Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 13: Analysis

Quality statement: the Serious Case Review (SCR) analysis is transparent and rigorous. It evaluates and explains professional practice in the case, shedding light on routine challenges and constraints to practitioner efforts to safeguard children

Rationale

The purpose of SCRs is to support improvements in safeguarding practice. This means it is not sufficient to describe professional activity in a case or to identify elements of practice that were problematic, without explaining why they occurred. The analysis needs to identify what has led to and sustained the kind of practice problems that the case reveals, so as to focus improvement efforts. This requires the following.

- Relevant aspects of work with the family are explored and evaluated, and this assessment utilises appropriate research evidence about good practice, and references available guidance, relevant legislation and professional requirements. Those leading the review minimise the influence of hindsight and outcome bias on the evaluation of practice.
- The SCR analysis attains an understanding of professional practice. It provides an explanation of what influenced professional activity and decision-making at key points in the management of the case. The analysis utilises available frameworks of 'human factors' in the safety management literature so that the interaction of individual, human, cultural and organisational aspects is assessed.
- The SCR's conclusions stem from the analysis of the individual case but highlight underlying strengths and weaknesses in how service delivery across similar cases worked more generally and routinely. The analysis is informed by an understanding of how complex systems function.
- Findings/recommendations are prioritised according to the areas of greatest need for improvement. This interpretation can be strengthened by addressing whether the same kinds of practice problems still occur and by utilising information from sources other than the individual case, including performance data.
- There is rigour to all aspects of the analysis process. The methods used are clear and transparent, drawing on knowledge in the research methods literature.

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

1. Is the approach to analysis contained in the QM understood by those who commission and undertake the review?

2. Is it clear from any descriptions of the method/approach used for the SCR that it enables the approach to analysis described in the rationale section of the QM?
3. Has the analysis established what happened in the case, with comments on the quality of practice but also explanations of professional actions and decision-making?
4. Is the research evidence about what constitutes good practice that is used in the analysis up to date and accurate?
5. Does the analysis provide explanations of professional behaviour that call on a range of factors related to the tasks, tools and organisational issues rather than only being concerned with whether staff were adequately skilled and the relevant procedures were available?
6. Is it clear what specific techniques have been used to minimise the bias of hindsight and outcome knowledge on the analysis?
7. Does the presentation of the analysis in both working documents and the final report show enough of the working-out process to allow the interpretation to be critiqued and counter evidence to be brought to bear?
8. Does the analysis draw attention to what professional activity in the case reveals about how service delivery worked, or is working more generally and routinely?
9. Is it clear where knowledge about the wider safeguarding system at the time of the case, or now, has come from? For example, working with a review team, input about practitioners' wider experiences.
10. Does the analysis show clearly how the conclusions relate to the individual case as well as why they are relevant to wider safeguarding practice?
11. Does the lead reviewer(s) access supervision or peer challenge to support the quality of analysis undertaken?

Knowledge base

- Methods of accident investigation in other sectors rely on an explicit model of 'why things go wrong' as a framework for analysis of material. These frameworks generally involve the identification of areas of practice that were below expected standards of quality and timeliness. They distinguish between particular combinations of 'contributory factors' that influence a specific course of events, from 'latent conditions' that affect all professional activity (e.g. Reason, 1997).
- 'Human factors' is an established field of study aimed at understanding how people perform in different circumstances, by looking at the interaction of individuals at work, the task, tools and equipment they use and the environment in which they work. Human factors knowledge has been applied across a wide range of industries and settings to underpin improvements in performance and safety.
- Research in health promotes the benefits of investigations of incidents, providing a 'window on the system' rather than only identifying the cause of the particular incident being reviewed (Vincent, 2004).
- Hindsight bias is the tendency to 'consistently exaggerate what could have been anticipated in foresight' (Fischhoff, 1975) and is a well reproduced research finding.

Outcome bias is an element of this whereby we judge decisions or actions that are followed by a negative outcome more harshly than if the same decisions or actions had ended either neutrally or well. Blaming bad outcomes on simple causes such as human error can literally seems to make sense because knowledge of the outcome changes our perspective so fundamentally (Woods et al., 2010).

Link to statutory guidance and inspection criteria

The 'Working Together' guidance (HM Government 2015) supports the bullet points of the rationale. It states that SCRs should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- is transparent about the way data is collected and analysed
- makes use of relevant research and case evidence to inform the findings (para 11, p 74).

Tackling some common obstacles

- Determining what is good and poor practice is easier for lead reviewers when working with a review team of senior managers from relevant disciplines.
- There is not always a strong research evidence base about good practice, nor consistency of expectations across agencies, so discussion and judgement are often necessary.
- SCR analysis is more complicated when the case involves a large number of children and/or professionals. Planning in advance how this will be approached is helpful.
- It is useful to discuss the possibilities of supervision with lead reviewers as there is no standard structure for this provision.
- Clarity about the extent to which the aim of the SCR is to assess whether any problematic practice was more widespread at the time, and the current relevance of underlying reasons for past practice issues identified in the case, enables the boundaries of the task of analysis to be clear and agreed by all.

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