

9th Annual International Campbell Collaboration (C2)

Colloquium, *Better Evidence for a Better World*

New types of evidence in child welfare:
a practice-based “systems” model for
learning from tragedies

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0900 Monday, May 18th; Oslo.

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Overview of the session

- Baby P case and the aftermath: a UK example
- Lessons from high risk industries for child welfare; SCIE's work to adapt the engineering model
- Questions this work raises about kinds of evidence and models of knowledge production
- Discussion

High profile child abuse deaths



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The aftermath



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The problem of unresolved puzzlement

- “despite 60 contacts ...”
- “as a social worker people keep asking me about Baby P – how could this possibly have happened. And all I can say is – there must have been reasons ...”
- incredulity quickly turns to anger and condemnation of those involved - hard to believe that a motivated, well-meaning, competent worker could act this way, so must be the result of stupidity, malice, laziness or incompetence
- a problem common in Serious Case Reviews and public inquiries into child abuse tragedies

Yet

- reasonable to assume that most people come to work each day wanting to help children, not to allow them to be harmed;
 - practitioners rarely intend to make mistakes
 - so better explanations are required
-
- How have other sectors dealt with this issue?

Lessons from aviation

- Traditional person-centred investigation



vs.



- System-centred investigation

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Getting to the bottom of things

- “An organisation with a memory” (DH, 2000)



National Patient Safety Agency

- Relevance to child welfare in theory
 - Munro (2005) ‘A systems approach to investigating child abuse deaths’ *British Journal of Social Work*, 35, 531-546
- not ‘off the shelf’; detailed developmental work required to adapt it

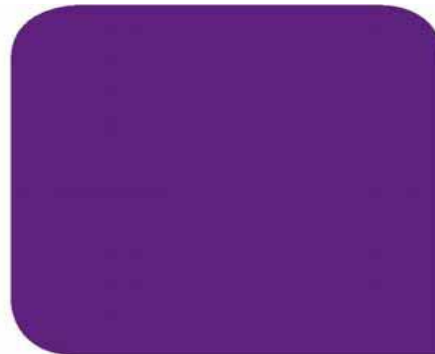
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SCIE Guide 24

Authors: Sheila Fish, Eileen Munro & Sue Bairstow

Learning together to safeguard children: developing a multi-agency systems approach for case reviews



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Why do things go wrong? The person-centred approach

- We analyze the causal sequence until we get to a satisfactory explanation.
- Human error provides a satisfactory explanation.
- ***If only*** the social worker had done
then the tragedy would not have happened.
- Erratic people degrade a safe system so that work on safety requires protecting the system from unreliable people.

To reduce human error, we

1. Put psychological pressure on workers to perform better.
2. Reduce human factor as much as possible.
formalize/mechanize/proceduralize.
3. Increase surveillance to ensure compliance with instructions etc.

A false charm

- Hindsight bias leads us to grossly overestimate how reasonable this action would have looked at the time and how easy it would have been for the worker to do it.
- It is only with hindsight that the world looks linear because we know which causal chain actually operated.



The domino theory of
causation social care
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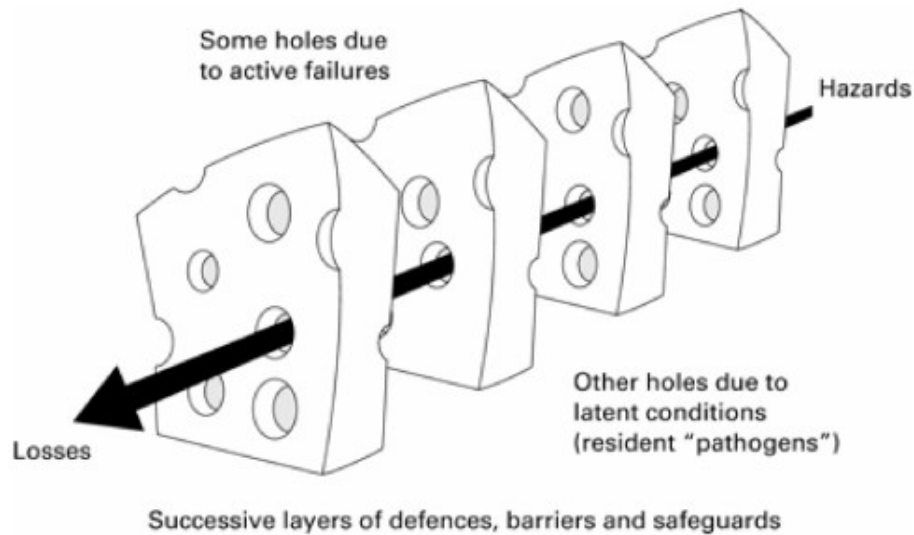
Why do things go wrong? The alternative system-centred approach

- Individuals are part of the system and their behaviour is shaped by systemic influences
- So, don't stop when you find human error but ask
- 'why did this seem the sensible thing to do at the time?'
- Need to understand the "local rationality"

Basic assumptions

- Individuals are not totally free to choose between good and problematic practice
- The standard of performance is connected to features of people's tasks, tools and operating environment.
- Improving practice involves identifying innovations that maximise the factors that contribute to good performance and minimise the factors that contribute to problematic practice
- i.e. making it harder for practitioners to safeguard poorly and easier for them to do it well

Reason's Swiss cheese model



Complex emergent model



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Improving practice

- Heroic workers can achieve good practice in a poorly designed system
- Aim to re-design so that average workers can do so
- Nb. people create safety not just error

Starkly contrasting views of how to understand the human role

- **Replace and substitute human beings**
 - Emphasis on fallibility and irrationality
 - Requirement for procedural interventions and standardisation
 - Increase use of technical solutions
- **People create safety**
 - Emphasis on flexibility and adaptability
 - Recovery from error
 - High reliability organisations -- mindfulness, anticipation, teamwork, respect expertise, intolerance of failure

How the systems model can be used

- ‘The SCIE model is intended to be used in any circumstance where practice needs to be reviewed, not just in the cases of serious harm or death’

Community Care “blueprint for serious case reviews” 16 February 2009

- **Good reasons to focus on:**
 - routine practice,
 - practice that practitioners and/or families are happy with and
 - innovations that seem to be working well

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Key features of the process

1. Multi-agency team ownership as opposed to starting with Individual Management/Agency Reviews
2. Includes in-depth 1-1 conversations as well as documentation
3. Involves high degree of collaboration
 - o Introductory meeting to explain the approach
 - o Sharing of draft reports
 - o Dialogue about analysis and broader relevance

Key aspects of organising and analysing the data

- Abandoning an objective chronology to focus on people's differing perspectives
- Identifying key practice episodes & contributory factors
- Identifying & prioritising underlying patterns
- Continual checking back & exploring further through sharing drafts & holding feedback meetings

Where it gets you

- Is to make one case act as a “window on the system” (Charles Vincent 2004)
- Good or problematic practice may look the different in different cases but the sets of underlying influences may be the same
- 6-part typology of such patterns for child welfare

Typology of patterns

1. human-tool operation

e.g. the influence of assessment forms

2. family-professional interactions

e.g. dominance of the mother in social care involvement & losing focus on the child

3. human judgement/reasoning

e.g. failure to review judgements and plans

4. human-management system operation

e.g. resource-demand mismatch

5. communication and collaboration in multi-agency working in response to incidents/crises

e.g. referral procedures and cultures of feedback

6. communication and collaboration in multi-agency working in assessment and longer-term work

e.g. understanding the nature of the task; assessment and planning as one off event or on-going process?

Benefits of such a typology

- provides a conceptual framework for organising all the layers of interaction influencing the work done with a family
- comparisons across cases can be easily conducted, providing greater opportunity for cumulative learning from the series of SCRs

Better understanding doesn't mean there are any simple solutions

- Not all recommendations can be immediately “SMART”
- Systems models suggest three different :
 1. clear cut
 2. require judgement and compromise
 3. need further research

What the benefits are

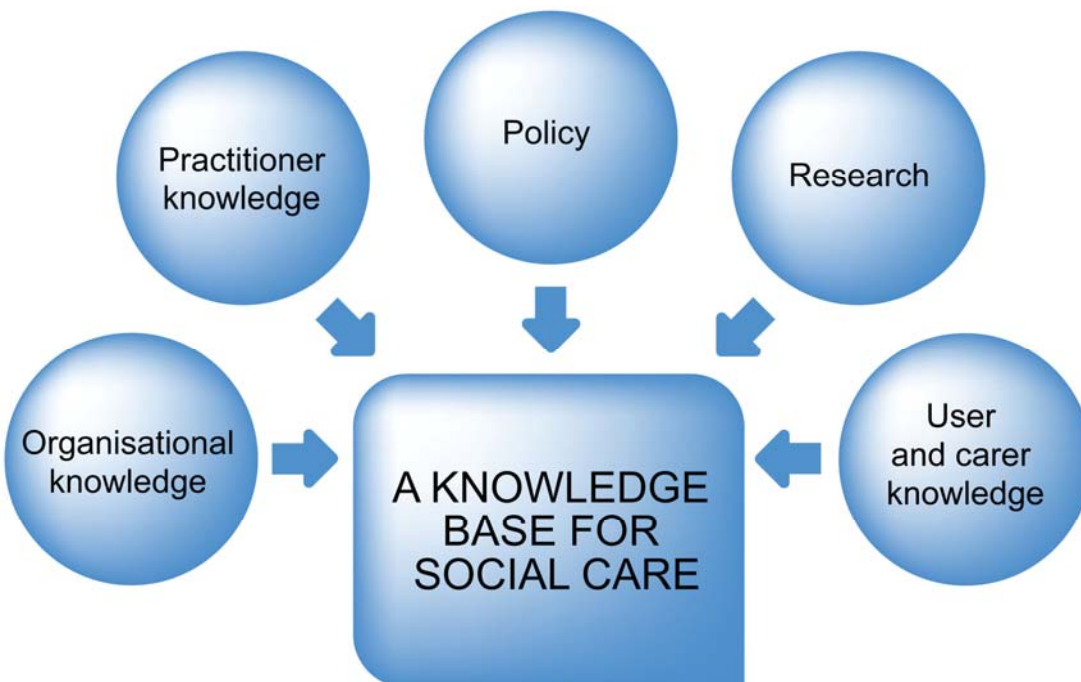
- SCRs
 - Transparent methodology
 - Rigorous analysis; nuanced understanding
 - Process is a learning exercise in itself
 - Aids cumulative learning from a series of SCRs
- Learning *before* tragedies occur
 - providing vital feedback about the “real difficulties of shop floor workers”

Where does 'evidence' fit in the systems model?

- "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research." (Sackett D, 1996)

SCIE's five sources of knowledge

Source 1	Source 2	Source 3	Source 4	Source 5
Organisational	Practitioner	Policy community	Research	User and carer
Knowledge gained from organising social care	Knowledge gained from doing social care	Knowledge gained from wider policy context	Knowledge gathered systematically with a planned design	Knowledge gained from experience of and reflection on service use



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Systems case review model as

- a dynamic, practice-led model of knowledge production?
- with so many agencies with varying priorities interacting, it becomes increasingly difficult to predict with any certainty what the effects of any attempted change to working practices will be
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