Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 5: Clarity of purpose

Quality statement: the Local Safeguarding Children Board (LSCB) is clear and transparent, from the outset, that the purpose of the Serious Case Review (SCR) is organisational learning and improvement, and acknowledges any factors that complicate this goal

Rationale

SCRs often provoke fear, for individuals and agencies, that the process involves looking for someone to blame for the incident or outcome of the case. In contrast, the purpose of SCRs should be organisational learning and improvement and, where relevant, the prevention of the reoccurrence of similar incidents. This framework accepts that errors are inevitable and, where they are identified, they become the starting point of an investigation. Individual and organisational accountability is manifest through being open and transparent about any problems identified in the way the case was handled, and demonstrating a commitment to seek to address the causes. In many SCRs this is what the LSCB wants the SCR to achieve. It is as simple as that. Communicating with clarity the learning and improvement purpose helps address fears and uncertainties over the function of the SCR. It also helps reduce defensiveness on the part of those affected.

In some cases, the situation is not as straightforward. Certain cases and/or local circumstances can trigger government and/or media expectations about individual(s) and/or agencies being held to account by disciplinary means. The need to identify someone to blame can also become a driving factor for senior managers. Alternatively, there is often an expectation that any practice identified through the SCR as falling below expected standards is reported to the agency concerned, so they can consider the need for disciplinary or capability processes. These different agendas can create significant challenges to the learning and improvement goal of the SCR. On the one hand, they can create false expectations that the SCR itself will ascribe individual or corporate blame. On the other hand, such circumstances can muddy the waters about the purpose of the SCR because while the SCR is not designed to apportion blame, it can provide information that feeds into individual or corporate discipline processes, or clarify the grounds for needing to initiate them. As a result, claims that the purpose of the SCR is learning can ring hollow for those involved. An honest articulation of any tensions and contradictions that exist in relation to the goal of learning in an SCR is therefore recommended.

How might you know if you are meeting this quality marker?

1. Has there been communication with all the necessary parties about the purpose of the review (e.g. LSCB members, involved agency leaders and practitioners directly involved as well as those conducting the review)?
2. Has this communication been articulated in a strong and positive fashion, underlining the learning and improvement purpose of the SCR?
3. Have any complicating circumstances been honestly acknowledged?

Knowledge base

- There is a large body of safety management literature that addresses the same problems as child protection of understanding how poor outcomes arise and how they can be reduced. A key lesson is that practitioner errors generally arise from the interaction of several areas of weakness in the system, not from one major mistake by an individual. Investigations are therefore seen to need to explore how the system functions more generally and routinely. They seek to identify what supports good practice and what is making poor standards of performance more likely. See also 'An organisation with a memory' (The Chief Medical Officer, 2000), ACPO risk assessment principles as quoted in 'The Munro review of child protection: interim report - the child's journey' (Munro, 2011p 96), and the Munro Review of Child Protection reports themselves.
- Professor Don Berwick, in the report of his review into patient safety in the NHS (2013) stresses the need to differentiate carefully between error and neglect or wilful misconduct: 'Because human error is normal and, by definition, is unintended, well-intentioned people who make errors or are involved in systems that have failed around them need to be supported, not punished, so they will report their mistakes and the system defects they observe, such that all can learn from them. On the other hand, harm caused by neglect or wilful misconduct does warrant sanctions in health care, just as it does in other settings' (p 12). NHS England recommends ascribing culpability only for reckless or malicious actions by individuals – see the NHS Incident Decision Tree (The Health Foundation 2013).
- Research about accident investigation supports developing a just culture for SCRs that accepts accountability (organisational and individual) but does not apportion blame (Dekker 2012).

Link to statutory guidance and inspection criteria

- 'Working Together' (HM Government 2015) defines the purpose of SCRs as 'organisational learning and improvement, and the prevention of reoccurrence'. There is a requirement for 'transparency about the issues arising from individual cases and the actions which organisations are taking in response to them' (p 72).

Tackling some common obstacles

- Strong, overt leadership about the purpose of the SCR being to understand 'what happened and why' and to make recommendations which will lead to the improvement of services, helps address tensions and uncertainties over the function of SCRs and minimise defensiveness on the part of everyone affected by the SCR.
- Adopting and promoting an agreed model of organisational accident causation can help clarify what a focus on learning means, and provide a range of new terms to explain it.
- The establishment of a 'just culture' ahead of time will help senior managers and board members deal with tensions and contradictions about 'accountability' with honesty and integrity. The principles of a 'just culture' can be established as foundations to the local learning and improvement framework, and applied to all review, audit and evaluation work.
- Establishing a 'just culture' will make it less likely that senior managers and board members will be unduly influenced by inappropriate attention from government, regulatory bodies and other external influences such as the media expectations about individual(s) and/or agencies being blamed and punished through the SCR.v

This is one of a set of 18 Quality Markers which aim to support commissioners and reviewers to commission and conduct high quality reviews. Covering the whole process, the quality markers provide a consistent and robust approach to SCRs. They are based predominantly on established principles of effective reviews / investigation as well as SCR practice experience and expertise, and ethical considerations.

The SCR Quality Markers were produced as part of the Learning into Practice Project, a one-year DfE-funded project conducted by NSPCC and SCIE between April 2015 and March 2016. For more information see nspcc.org.uk/lipp or scie.org.uk/lipp