-

- Actively involves both family members and frontline workers from across agencies in the review process.
- Finds out how people saw things so that their actions or decisions seemed sensible at the time.
- And examines the way in which internal and cross-agency factors influenced the work that was done.

Poor individual practice does sometimes occur. The systems approach does not make excuses for this; rather it aims to provide a fuller explanation of why things have gone wrong when there is more than simply individual error at stake. This is necessary if more effective remedies are to be found.

Oxfordshire and Sheffield are two local authorities that have recently tried the systems approach in practice. Because of issues of confidentiality the authorities cannot talk about details of the cases. However, the frontline social workers and managers are able to share their experiences of being involved in a case review using this approach.

Sue Waldbridge: It gave us a better understanding of how the people who were being reviewed had worked.

Damian Griffiths: Agencies and individuals feel that they are undergoing this process with those who are conducting it; rather than having it done to them.

Narrator: Sue Waldbridge is the practice research officer for Children and Social Care in Sheffield. During her previous career as a social workers, she took part in a review that adopted the systems approach.

Sue Waldbridge: The review started by us having a meeting with everybody who'd been involved with the case and the people who were going to conduct the review. I think there were anxieties, because nobody likes to have their practice looked at in a critical way. But we were given a lot of information about how it would work, before we agreed to it, and quite

a lot of re-assurance from the people who were undertaking the review.

Dr. Sheila Fish: A key part of the systems review process is quite in-depth one-to-one conversations with all the participants involved. And we've consciously chosen to call them conversations, not interviews, because it's not meant to be an interrogation in any way.

Narrator: Damian Griffiths is lead officer for safeguarding in Oxfordshire. Damian found that the involvement of his team in a recent systems review helped during a difficult process.

Damian Griffiths: The systems approach is not a magic bullet this, it doesn't make it all a lot easier for staff; this process will never be easy for staff, and probably rightly so. However, what it does do, is given them the opportunity to be involved in it and to have interaction with the overview author in the process. So they feel far less distanced from it.

The systems approach is more holistic and therefore it promotes more reflection. And because it's more involving, because it's more inclusive, reflective and holistic, it feels more collaborative.

Narrator: One way this collaboration is enabled is through opportunities for feedback, given to participants by the review team.

Sue Waldbridge: They regularly sent us what they thought so far, via e-mail, and we could make comments that way. And they normally sent analysis before we had a meeting of everyone there, so that we had an opportunity to read those things and comment on them, and then feedback.

One particular meeting I recall, my line manager and I had looked at something prior to the meeting that had been sent to us, and we thought the review team hadn't got it right. And we were able to say that to them in the meeting, and afterwards in the next analysis that bit was altered; not exactly with our interpretation but put in a different way. And I think that made people feel like the people conducting the review were taking our views seriously, and not always putting their views over our own.

Narrator: Unlike traditional approaches, the systems model emphasises the need to bring people from different agencies together.

Dr. Eileen Munro: At the moment, case reviews tend to get each agency to do an internal management review, which can involve some interviews, but is mainly paper based. And then somebody does an overview report. Whereas in the systems approach you are much more interested in the interactions between the agencies.

Sue Waldbridge: Being together in a room with the other professions who had been involved meant that we had a much better idea about how other agencies had acted on information they had got from another agency. Health adapted on information they got from housing; social services had acted on information they got from health. The process of decision making about what was to happen in the family was kind of laid bare in a way that it hadn't been, in any way, while the work was going on.

Narrator: The systems approach attempts to link up findings to highlight recurrent issues across organisations.

Damian Griffiths: One of the key differences in the findings was the themes emerging for practice, and that's very useful and important. Rather than identifying one thing that wasn't done right over here, and something else that went wrong over there, actually you can draw out the key themes. And that's much more useful if you want to learn the lessons.

Dr. Sheila Fish: The aim of a systems case review is go beyond the findings of a particular case and to actually use that one case to act as a window on the system, identifying more broadly strong areas in the system and also problematic areas of practice, so that they can be addressed.

Damian Griffiths: One of the key lessons that emerged from this particular case was human reasoning. One of the flaws in the human reasoning which was repeated was the propensity for individuals to fit new information which was coming in about the situation in the case, the child and the family to their existing understand about what had gone on. We ended labelling that the garden path syndrome.

But it didn't stop there in terms of analysis, it looked at the context of why individuals found themselves on the garden path, and what helped to keep them on the garden path.

Narrator: For Sue Waldbridge, her systems review revealed that she and her colleagues had struggled with a similar problem.

Sue Waldbridge: One of the big learning points for practitioners in the review was it felt like a lot of workers had had similar feelings of uneasiness, that's the only way I can describe it, about what was happening within this family, but there was nowhere clear to document that in any of the kind of assessments that we had. And it wasn't shared at the time in any meetings, or it wasn't specific enough for anybody to be able to act on. And through the process of the review, we looked at actually how most of us had had those feelings of unease and what did we do with them?

Dr. Sheila Fish: If you are really going to get close to some idea of how the world looked at them at the time; so that their decisions or actions, or inactions seemed sensible, you need to speak to them. That kind of data isn't available from the formal documentation; from the paperwork.

Narrator: At the end of the review process Damian Griffiths found that changes to services were not dictated to his team.

Damien Griffiths: The recommendations made by the overview author were less specific than is traditional, and I think rightly so. They were specific in targeting, or highlighting the area of difficulty, but not specific in dictating to each agency, or the multi-agency group the minutiae or the details of how that ought to be changed. And I think that's right, because that's where the expertise of the agencies is better. So there's a bit more work at the end of the process for agencies to do. And for some agencies I think that was a little bit uncomfortable. Maybe some of them would have found it easier just to be told what to do, but of course that would mean less ownership by them of those recommendations.

Narrator: For Sue and Damian, by using the systems approach, the review process became a more constructive experience.

The effect of case reviews on staff is an important consideration for local authorities.

The Systems Approach: The Broader Implications

Narrator: Using the systems approach to look at any aspect of an organisation helps interlink the actions of frontline workers with decisions made by senior management.

John Harris: The big concern is about you go from high level strategy to ensuring that you have got effective and consistent work on the ground to improve outcomes. So you often, if you are looking at serious case reviews, or reviews where things went wrong, people describe what happened but it doesn't necessarily get behind the reasons why. And I start from the view that social workers and other people working with children come to work each day to do the best job that they can, that's why they are in the job.

Sue Waldbridge: Frontline workers, no matter what agency they are working for, make judgements about what to do with families all the time. That is the nature of the job. And sometimes they make the wrong judgements, but that's not through malice or laziness or ignorance a lot of the time. It's because so many other things are happening that are putting pressure on all sorts of areas of workers lives and families lives. And I think this review process could get a grip of that far more effectively.

Colin Green: The study from SCIE of learning together is a really important contribution, because I think it's giving us a way out of the current, I think rather arid, approach to serious case reviews, into one that has much more focus on learning and doing so in a systemic way. We need more of this thinking in social care.

So when I read the SCIE report I kind of recognised that, I thought great, somebody has really taken this on board, and has taken this a step forward, looked at how this could applied to serious reviews, tried this out, validated the method. And now we are working in Coventry on a serious case review that we are using this method for; not where children died, but where there was a serious incident.

Damian Griffiths: In these particular cases, the serious case reviews we are looking at, we are talking about some very, very difficult issues; we are talking about children getting seriously injured and sometimes dying. And that can be a devastating thing for any practitioner who has been involved with it, and can provoke them leaving the profession, not uncommonly.

Colin Green: The feedback I have had from social workers in Hertfordshire, when we have talked about what are the factors that would keep you in the role and keep you working for this organisation? What they actually say is that the key thing for them is that they feel they have management support. And if you do that people will feel safe to do the job, where they are often making very difficult judgements that have profound impacts on children and families. And this approach, which is about understanding learning, and understanding the context, it seems to me reinforces that point that they are part of a learning organisation, and it's very much around finding ways to learn, rather than finding somebody to fix the plane.

Dr. Sheila Fish: At the end of the day, this approach is aimed at better supporting multi-agency workers to better support families. So we are hopeful that we will get more people trying it out in practice. We will be able to further fine tune the model and fundamentally change the culture of multi-agency working. So that people do feel that it's their responsibility, from the frontline, to feed back to those higher up in the system when problems are identified, so that they can be addressed sooner rather than later. Most importantly it will help us learn the lessons that we need to learn in order to keep children safe.

Narrator: The systems approach to case reviews will not single-handedly ensure better support for families or guarantee that children are protected from harm, rather as a tool for learning it promises to uncover the deeper causes of poor practice, so that measures to improve safeguarding really hit the mark. Importantly it brings people from all layers or organisations together in pursuit of that common goal.

The learning together model has great potential to benefit serious case reviews, making it a valuable contribution at an important time.

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