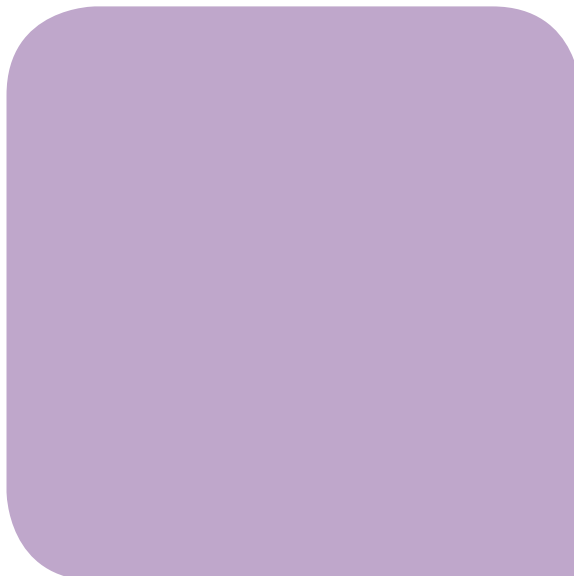
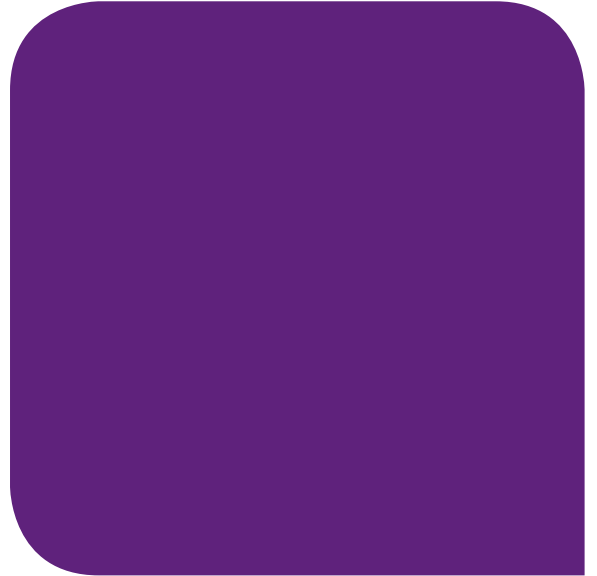


Learning together to safeguard children: developing a multi-agency systems approach for case reviews



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Executive summary

What is this report about?

Children's safety and welfare are key concerns in all countries, with continual efforts being made to improve child welfare and child protection services. Learning is central to these endeavours as the means whereby current problems can be identified in order that future solutions can be sought. But is the current repertoire of learning approaches adequate for the task?

This report presents a preliminary model of a 'systems approach' to learning that can be used across agencies involved in safeguarding and child protection work. It has been adapted from accident investigation methods used in aviation and engineering and, more recently, in health.

What will the systems model help with?

Engineering systems may appear predominantly technical and children's services appear predominantly social. Yet both are usefully considered to be 'socio-technical' systems, although with different degrees of mix. This means that the interactions between people and equipment or cultures are fundamental in shaping the way work gets done.

At the present time, when the various services dealing with children are undergoing major changes in the tools they use and the way they cooperate with each other to try and improve outcomes for children, a systems framework has particular value. It can be used not just for examining cases with tragic outcomes but for conceptualising how services routinely operate and for learning about what is working well or where there are problematic areas – a task that is particularly vital as changes linked to the safeguarding agenda get embedded. Importantly, the systems approach allows for the study of the *horizontal* interactions between agencies as well as the *vertical* interactions within agencies.

Using the approach in Serious Case Reviews

There is also a match between this model and the requirements of Serious Case Reviews (SCRs) in England and Wales and Case Management Reviews (CMRs) in Northern Ireland. We propose that the systems approach could form the basis for a nationwide framework that would facilitate reviewing cases in a consistent way so that wider lessons could be drawn from their similar findings.

How has it been developed?

Taking an approach from a radically different area such as engineering requires detailed work to adapt it to children's services. Therefore, in a two-year Social Care Institute for Excellence (SCIE) project the approach was trialled with the cooperation of two Local Safeguarding Children's Boards (LSCBs) in England. Two detailed case reviews were conducted and valuable feedback was provided by staff at all stages in order to progressively adapt the model in the process. A scoping review of the safety

management literature provided the theoretical underpinning (Munro, 2008) and is available on SCIE's website (www.scie.org.uk).

The basics of the approach

The cornerstone of a systems approach is that individuals are not totally free to choose between good and problematic practice. Instead, the standard of performance is connected to features of people's tasks, tools and operating environment. The approach, therefore, promises a nuanced picture of multi-agency professional practice that illuminates *why* particular routines of thought and action become established. Ideas can then be generated about ways of reshaping the environment or redesigning the task so that it is easier to do the task well and harder to do it badly.

The goal of a systems case review, then, is not only to understand why a particular case developed in the way it did, for better or for worse. Instead, the aim is to use one particular case as the means of building up an understanding about strengths and weaknesses of the system more broadly and how it might be improved in future.

Outline of the adapted model

1. Collecting data

There are two important sources of data relevant to a systems investigation – the written records of different agencies and interviews with key staff as well as service users and carers. These are referred to as conversations to avoid the connotation of formal, fact-finding endeavours.

Records provide the formal account of professional involvement. However, one-to-one conversations are essential because they provide the data that allow us to build a picture of how things looked to the people involved, at the time they were involved.

For this reason, the conversation begins with a narrative account of the worker's involvement, unstructured by the interviewers. To facilitate the subsequent analysis, participants are then asked to identify key practice episodes that they believed influenced the way the case developed. Referring to a list of 'contributory factors' from various aspects of the wider system, the person is then encouraged to consider why they acted as they did.

2. Organising and analysing the data

a) Producing a narrative of multi-agency perspectives

The format of the interviews creates an initial organisation of the data from which the review team constructs accounts of the history of the case. In a traditional review, a single chronology is usually constructed outlining the generally agreed events. In this work, however, the team found that the level of detail needed did not lend itself to compilation into a single story since the subtle differences in people's views were so important. We therefore recommend the production of a set of

narratives, each detailing the history of the case through the eyes of one individual or agency.

b) Identifying 'key practice episodes' and their contributory factors

Within the narratives are a number of key episodes that are then analysed in more detail. This process draws on the interviewees' comments on the contributory factors influencing them at that point and brings together the views of the different participants.

3. Reviewing the data and analysis

Neither data source provides a reliable, consensus view. The documentation of different agencies may conflict in the basic factual details presented or it may have a very different focus. Similarly, interviews reveal how people's different reasons for involvement lead them to focus on different aspects of the family. Putting together the various accounts involves a degree of interpretation by the review team. It is therefore important to check out these interpretations with those interviewed. This can be done by sending draft reports to participants for comment as well as holding group discussion meetings. This is likely to produce some corrections or challenges to the review team's interpretation and also some valuable additional insights. A three-staged process of dialogue between the review team and participants is proposed.

4. Identifying generic patterns of systemic factors that contribute to good practice or make problematic practice more likely

Building on work done in healthcare by Woods and Cook (2001), the deeper analysis of the data categorises them in terms of patterns of interactions. These patterns can either be constructive or create unsafe conditions in which poor practice is more likely. An initial typology of patterns significant for child welfare work is presented. This includes the following six different categories.

Patterns in:

1. Human–tool operation
2. Human–management system operation
3. Communication and collaboration in multi-agency working in response to incidents/crises
4. Communication and collaboration in multi-agency working in assessment and longer-term work
5. Family–professional interactions
6. Human judgement/reasoning

5. Making recommendations

The identification of underlying patterns of systemic factors leads to the identification of issues that need further exploration and, where possible, to the generation of ideas about ways of maximising the factors that contribute to good performance and minimising the factors that contribute to poor-quality work. This

distinction is important; it highlights that recommendations can take three distinct forms that are usefully distinguished.

Firstly, there are those patterns for which there are clear-cut solutions that can be addressed at a local level and are, therefore, feasible for a LSCB to implement, for example, creating a consistent rule across agencies of what the writer means to convey by 'copying in' someone to a letter rather than addressing it directly to them.

Secondly, there are recommendations that cannot be so precise because they will highlight weaknesses in practice that need to be considered in the light of other demands and priorities of the different agencies. This is a task more properly done by the senior management than the review team, for example, more attention in supervision to detecting errors in reasoning requires more time; can that be obtained by cutting back on some other tasks?

The third category of recommendations includes those that point to issues that need detailed development research in order to find solutions, although those solutions would then have wide relevance to children's services. For example, difficulties in capturing risk well when completing Core Assessments indicate a need to research how widespread this problem is and, if necessary, experiment with alternative theoretical frameworks, structuring and formatting of forms and possibly software.

Structure and content of the report

In approaching the task of adapting a systems investigation we were guided by the wisdom acquired in other disciplines about the importance of thinking first about what you are ultimately looking for before deciding how to collect and categorise it (Vincent, 2006; Wallace and Ross, 2006). The alternative approach of first collecting data creates the risk of amassing a mountain of disparate data that is well nigh impossible to make sense of. The structure of the report reflects this. Unlike this summary in which the model has been described in the temporal sequence in which it would be carried out in a case review, in the full report it is described in reverse order. We begin with the goal of the review and work backwards through the process of achieving it.

The challenge of escaping our deeply entrenched frameworks for thinking about and understanding front-line practice should not be underestimated. As we all tend to interpret new material in terms of familiar ideas and concepts, it is easy to misunderstand the fundamental nature of the change in moving to a systems approach and, therefore, to misapply the model. Consequently, the report includes a significant level of detail about the process of both developing and using the model. This includes difficulties encountered and areas for further development.

1 Introduction

1.1 What is this report about?

1.1.1 A new 'systems' approach to learning

Children's safety and welfare are key concerns in all countries, with continual efforts being made to improve child welfare and child protection services. Learning is central to these endeavours as the means whereby current problems can be identified in order that future solutions can be sought. An important question, then, is whether the current repertoire of learning approaches is adequate to the task. Are there better ways of learning that could help improve the delivery of child welfare services and improve outcomes for children and their families? This report presents initial steps towards the development of what is generally called a 'systems approach' to learning in children's services.

In brief, a systems approach seeks to provide a nuanced understanding of front-line practice by getting behind *what* professionals do and illuminating *why* they do what they do. In reviewing past practice, this involves taking account of the situation they were in, the tasks they were performing and the tools they were using etc, in order to highlight what factors in the system contributed to their actions making sense to them at the time. This allows an understanding of how both good and problematic practice are made more or less likely depending on factors in the work environment. Ideas can then be generated about ways of reshaping the environment or re-designing the task so that it is easier for people to do the task well and harder to do it badly.

1.2 Why do we need new methods of learning?

1.2.1 Limitations of current approaches

Traditionally, one of the most public ways of learning has been through the inquiry into a death of a child from child abuse or neglect. In the UK, as in many other countries, these inquiries have had a major influence on the way services have developed (Parton, 2003, 2004; Stanley and Manthorpe, 2004). However, their value has been increasingly questioned as it has become apparent that they keep identifying the same problems in front-line practice and making similar recommendations and yet the problems reoccur. This raises the question of whether the current methods of learning lessons are providing satisfactory explanations of the problems and, therefore, effective solutions.

In other areas of high-risk work, similar problems in improving the quality of services have led to the development of a systems approach. This offers a framework not just for examining cases with tragic outcomes but for conceptualising how services routinely operate and for learning about what is working well or where there are problematic areas. It offers the possibility of novel and more effective solutions, so that steps can be taken to strengthen practice before a tragedy occurs.

1.2.2 Context of major policy change and the importance of inter-agency collaboration

Children’s services have the dual mandate of protecting children and promoting their welfare. In recent years, there has been growing concern that the priority given to the child protection function has been adversely affecting the range and quality of services for supporting families and promoting children’s well-being, especially preventive and early intervention services (DH, 1995; Waldfogel, 1998). This has led to many countries, including all four countries of the UK, adopting highly innovative strategies for widening the remit of children’s services and improving inter-agency working to provide more timely help to a larger number of families.

In England, Wales and Northern Ireland (Scotland is excluded) a new language of ‘safeguarding’ reflects the extension of the aims of children’s services from protecting the small number of children suffering or at risk of suffering significant harm, to enabling and ensuring that *all* children achieve their full potential. This has been linked to the development of high-level outcomes frameworks that, in Northern Ireland and Wales, are drawn from the UN Convention on the Rights of the Child (see Table 1 below). It is against improvements in these outcomes that progress on delivery will be measured.

Table 1: Outcomes frameworks for children’s services in the UK

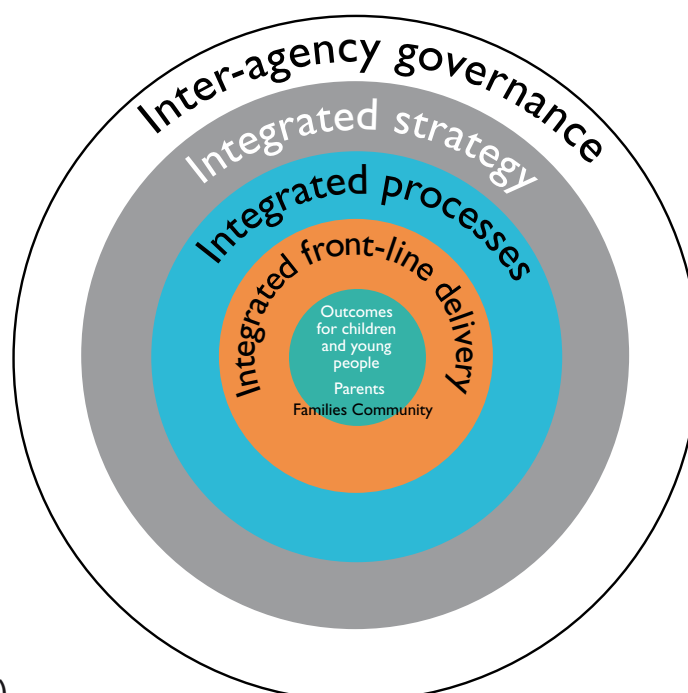
England (HM Treasury, 2003)	Northern Ireland (OFMDFM Northern Ireland, 2006)	Wales (WAG, 2002)
<ul style="list-style-type: none"> • Stay safe • Be healthy • Enjoy and achieve • Make a positive contribution • Achieve economic well-being 	<ul style="list-style-type: none"> • Healthy • Enjoying, learning and achieving • Living in safety and with stability • Experiencing economic and environmental well-being • Contributing positively to community and society • Living in a society that respects their rights 	<ul style="list-style-type: none"> • Have a flying start in life • Have a comprehensive range of education and learning opportunities • Enjoy the best possible health and are free from abuse, victimisation and exploitation • Have access to play, leisure, sporting and cultural activities • Are listened to, treated with respect, and have their ‘race’ and cultural identity recognised • Have a safe home and a community which supports physical and emotional well-being • Are not disadvantaged by poverty

This is a major change in policy. The new 'safeguarding agenda' has significantly extended the goals and tasks of child welfare work. No longer is intervention aimed only at children 'in need' or 'at risk' but also at the early identification of the far larger group of children who in England are categorised as having 'additional needs' beyond those met by the universal services. The range of organisations and professions tasked with achieving these extended goals has also been significantly broadened. Safeguarding is now 'everyone's business' (cf DfES, 2006). Responsibility is ascribed not just to social workers but also to 'those working in childcare settings, schools, health services, social care, youth services, the police and criminal justice system and culture, sports and play organisations' (DfES, 2004: 7).

Far-reaching and complex changes in structures, roles and working practices have accompanied this policy change. These are aimed at strengthening partnership among these disparate bodies and workers, and producing integrated approaches to service planning, processes, provision and governance. They include new tools for use by the extended range of people. Key here is the introduction of a standardised approach to carrying out an assessment of a child's and their family's additional needs and deciding how those needs should be met. In England and Wales this is referred to as the Common Assessment Framework (CAF), in Northern Ireland as Understanding the Needs of Children in Northern Ireland (UNOCINI). In all countries, these tools are seen as playing a key part in ensuring a more effective, earlier identification of additional needs and improving integrated working and processes across agencies by promoting coordinated service provision.

For our purposes the details of these changes, and differences between countries, are less significant than the scale of the change occurring and the centrality of multi-agency/professional working in them. Both points are illustrated clearly in the English government's 'onion' diagram below (see Figure 1).

Figure 1: The English government's model of whole-systems change



Source: DfES (2004: 6)

This policy context gives the need for new methods of learning a pressing urgency for two key reasons outlined below.

Learning together horizontally: front-line workers from different agencies/ professions need to learn about and from each other

Inter-agency and inter-professional working in child welfare work represents something of a conundrum because it is simultaneously seen as both the problem and the solution (Hudson, 2000; Rose and Barnes, 2008). Current UK policy context requires increased communication and collaboration across agencies and professions in the provision of safeguarding and child protection work, yet this is known to be a complex task where misunderstandings, omissions and duplications easily occur (Munro, 1999; Reder and Duncan, 1999, 2003). The challenge of translating policy aspirations into behavioural change on the part of practitioners and front-line managers, therefore, brings the issue of learning to the fore.

Practitioners need to develop an understanding of the commonalities and differences between their own professional patterns of thought and action and those of others, as a precursor to integrated professional practice. This is evident in the English government's aspirations for the evolution of a 'common language' among child welfare practitioners (for example, DH et al, 2000; Cleaver et al, 2004; Axford et al, 2006), although whether this is either feasible or desirable is debated (for example, Reder and Duncan, 2003; White and Featherstone, 2005; White et al, 2008). Either way, opportunities and methods for learning from and about each other are required.

Learning together to safeguard children, the title of this report, is a play on a key government policy document in England called *Working together to safeguard children* (HM Government, 2006), that sets out guidance on how individuals and organisations should work together to safeguard and promote the welfare of children. With this, we draw attention to the need for practitioners from across multiple agencies and professions to be included in singular learning processes. The systems approach offers a valuable mechanism for achieving this.

Learning together vertically: policy makers and senior/strategic managers need to learn about and from the realities of front-line practice

The second impetus for new learning methods stems from a different conundrum. This relates not to the role of inter-agency/professional working on the front line but to the task of policy makers and those responsible for managing children's services. On the one hand, it is right and proper for ministers to determine what the priorities and directions of government policy and action should be. On the other hand, however, it is increasingly difficult for them, or those responsible for strategic and operational management within individual delivery agencies and the interagency system (epitomised, in England, in Local Safeguarding Children's Boards, or LSCBs), to dictate with any confidence how exactly to achieve those goals. Two key, overlapping issues are involved.

Firstly, the *delivery* of public services always depends on the actions of people and institutions that cannot be directly fully controlled by central government departments and agencies (Chapman, 2004). A so-called command and control approach is, therefore, of limited use. Secondly, children's services is a 'complex' system that means that the relationship between cause and effect is not straightforward. Implementation plans are, therefore, easily scuppered by the non-linear dynamics both within and between delivery organisations. Put simply, policy and management interventions and guidance may have unpredictable and unintended consequences (Axelrod and Cohen, 1999). Again, therefore, the challenge of translating policy aspirations into practice brings the issue of learning to the fore.

Rather than presuming to know best about the 'how' of achieving policy goals, those in top positions in the hierarchy need opportunities and methods for learning *from* front-line workers and their managers. This is imperative if feedback is to be obtained about the actual effects of new policies and guidance, strategic and operational decisions *on the ground*. By calling this report 'learning together', then, we draw attention to the need not only for horizontal learning across agencies but also for methods of learning together vertically, between practitioners and front-line managers and those at a senior/strategic level locally as well as policy makers at a national level.

This need is made urgent by the scale of change being planned in the Safeguarding Agenda. The broadening of workers' goals and tasks, combined with many new information tools and forms, will transform the experience of front-line work. The skills required for the broader task of 'safeguarding' are different from the highly specialist task of 'child protection'. It is crucial to ascertain whether workers have the necessary and relevant expertise to implement the changes, whether they find the new tools are helping them work better, and, most importantly, whether children are benefiting from it all. The systems approach offers a reliable approach to understanding front-line practice in order to be able to learn from it.

1.3 How have we gone about it?

1.3.1 Background

Phase I of this project started an important debate about the management of risk at an organisational level in children's services, as distinct from the assessment of need for an individual child. It demonstrated the potential of risk management strategies developed in other sectors, particularly the promotion of learning *before* harm is caused to children, and the use of a systems approach to investigating errors and learning how to improve practice. It culminated in the Social Care Institute for Excellence (SCIE) report *Managing risk and minimising mistakes in services to children and families* (Bostock et al, 2005).

Yet translating methods across fields of practice is inevitably a complex process. While social work academics (for example, Munro, 2005; Lachman and Bernard, 2006) had argued for the benefits of adopting a systems approach in child protection and safeguarding work *in theory*, scant research evidence was available on the feasibility of this in practice (for example, Rzepnicki and Johnson, 2005). Further

research and development work was, therefore, required to adapt the engineering and health models of a systems approach to the nature of safeguarding and child protection work so that it might work in practice.

1.3.2 Trying it out in practice

Against this background, Phase II has consisted of trying out the systems approach in practice. In two different inter-agency forums we have worked collaboratively with practitioners to conduct pilot case reviews. Methodologically these test reviews were conceptualised in terms of participative action research. The aim was to enable the SCIE team and participants to be jointly involved in a continual cycle of reflection and learning throughout the course of the case reviews in order to progressively adapt the systems model in the process. A scoping review of the safety management literature provided the theoretical underpinning of this work and is available on SCIE's website (www.scie.org.uk). Further details of our conduct of the pilot cases are provided in Chapter 3 of this report.

Despite positive interest from Wales and Northern Ireland and significant arrangements with sites in both countries, pragmatic constraints meant that the planned collaboration could not, in the end, proceed. One site was dealing with the aftermath of a tragedy and, in the other, plans coincided with a large inspection process. Both our pilot sites were, therefore, in England.

1.3.3 This report and other project publications

The ultimate aim of the research and development (R&D) work described above was to develop an adapted model of the systems approach for use in case reviews of safeguarding and child protection work. This is presented in summary form in the publication *How to conduct a systems case review in children's services* and is available on SCIE's website (www.scie.org.uk). Various practice tools accompany this brief document. However, it is important that the 'how to do it' document is not the sole publication of this work.

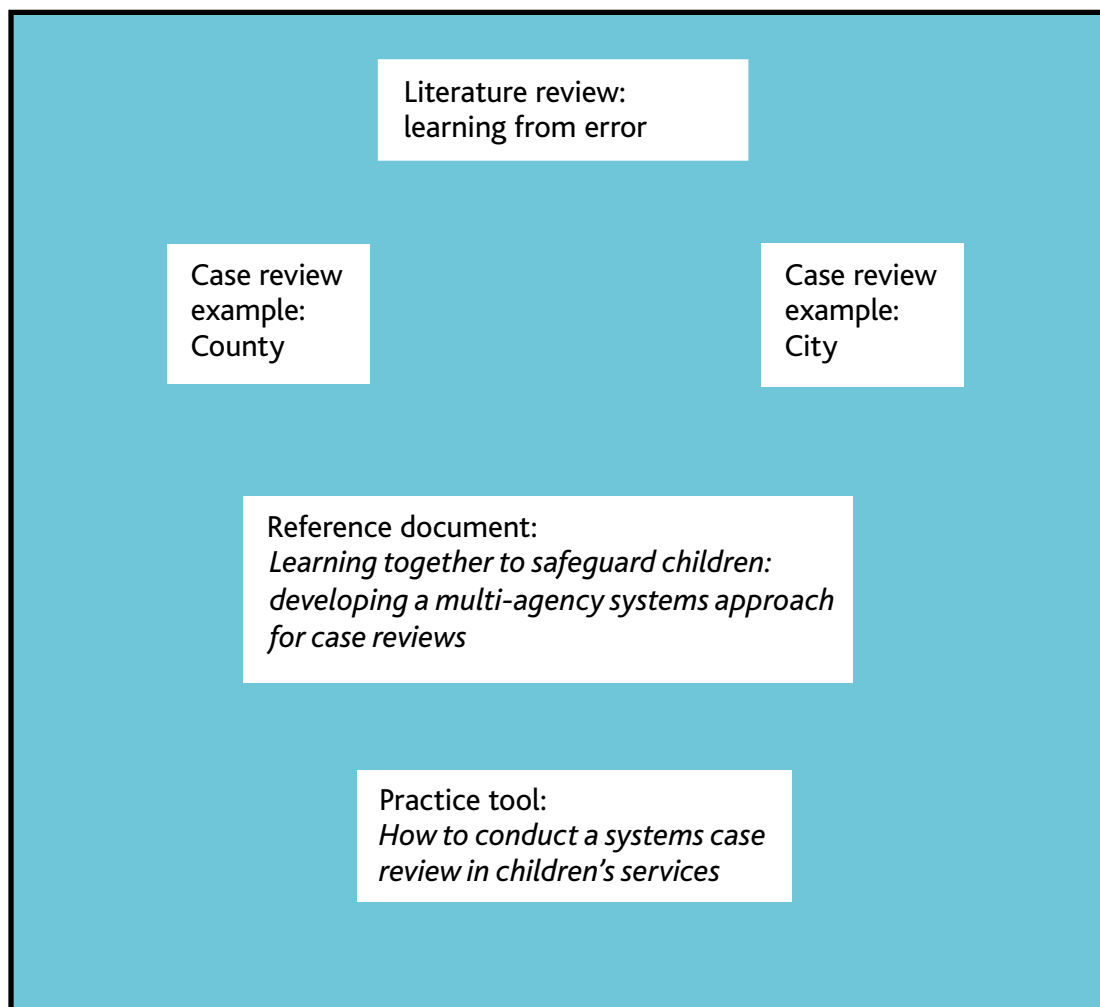
Based as it is on the learning gained from only two pilot case reviews, the model we present should only be considered an initial version. Rather than becoming set in stone, there is a need for it to be tried out and discussed in order that it can be further refined and developed. Yet our experience from the pilot case reviews has taught us that putting the systems approach into practice is far from easy. This is not connected to the theory of the model, which is relatively straightforward. Instead, it is the challenge of escaping our deeply entrenched traditional frameworks for thinking about and understanding front-line practice that cannot be underestimated. As we all tend to interpret new material in terms of familiar ideas and concepts, it is easy to misunderstand the fundamental nature of the change in moving to a systems approach and, therefore, misapply the model (cf Dekker, 2002b). Both these issues mean that it is important that we make transparent not only the final outcome in the form of the model itself but also how we developed our thinking in the adaptation and application of it.

To this end we have made available our unpublished interim working documents on SCIE's website as illustrated in Figure 2 below. These include the scoping review of literature relevant to the systems approach and the pilot case reviews themselves, which include detailed accounts of the methodology and reflections on the process:

- 'A review of safety management literature' (Eileen Munro)
- 'A new approach to case reviews: developing an inter-agency systems methodology in children's services. County'
- 'A new approach to case reviews: developing an inter-agency systems methodology in children's services. City'

It is important to stress that the pilot case reviews were a key part of our working method and are not proffered as exemplars.

Figure 2: Range of project outputs



This report can be considered the main reference document for this work. It draws on all three of the above interim working documents. The 'how to' publication has, in turn, been drawn from it. It presents an exposition of the model both in terms of both 'what to do' and 'why', addressing the theoretical premise. It includes a

significant level of detail about the actual process of both developing and using the model, including, and especially, about difficulties that we encountered. Vignettes from the case studies are used throughout as illustrations. Importantly, we have also included the identification of several key debates and areas for further development. Consequently, it is not insubstantial. However, for the specific audience of those who conduct case reviews and want to try these new methods out for themselves, we hope it will be of significant help.

1.4 Starting in the thick of the dialogue and clarifying meanings of key terms

Many of the terms used in this report are familiar but in the course of the work we have become acutely conscious of the rival ways in which they are understood. Within a systems framework, they are used very precisely and often in ways that are odds with their meaning in other discourses. Consequently, in order to avoid confusion, we need to start in the thick of the dialogue and complete this introduction with some key clarifications. This is important for our purposes of introducing the model. Successful use of the model in a multi-agency and multi-disciplinary/professional context also requires time to be spent on gaining a shared understanding. More detailed explanations follow in the main body of the report.

1.4.1 By 'systems issues' do we just mean policies, procedures and protocols?

When talking about 'systems', people often think in terms of policies, procedures and protocols, hence the question: 'Are the appropriate systems in place?'. In the systems approach that we are presenting, the term 'systems' is used in a far broader sense and includes *all* possible variables that make up the workplace and influence the efforts of front-line workers in their engagement with families. Importantly, as well as the more tangible factors like procedures, tools and aids, working conditions, resources etc, a systems approach also includes more nebulous issues such as team and organisational 'cultures' and the covert messages that are communicated and acted on. It treats these apparently softer factors as systems issues as well.

Commonly, talk about systems as policies, protocols and procedures includes an assumption that protocols and procedures are a key part of the solution to whatever problem in front-line practice is at hand. Compliance with procedures is, thus, presumed to be linked to safety and the attainment of good outcomes. There are two problems with this. Firstly, at best, procedures only provide outline advice on what to do with the result that in many cases procedures can be followed but practice may still be faulty. Secondly, while procedures are generated from the wisdom of experienced workers and, increasingly, according to evidence-based knowledge, there is no empirical evidence to show that they are 'right' in the sense of guaranteeing the best outcomes for children. There is always a possibility that they may themselves contribute to adverse outcomes. Consequently, in a systems approach one assumes that the actual impact of procedures needs to be confirmed by findings. They are seen as part of the work environment to be reviewed, as they interact both with workers and other factors to influence the quality of front-line work.

1.4.2 Is this about better understanding families, linked to systemic family therapy ideas?

There is a long history of systems thinking in child welfare work and it is particularly familiar to social workers through the family therapy literature and the use of its principles as a means of understanding family dynamics and improving the assessment of children by focusing on their systemic family context. In this framework the focus is on better understanding families by treating the family as a system.

The focus of the systems approach that we are presenting is not on families, but on front-line practice. This, of course, includes families in their interactions with front-line workers but this is only one of multiple interactions that are brought under the spotlight. In order to better understand front-line practice, the focus of a systems approach is on the macro or total system, if you like, of which the family is just one part or sub-system, albeit an important one.

1.4.3 Is it the same as root cause analysis?

Root cause analysis is a term familiar to health colleagues and others in the UK because it has been taken up and promoted by the National Patient Safety Agency (NPSA) as a method for the investigation of patient safety incidents. It originated in industry and provides an assortment of useful techniques and tools for identifying 'root causes' from the investigation and analysis of incidents (see www.npsa.nhs.uk/patientsafety/improvingpatientsafety/rootcauseanalysis/). It is a concept that overlaps closely with a 'systems approach' but the name itself is misleading (Taylor-Adams and Vincent, 2004) so we have chosen not to use it.

The term implies that there is a single root cause to any incident, when typically incidents arise from a chain of events and the interaction of a number of factors. It also implies that the purpose of the investigation is restricted to finding out the cause of the particular incident under investigation rather than learning about strengths and weaknesses of the system more broadly, and how it may be improved in future. Putting the word 'system' in the name draws attention to a key feature of the model – the opportunity it provides for studying the whole system, learning not just of flaws but also about what is working well.

1.4.4 Is this about learning from mistakes and near misses?

Case reviews or inquiries can be conducted for a variety of reasons

In engineering and high-risk industries, systems analysis is used primarily in accident investigations and near misses. In health, similarly, root cause analysis tends to be used for the analysis of so-called 'patient safety incidents' – where things have gone wrong and harm has been, or could have been, caused. This has led some to think that a systems approach is inherently 'adverse incident driven'. Consequently, some dismiss the possibility of its relevance for reviewing child welfare practice because, it is argued, it 'is not a good methodology for considering cases of neglect or most cases of sexual abuse' (Brandon et al, 2008: 27) in which the neglect or abuse

extends over some time. Such an argument confuses the logic of a systems approach with the context in which it tends to be used.

You have to have a reason for conducting an inquiry or case review regardless of the method of learning used – some curiosity to answer some question. However, the reason does not need to be a specific adverse event happening to a child. It can just as well be recognition of the level of neglect the child is suffering and questioning why it was not noticed sooner, a decision to remove a child or noticing that the family has not changed significantly in a number of years so it is worth doing a deep re-think on how the case is being handled. Equally, the focus of curiosity can be either a particularly successful case or one considered to represent routine or normal practice, with a view to gaining a deeper picture of how the system is operating to support front-line workers. In this sense, then, the systems model we are presenting is not about learning from mistakes specifically and, as we will argue later, there are very good reasons not to prioritise learning from tragedies to the exclusion of other triggers.

Identifying incontrovertible mistakes is difficult in child welfare

There is another way too, in which the model we are presenting is not about learning from mistakes. This relates to the fact that a 'mistake' or error is a problematic concept in the field of child welfare, where the knowledge base is less developed and practitioners have relatively little scope to control the whole environment where change is sought. Errors are defined in relation to some standards as to how the work should be carried out. This presupposes some standard of 'correct' performance against which a shortfall can be judged. Compared with engineering and health, however, there are far fewer processes in child welfare services where there is consensus on exactly the right way to work with families. There are few instances where one can confidently say 'this is the correct course of action' or 'if I do X then the outcome will be Y'.

This requires that we distinguish between *outcome* failures or incidents and mistakes in the *process* in any judgement of practice, because a good decision process can lead to a poor outcome and a poor decision process can be followed by a good outcome. For these reasons, in producing a systems model for child welfare, we consciously employ only a limited use of the language of error and mistakes, and talk instead of good and problematic practice.

1.4.5 Does 'no blame' mean 'no judgement'?

A systems approach is often described as a 'no blame' approach and it is understandable, therefore, that this can lead to an expectation that the model does not include any judgement of the practice of individual front-line workers. Yet this is a false assumption; the systems model as developed in other fields is premised on the definition and identification of errors whether of omission or commission. The first step in any analysis is to identify so-called 'active failures' or 'process failures' carried out by those at the sharp end of the system and only subsequently to consider how the conditions in which those errors occurred influenced staff performance. Human error becomes the starting point of an investigation and not

the conclusion. In child welfare too practitioners involved in a case review using a systems approach should expect that the quality/adequacy of their practice will be judged as good or problematic, even if incontrovertible mistakes cannot be identified.

1.4.6 Does 'no blame' mean no accountability? What about the 'bad apples'?

Descriptions of a systems approach as a 'no blame' approach also often lead to concerns that there is no recognition of personal responsibility or accountability in the systems model. Hence the question arises: 'What about the bad apples?'. As with 'root cause analysis', language here proves misleading and unhelpful:

The slogan of 'moving beyond a culture of blame' in the patient safety movement is a call to abandon *poor* systems of accountability and ... *not* a tolerance for an absence of accountability. (Woods, 2004: 3; emphasis added)

Consequently, it has been argued that a better description of the objective is the development of 'an open and fair culture' which 'requires a much more thoughtful and supportive response to error and harm when they do occur' (Vincent, 2006: 158).

What the systems approach highlights is that holding a particular individual or individuals *fully* responsible and accountable is often highly questionable because, as stated earlier, typically incidents arise from a chain of events and the interaction of a number of factors, many of which are beyond the control of the individual concerned. Decisions about culpability, therefore, need to be far more nuanced and tools have been developed to aid this process, such as Reason's 'culpability matrix' (Reason, 1997) and the UK NPSA's *Incident decision tree* (2004). There is, however, nothing inherent in the model to prevent the recognition and identification of, for example, malicious practice where the causing of harm was intended.

1.5 Structure of the report

The following two chapters provide further background material by presenting, firstly, in Chapter 2, an introduction to the history of the development of a systems approach in other fields and its relevance to child welfare. Then, in Chapter 3, more detail is given on how we carried out the pilot case reviews, including brief synopses of the cases themselves.

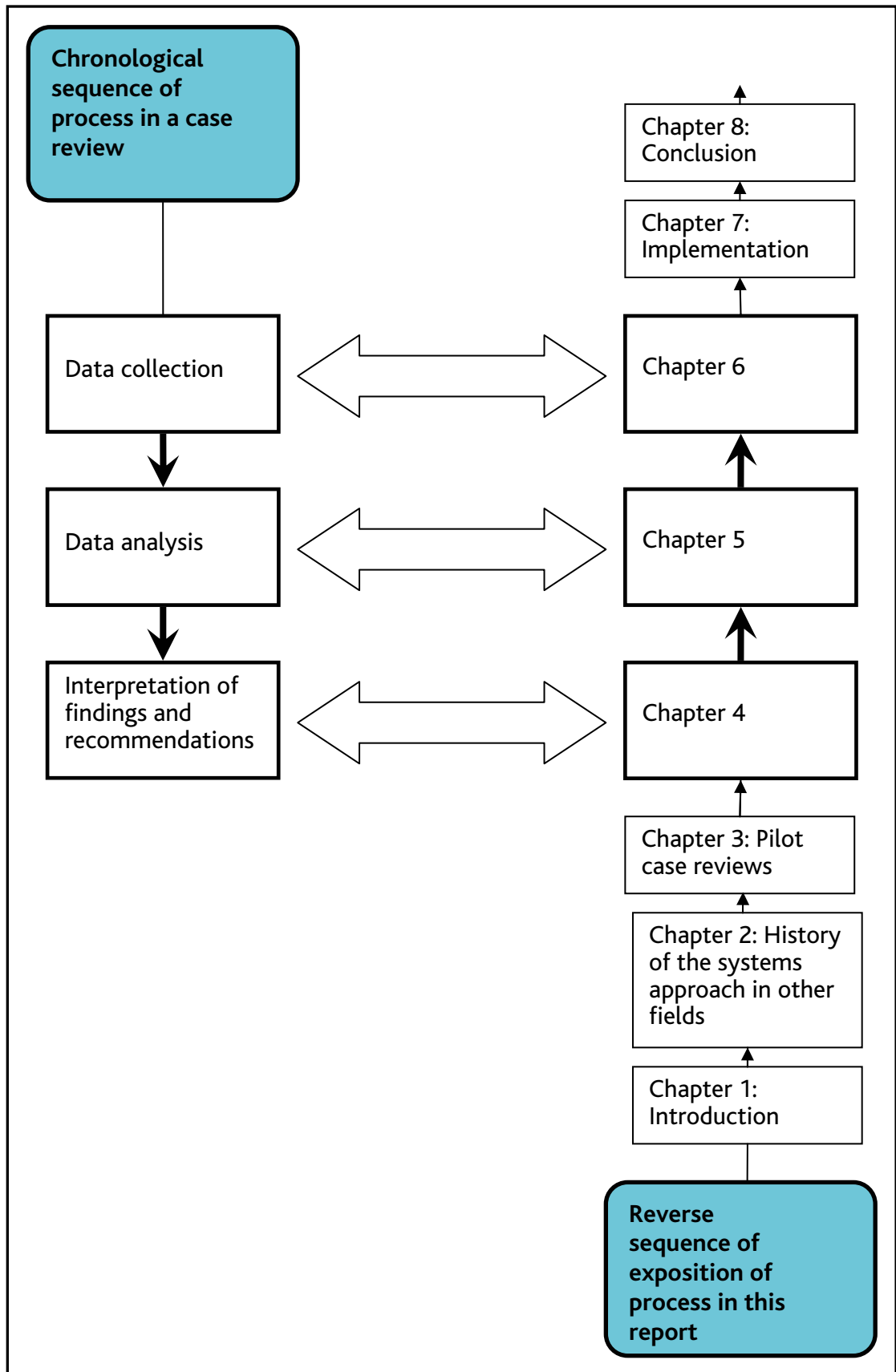
The exposition of the adapted systems model is presented in the main body of the report – Chapters 4, 5 and 6. The standard format would be to present it in the sequence in which it is intended to be used – data collection would be followed by methods for its analysis, and the interpretation of findings and making of recommendations would come at the end. The 'how to do it' practice tool is structured in that way; however, for our purposes in this reference report there would be significant drawbacks to the reader of such a chronological ordering. Most importantly, it would underplay the influence of theoretical assumptions and the reviewer's position in relation to the case on what is observed and which aspects of it are described and which ignored.

Instead, therefore, the chapters are structured by beginning with the aim of the review and working backwards through the process of achieving that goal – see Figure 3. This is unusual and may be disconcerting to readers but, we hope, in a useful way. By beginning explicitly with how we want to analyse the data, it encourages reviewers to explain and justify their choices in collecting and categorising data; it helps you decide what data to collect and how to categorise it. It also reduces the risk of amassing a large random quantity of data that it is difficult to analyse.

Discussion about what kinds of case are most usefully reviewed in this manner using the systems model and, therefore, different ways in which the model might be implemented, are dealt with in Chapter 7. This chapter also locates the model in relation to the current approaches to case reviews in the UK, including discussion of how the model links with current English government guidance on serious case reviews and Ofsted’s evaluation criteria.

Chapter 8 concludes with a summary and brief note on what we hope will be the next steps to furthering this approach.

Figure 3: How report structure relates to the case review process



2 The development of a systems approach in other fields and its relevance to child welfare

We noted in the introduction that learning is often central to efforts to improve child welfare and child protection services; it is a key means through which current problems are identified and future solutions sought. In the UK, public inquiries and serious case reviews (SCRs) into a tragic death or serious injury of a child from child abuse or neglect form a key plank of the repertoire of learning methods. Yet their value has been increasingly questioned as it has become apparent that they keep identifying the same problems in front-line practice and making similar recommendations and yet the same problems reoccur.

Other fields have a similar history of inquiries producing recommendations that failed to lead to the desired improvements, particularly high-risk engineering industries such as aviation and nuclear power. This has led investigators to reformulate their ideas of how accidents are best studied. The shift from the traditional to the new form of inquiry has been described as that from a person-centred to a system-centred approach (Reason, 1990). This chapter provides a summary of these developments.

We begin with an account of the methodology of the traditional inquiry, the type of solutions it produces and some of the reasons for its appeal. Similarities to the situation in the field of child welfare practice are highlighted. The alternative approach of seeing human error in its wider systemic context is then presented, including more recent adaptations to the model. We end by considering key features of safeguarding and child protection work that pose a challenge to the engineering model and underline the need for its adaptation.

2.1 The traditional 'person-centred' approach

2.1.1 Human error as the cause of accidents

Erratic people degrade a safe system so that work on safety is protecting the system from unreliable people. (Woods et al, 1994)

When an accident or tragedy occurs, it has been a standard and understandable response for people to ask why and how it happened. This leads to an inquiry into its causation. These generally have at least two aims: the first is to learn where in the process the error occurred with a view to learning how to prevent a recurrence and the second to judge whether any individual(s) were responsible and to allocate blame.

In analysing why something happened, we follow a chain of events back into the past, seeking a causal explanation for why the process did not proceed as expected and led to the undesired outcome. In the traditional inquiry into accidents and mishaps, unless there is evidence of technical failure, the causal factor most commonly identified is human error. There is a remarkably consistent finding of 70–80 per cent of inquiries across a range of industries and professions attributing

tragedies to human error: in anaesthesia (Cooper et al, 1984; Wright et al, 1991), and in aviation (Boeing Product Safety Organization, 1993). That is to say, that of the myriad causal factors in the complex sequence of events that led to the final accident, the actions of one or more humans are picked out as being of crucial causal significance. These usually focus on the errors of omission or commission of someone close or closest to the accident – *if only* this worker had taken the correct action *then* the accident would not have occurred.

The parallels with child abuse inquiries are illustrated dramatically in the treatment of Victoria Climbié's key social worker on whom much of the blame for Victoria's death was put,¹ reflected in the fact that she was sacked from her job and placed on the Protection of Children Act list of those deemed unfit to work with children in any capacity. The prevalence of this person-centred approach in child welfare also seems to have statistical similarity – one study of child abuse inquiry reports (Munro, 1999) that collected data on the judgements reached by the inquiry teams found that in 75 per cent of cases human error was cited as being a significant factor.

2.1.2 Solutions as the reduction or control of human elements

When the traditional inquiry is satisfied with human error as the explanation, then it logically produces solutions based on that conclusion. If safety is regarded as having been corrupted by human error, it follows that improving safety requires reducing or controlling human performance. This has been accomplished in three main ways:

- Psychological strategies. Punishments or rewards have been used to shape performance and encourage people to operate at a higher level. Naming, shaming and blaming those deemed responsible gives a powerful message to others about the need to improve the standard of work. Management, too, can introduce strategies that monitor and reward a greater attention to complying with accepted standards of good practice.

¹ 'Victoria Adjo Climbié was born near Abidjan in the Ivory Coast on 2 November 1991, and was the fifth child of seven children. In November 1998, she travelled with her aunt, Marie Therese Kouao, to Paris and eventually arrived in London on 24 April 1999. In the following 18 months, the family were known to four different local authority social service departments, two hospitals, two police child protection teams and a family centre run by the NSPCC (National Society for the Prevention of Cruelty to Children). However, when she died on 25 February 2000, the Home Office pathologist found 128 separate injuries on her body as a result of being beaten by a range of sharp and blunt instruments. No part of her body was spared. Marks on her wrists and ankles indicated that her arms had been tied together. It was the worst case of deliberate harm to a child that he had ever seen. Marie Therese Kouao and her boyfriend, Carl Manning, were convicted of her murder on 12 January 2001. The government immediately set up a public enquiry chaired by Lord Laming to investigate the involvement of the various public agencies in the case and to make recommendations for change to ensure that such a death could be avoided in the future. The report of the Inquiry (Laming 2003) was published on 28 January 2003' (see Parton, 2006: 977).

- Reducing the autonomous role of humans as much as possible. In engineering, increased automation, replacing human operators with machines, has been a major solution. Even where individuals cannot be removed from the process, there are ways to reduce their scope for independent decision making by introducing increasingly detailed procedures and protocols to provide a step-by-step account of how the operation should be carried out.
- Increasing monitoring of the workforce to ensure they are complying with rules and guidance. As procedures and protocols play a more significant part in practice, there is a corresponding need to check that they are being followed and to intervene and punish if deviations are observed.

All these solutions will be familiar to people in child welfare services. Reductions in the role of the individual worker are most prominently evidenced in the increased amount of guidance and prescription provided through standardised protocols, detailed procedures and guidelines as well as decision-making aids. A more recent phenomenon has been the introduction in some agencies of actuarial tools for making risk assessments or decisions about interventions, reducing the worker's role to inputting the data but giving the tool the task of computing the data and producing a conclusion. Increased surveillance is apparent in the growing requirement to document actions and to work towards targets and performance indicators (PIs) set by government.

The person-centred model of accident causation

The dominant image in person-centred investigations has been Heinrich's 'domino theory' (see Figure 4 on page 22). In this conceptualisation, human error triggers the next error, and so on, until the accident happens – like a row of dominoes falling. The process is fully determined and there is an identifiable first step in the chain.

2.1.3 The limitations

Its solutions are not effective enough

All these solutions, at first glance, look very sensible. Indeed, it is possible to find numerous examples where they have contributed to substantial advances in safety management. Psychological pressure on the workforce prioritises the importance of safety. Automation has, in many cases, replaced fallible humans with highly reliable machines. Procedures and protocols try to capture the wisdom of the most expert and, increasingly, evidence-based knowledge and make it available to all operators, reducing the chances of error occurring due to ignorance. Surveillance improves the organisation's knowledge of what is going on and so increases the possibility of spotting weak points in the process that need further attention.

The traditional approach has clearly made a significant contribution to improving safety and the quality of practice but it began to be questioned primarily because of its empirical limitations: accidents were still occurring (Rasmussen, 1990; Reason, 1990). Its solutions, while eradicating some problems, were not sufficient to reduce the risk of accident to an acceptable level.

Its solutions create new problems

Besides a concern that the traditional approach was not producing good enough solutions, there was increasing concern that the solutions it produced were themselves contributing to new forms of error and unintentionally contributing to the causation of future accidents. Increased psychological pressure, automation, proceduralisation and surveillance all alter the context in which people operate and, in some cases, alter it in undesirable ways.

'Alarm overload' is one example of how solutions can unintentionally create new problems. Traditional inquiries have frequently led to the introduction of alarm mechanisms to ensure that operators are alerted if a mechanical failure occurs. Each alarm has the sensible function of alerting operators to the existence of a specific problem in the equipment or process. When a single red light comes on, operators can see it and know they need to look at a particular part of the equipment to find the cause. The problem arises when several light up at once, as happens in a crisis. Then operators quickly become overwhelmed and confused by the alarm system so that they are unable to interpret what is going on and deal effectively with the crisis.

One space controller in mission control made the following comment after the Apollo 12 spacecraft was struck by lightning:

The whole place just lit up. I mean, all the lights came on. So instead of being able to tell you what went wrong, the lights were absolutely no help at all. (cited in Woods and Hollnagel, 2006: 88)

In their efforts to make the system safer, engineers had inadvertently changed the nature of the tasks required of the operators so that they were a challenge to human cognitive abilities and so harder for the operators to carry out well.

The parallels noted earlier in relation to the types of solution prevalent in child welfare inquiries also extend to the discovery that they are not working exactly as expected and indeed creating new problems. Naming, shaming and blaming those deemed responsible for errors, both internally and publicly by and via the media, produces climates of fear and cultures of blame. On the one hand, this is seen by many as a contributory factor to the current recruitment and retention problems being experienced by many child welfare systems, which in itself creates a new form of vulnerability. On the other hand, there is evidence that the potential culpability for preventable harm to children known to services is becoming a preoccupation for practitioners and managers. Instead of improving the quality of practice and outcomes for children, this runs the danger that blame avoidance becomes the goal, over and above the promoting and protecting the welfare of the child (White and Wastell, 2007).

Similarly, with the increased 'paperwork' linked to the increasing proceduralisation of tasks and their close monitoring, "putting (data) in" and "going out" to see families' (Peckover et al, 2008: 391) have, inadvertently, been made into competing priorities. It is now being questioned whether the cumulative effect of this is dramatically reducing the amount of time left to talk to children and parents and what effect this

might be having on the service users' perceptions of the service and on the quality of assessments and decisions.

Lastly, key indicators of performance that support the system of regulation and proceduralisation have led to suspicion that things that are easily measurable become what is valued; skills involved in doing what many would argue is the core of the job, like talking to children, become neither supported nor rewarded. There is also growing evidence that PIs are inadvertently creating new sources of accountability and blame (White and Wastell, 2007).

2.1.4 Initial challenges to the orthodoxy

The pressure to find a more effective approach was experienced most strongly in high-risk industries, where mistakes caused the loss of life, not just the loss of industrial output. Foremost among the researchers for improving safety were the US military forces, in particular the Air Force. This research started to reveal how features of the work environment made human error more or less likely.

An early example comes from 1947, when Fitts and Jones (1947) demonstrated how features of Second World War airplane cockpits systematically influenced the way in which pilots made errors. Pilots often confused the flap and landing gear handles because these often looked and felt the same and were located next to one another. In a typical accident, a pilot would raise the landing gear instead of the flaps after landing, damaging the propellers, engines and air frame. Such errors were shown to be not random individual failings but systematically connected to features of people's tools and tasks. The mistakes became more understandable when researchers looked at the features of the world in which the pilots were operating, and analysed the situation surrounding the pilot. The potential to operate the wrong control was built into the design and error was particularly likely when there were a lot of tasks demanding the pilot's attention, as there were when coming in to land. During the war, pilots had developed a short-term solution of fixing a rubber wheel to the landing gear control and a small wedge-shaped end to the flap control. This basically solved the problem by making it easier for pilots to select the right handle and, therefore, reducing the rate of human error.

This kind of research laid the basis for the development of the 'new' systems approach. A key change, illustrated in the above example, involved seeing error as relative to the context, not as an absolute.

2.2 The 'new' systems approach

2.2.1 Human errors are consequences not just causes

Errors are consequences not just causes ... they are shaped by local circumstances: by the task, the tools, and equipment and the workplace in general. If we are to understand the significance of these contextual factors, we have to stand back ... and consider the nature of the system as a whole. (Reason and Hobbs, 2003: 9)

The cornerstone of a systems approach is to take human error as the starting point of an investigation and not its conclusion. In the traditional inquiry, the mistaken action by the front-line worker closest in space and time to the accident has tended to be judged to be the cause of it. In a systems approach, in contrast, when human error is identified the investigation looks for causal explanations for the error in all parts of the system, not just within the individual. The so-called human operator is only one factor. The final outcome is the product of the *interaction* of the individual with the rest of the system. In other words, the causes of errors are looked for not just within the skills and knowledge of the individual operator but also in the many layers of causal factors that interact to create the situation in which the operator functioned.

A systems approach, then, is linked to a significant change in how the nature of causality is understood. Compared to the person-centred approach, it presupposes a more complicated picture. Recognition of the multi-factorial nature of causation has highlighted the importance of identifying *where* in the system the causal factors lie. It demands a multi-faceted explanation as to *why* errors occur. The goal of a systems approach, then, is not to understand why a particular accident happened and identify the person responsible but to build up understanding of how errors are made more or less likely depending on the factors in the task environment.

2.2.2 Solutions seek to make it harder for people to do something wrong and easier for them to do it right

A systems approach demands a multi-faceted explanation of why errors occur and this has implications for the type of solutions produced by this means. Improving safety involves identifying innovations that maximise the factors that contribute to good performance and minimise the factors that contribute to error.

Rather than presuming that it is within the control of an individual worker to act differently, avoid errors and therefore prevent accidents, a systems approach seeks to re-design 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: 2). The example cited earlier of re-designing the structure of the flap and landing gear handles in a plane shows how the solution involved making it easy to distinguish the two so that it was harder for the pilot, preoccupied with all the tasks required at landing, to confuse the two and make a mistake.

2.2.3 Systems models of accident causation: increasing complexity, decreasing predictability

Swiss cheese model

In place of the domino metaphor, the dominant image in systems-centred investigations has been Reason's 'Swiss cheese' model (see Figure 5 on page 22). He conceptualises a system as having a series of defence layers to detect and prevent error. These defences can be technological, dependent on people's actions, or on procedures and administrative controls. In an ideal world, each defensive layer would be intact, like sturdy slices of cheddar:

In reality, however, they are more like slices of Swiss cheese, having many holes.... The presence of holes in any one 'slice' does not normally cause a bad outcome. Usually, this can happen only when the holes in many layers momentarily line up to permit a trajectory of accident opportunity – bringing hazards into damaging contact with victims. (Reason, 2000: 769)

In this Swiss cheese model, an important distinction is made between two types of error:

Active failures are the unsafe acts committed by people who are in direct contact with the patient or system. They take a variety of forms: slips, lapses, fumbles, mistakes, and procedural violations. Active failures have a direct and usually shortlived impact on the integrity of the defences.

Latent conditions are the inevitable 'resident pathogens' within the system. They arise from decisions made by designers, builders, procedure writers, and top level management.... Latent conditions have two kinds of adverse effect: they can translate into error provoking conditions within the local workplace (for example, time pressure, understaffing, inadequate equipment, fatigue, and inexperience) and they can create longlasting holes or weaknesses in the defences (untrustworthy alarms and indicators, unworkable procedures, design and construction deficiencies, etc). Latent conditions – as the term suggests – may lie dormant within the system for many years before they combine with active failures and local triggers to create an accident opportunity. (Reason, 2000: 769)

In this model, the case for focusing on latent more than on active errors in investigations is that: 'Unlike active failures, whose specific forms are often hard to foresee, latent conditions can be identified and remedied before an adverse event occurs' (Reason, 2000: 769).

Emergent model

Reason's Swiss cheese model of investigation has flourished for decades and is responsible for many of the lessons now generally adopted. However, since the 1990s, its adequacy for responding to the empirical challenges of accident investigation has been increasingly challenged. There is an emerging school of thought arguing that the developments in natural science involving complexity and non-linear dynamics undermine the common assumptions about linear causality and predictability. This change has major implications for the whole framework in which error investigations are conducted.

The Swiss cheese model was developed because empirical problems linked to the domino model indicated that it offered too simplistic a model of the work environment. This defect has been magnified in recent decades as systems have come to involve a more diverse range of organisations and become more inter-connected, with a greater use of communication technologies and a dramatic increase in the pace of change within them. Consequently, it is argued, there is an increased need to take non-linear dynamics into account and this has repercussions for the model of accident causation.

The Swiss cheese model can be regarded as a linear systems approach. It assumes that a latent error is a constant error, thus latent errors can, with sufficient care and attention, be both identified and rectified. This presupposes that, if enough data is known, it is possible to predict how all the constituent elements of a system will interact and to what effect. However, complex systems have *emergent* properties. An emergent property is one that arises from the interaction of lower-level entities, none of which show it. If you mix blue and yellow paints, the colour green 'emerges'. There is no green in the original blue and yellow paints and we cannot reverse the process and divide the green back into the two other colours.

This raises questions about how far it is possible to predict what will happen as elements in a system come together. Factors that, on their own, are safe may become unsafe as they form a system with others. The earlier example of alarm overload demonstrates such a problem. The designers of each alarm system did not predict what would happen if their product interacted with several others. Complex systems theorists hold that not all interactions can be predicted because complexity, in as much as it implies non-linear dynamics, places limits on prediction; interactions lower in the system will be unexpected and senior management or designers cannot predict all that will occur.

In contrast with Reason's Swiss cheese model,² in this emergent model of accident causation, a latent error, rather than being constant, may 'emerge' from a combination of factors, none of which is necessarily a latent error in Reason's meaning of the term because only in combination with other factors does the potential for error 'emerge'. Some idea of differences between the two models is indicated with the inclusion of Figure 6. This school also raises questions about the overall goal of safety management: whether it is possible even in theory to create a system where errors do not occur or whether the aim should be to design systems that can detect and learn from the inevitable errors that will arise.

Moving from a deterministic view of the universe to a probabilistic one has radical implications. Wallace and Ross sum up the difference: 'instead of a deterministic view in which certain causes inevitably lead to certain effects, in the probabilistic view, certain causes may or may not lead to effects with differing degrees of probability' (2006: 17). Consequently, the ideal of a top-down control that can prescribe every action lower in the system is questioned.

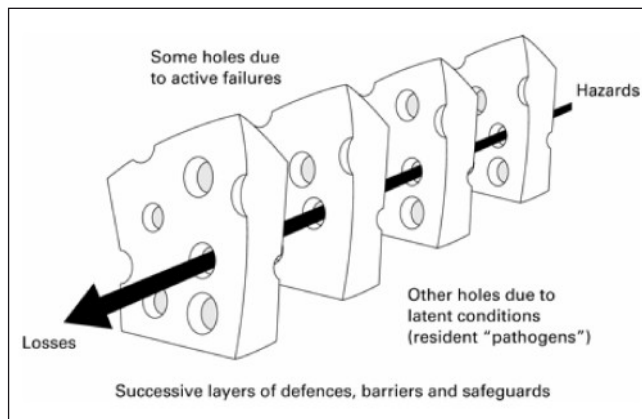
² Setting the two models up in contrast is an oversimplification. Reason's later work indicates an appreciation of non-linear dynamics. He clarifies, for example, that unlike Swiss cheese, the holes in the organisational defence layers 'are continually opening, shutting, and shifting their location' (Reason, 2000: 769). Similarly, rather than using the term 'latent error' he opts for 'latent condition' clarifying, of the decisions that can cause these, that they 'may be mistaken, but they need not be. All such strategic decisions have *the potential* for introducing pathogens into the system' (2000: 769; emphasis added), which can be read as saying that this potential is not fully predictable.

Figure 4: Heindrich's 'domino theory'



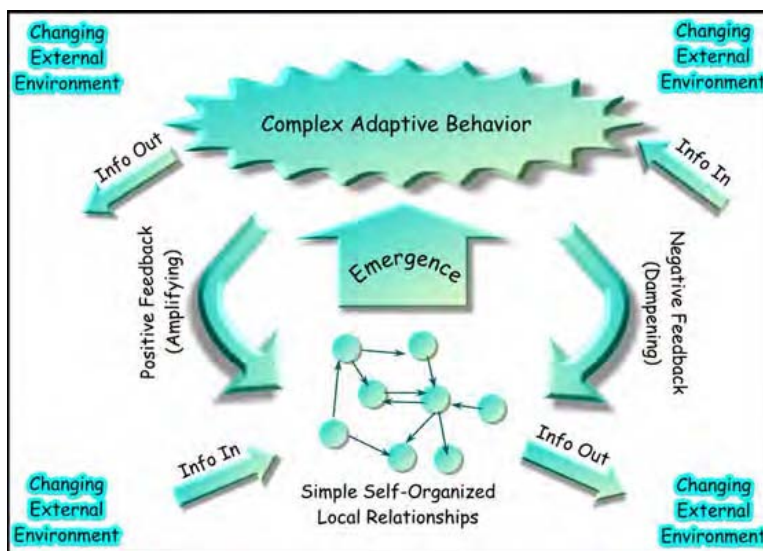
Source: jupiterimages.com

Figure 5: Reason's Swiss cheese model



Source: Reason (2001)

Figure 6: Emergent model



Source: softwarecreation.org

2.2.4 Seeing people as understandable: ascertaining their 'local rationality'

Questions of predictability aside, the goal of both systems models detailed above is to build up understanding of how errors are made more or less likely depending on the factors in the work environment. So instead of assuming that errors arise from 'aberrant mental processes such as forgetfulness, inattention, poor motivation, carelessness, negligence or recklessness' (Reason, 2000: 768), as in the person-centred approach, a systems approach presupposes that the actions that with hindsight are seen as mistakes actually seemed like the sensible thing to do *at the time*. This is referred to as the 'local rationality' and gaining an understanding of it is a fundamental part of a systems approach.

For the task of understanding why actions or decisions made sense at the time, a 'distant view of the workplace' (Woods and Cook, 2002: 139) is inadequate. Instead, it requires an:

... in-depth appreciation of the pressures and dilemmas practitioners face and the resources and adaptations practitioners bring to bear in accomplishing their goals. (Woods and Cook, 2002: 139)

A key element of the systems approach, in other words, is reconstructing how the situation looked from the practitioner's point of view.

A consequence of viewing complex systems as, to some degree, unpredictable is that it strengthens the need to find out what went on in the run-up to an accident in a more detailed manner. Specifically, more attention is paid to the social as opposed to the technical dimensions of systems.

Rather than assuming that the situation in which the error occurred is pre-given and exists separately from those who were working in it, the focus is on understanding how operators, partially at least, 'socially construct' the context within which they operate. In other words, it is argued by some that, to fully understand how the world looks to practitioners in the field, we have to recognise:

... how people use talk and action to construct perceptual and social order; how, through discourse and action, people create the environments that in turn determine further action and possible assessments, and that constrain what will subsequently be seen as acceptable discourse or rational decisions. (Dekker, 2005: xii)

Consequently, it is deemed 'a major fault to assume that we all share the same picture of reality' (Gano, 2003: 60). Therefore, in ascertaining people's local rationality, investigators in this mode have broadened their range of methods to include more sociological and interpretivist methods as opposed to drawing solely on the theories of cognitive psychology.

People as the source of safety

Such developments have also led to an interest in the social construction of what counts as error and what is understood as normal practice. Earlier approaches had taken it as possible to define 'error' and 'failure' in objective terms that are agreed by all in the organisation. Conversely, it was confidently assumed that official procedures defined 'safe' practice. In reality, however, official procedures are often not enough in complex situations to fully determine what should be done. In reality, practitioners make the system work successfully as they pursue goals and match procedures to situations under resource and performance pressure.

Consequently, if local cultures develop in which normal practice deviates from the official manual, rather than being wrong, these often prove to be sensible adaptations that in fact improve the safety of the system. It cannot, therefore, be decided in advance that all deviations are 'errors' and studying local rationality needs to include how normal practice is culturally constituted in the context where the error has occurred. Rasmussen (1986: 14) made an early case for rethinking practitioners in terms of being sources of safety – it is their intelligence and adaptability that is able to identify and intervene when processes are going wrong. In complex systems, however, the lack of predictability heightens need for this kind of initiative.

By and through ascertaining the local rationality of people involved in the accident, analysis is made of all the factors that influenced performance. How, then, have these different factors been conceptualised and how is 'the system' itself defined? We turn now to discuss both these two issues in brief.

2.2.5 The structure of the socio-technical system: layers of influence on human performance

There is a huge amount of research into types of error, task differentiation and human performance factors (Munro, 2008). We discuss these in more detail in the following chapters. Suffice here to note that they are often thought of as different 'layers' of influence. Although several models of the system and its constituent factors are available in the literature, the most commonly used image is of a triangle. Influences on human performance are grouped into layers ranging from the sharp to the blunt end, with front-line workers influenced by all the elements above.

Many of the available models cover much the same ground although varying in the degree of detail. The leading theorist, Peter Reason, presents a three-layer model of the causal factors for accidents:

- 1) the unsafe acts carried out by individuals that precede the accident,
- 2) local workplace factors, and
- 3) organisational factors (1997: 120).

Woods and colleagues similarly divide the triangle up into three layers:

- 1) operational system as cognitive system including attentional dynamics, knowledge and strategic factors
- 2) resources and constraints
- 3) organisational context (Woods et al, 1994).

In a later model, Woods and Hollnagel also include the elements of the front-line workers' tasks in their three-part model of components of the socio-technical system (2006: 7) (see Figure 7).

Figure 7: Three-part model of components of the socio-technical system



Source: Woods and Hollnagel (2006) (www.ashgate.com/isbn/9780754649045)

This draws attention to the need to study human reasoning in the work context. What is central to a systems approach is that it does not study human reasoning in isolation or in laboratory conditions remote from the noisy, crowded environment of the typical workplace. People are seen as interacting with their environment and being influenced by it in how they reason. Understanding the strengths and limitations of human cognitive capacity is fundamental to designing systems that fit typical levels of performance and do not inadvertently distort or encourage errors. At the pointed end of the triangle, therefore, analysis includes exploring how limited knowledge, a limited and changing mindset and multiple interacting goals shape the behaviour of people in evolving situations.

The broader layers draw attention to factors at the local/team and organisational levels respectively. These, although beyond front-line workers' control, also exert a strong influence at the sharp end of the system. They generally include factors in the design of technology and how it shapes human performance, and factors in team and organisational cultures, resources and priorities. The potential range of factors that

can be considered in a systems inquiry is, therefore, vast. Each factor requires specific investigatory methods to research its functioning and the contribution it makes to the organisation.

2.2.6 Defining a system, its sub-systems and boundaries

In place of a person-centred approach, then, the systems approach places individuals within the wider system(s) of which they are part. This raises important questions about how we define and identify a system. A system can be either natural (for example, the human body) or man-made (for example, a child welfare system). It is understood as consisting of a set of interacting elements – so the child welfare system is made up of multiple individual agencies and professions as well as the inter-agency system epitomised in LSCBs. The elements, however, include not only people but also technology – a socio-technical system. All are brought together for a particular purpose or purposes – to safeguard and promote the welfare of children.

Systems are seen to have boundaries (some people or elements are seen as inside, others are outside) but the boundaries are permeable – there is movement across them so the system is responsive to outside forces. Each person or element within the system may be a part of other systems as well. The total system, therefore, can be thought of as made up of sub-units or sub-systems. So teachers and others have a role in the multi-agency safeguarding/child protection system but also in the education system. An assessment framework can have a role in front-line practice and in management information systems.

The picture becomes more complicated, however, because these sub-systems can also be regarded as themselves systems in their own right containing their own sub-systems. So the education system, a sub-system of the child welfare system, contains schools, which can be regarded as systems. Conversely, the child welfare system can itself also be regarded as a sub-system of a larger macro-system, if we see it, for example, as part of a government department and ultimately the welfare state.

A system's behaviour is understood as arising from the relationships and interactions across the parts and not from the individual parts in isolation. Where you draw the boundaries, therefore, and whether a particular element is considered a micro- or macro-system depends on where you are looking from. This makes the boundaries of any investigation somewhat ambiguous. While the range of potential parts makes it difficult for any one inquiry to study all sub-systems in depth, where you put the boundary of any investigation is based on a theoretical assumption and not an objective fact.

2.3 Key features of child welfare that pose a challenge to the engineering model

2.3.1 Families are not machines

Engineering has recognised more of the social aspects of the socio-technical system in its development of the systems approach. Nonetheless, the model conceptualises

the organisational system as interacting with what is often called 'the managed process' – the plane that is being flown, the nuclear power plant that is generating electricity. In other words, it is a non-human conceptualisation of the target. While this is clearly appropriate in the engineering field, it obviously does not fit with child welfare work; families are not machines.

Adopting the engineering approach wholesale in safeguarding and child protection work would entail children and parents being seen as objects to be managed, to be worked on and not worked with. Their agency, or ability to act independently, would be regarded in terms of the complications this creates for the interactions between practitioners and the organisational system in achieving their goals, that is, as a hindrance to the managerial processes and messing up the interactions. Moreover, there would be no ethical or legal considerations when identifying solutions to these complications. There are no limits to what one can humanely do to planes to make it easier for pilots to fly them safely; legal considerations concern the air crew's rights, for example, employment and health and safety laws, but not the rights of the plane to freedom of choice over and above coercion.

Rather than being seen as objects to be managed, children and parents therefore need to be seen as active participants *within* the system, not outside it. Practitioners' work with families inevitably involves contributions from both parties:

One can 'deliver' a parcel or a pizza, but not health or education. All public services require the 'customer' to be an active agent in the 'production' of the required outcomes. Education and health care initiatives simply fail if the intended recipients are unwilling or unable to engage in a constructive way; they are outcomes that are co-produced by citizens. (Chapman, 2004: 10)

The same can be said for child welfare services. Safeguarding and promoting the welfare of children is by necessity a shared enterprise and social and emotional interactions shape the nature of the work. In terms of the theoretical premise of the approach, therefore, not to include families would be nonsensical. However, this raises practical complications for the organisational system in terms of how to do this. Much of the systems literature stresses the need to understand and value front-line workers' perception of events and processes. In a child welfare system, the same degree of attention would need to be given to the experiences of families. This is discussed further in Chapter 6.

Key issues relate to temporal aspects of the original model. Explaining why we have chosen not to use the term 'root cause analysis' in Chapter 1, we highlighted the way in which the approach looks at the past with a future orientation – finding out what happened in any particular incident and the factors that contributed to it is an important step in the process, but the ultimate purpose is to use this understanding to reflect on what it reveals about strengths and weaknesses of the system more broadly in order to improve future safety. Both retrospective and prospective orientations, then, are covered but what does not fit easily in this model is the present. It is not designed to address the fact that work is often *ongoing* with families during and after a review. This is a somewhat unique feature to child welfare, relative to engineering and industrial settings.

Despite our initial intentions, for pragmatic reasons we were not able to involve parents or children in either pilot case review. We have not therefore had any empirical data with which to ground development of this aspect of the model. This is regrettable and future development of the model should include exploration of this area.

2.3.2 Limitations of the knowledge base

The second key feature of child welfare work that poses a challenge to the engineering model is our relative lack of knowledge about how to tackle effectively families' problems in order to secure good outcomes for children. As stated in Chapter 1, this raises problems in defining error in child welfare because it presupposes some standard of 'correct' practice. These problems are exacerbated by the fact that the intended outcomes of the system in child welfare are often long term. Consequently, we cannot assume a sufficiently close temporal link between the action and the faulty outcome so that the action's contribution to the outcome can be confidently asserted. Yet the systems model as developed in engineering and taken up in health is premised on the definition of error; investigating the cause of errors and improving safety by reducing the incidence of errors is the central aim of safety management.

In the disciplines where safety management originated there is a considerable body of technical knowledge about the tasks and how they contribute to the intended outcome. Aviation experts have a good understanding of the mechanical principles involved in getting a plane off the ground, flying it to a destination and landing it in one piece. Against this background, flying the plane into a mountain and killing all on board is clearly an error. The relative confidence in the abstract principles of the technical dimension has, as we have detailed above, to be tempered with the reality that technical knowledge is not used in a vacuum but in a socio-technical system. Further, the recognition in engineering of the social aspects of the socio-technical system has led to a focus on the social construction of error and normal practice. However, even such relative confidence looks enviable compared with the knowledge base underpinning the tasks of child welfare workers.

Increasingly rules or standards in social work and social care are defined by being evidence based. As in other policy areas, 'systematic reviews' of the available evidence have become a favoured instrument:

By undertaking an exhaustive search for relevant knowledge, systematic reviewers aim to ensure that *all* relevant work is brought to bear on a given question. By subjecting that knowledge to systematic quality appraisal and synthesis, systematic reviewers aim to remove the biases arising from poor quality studies or from flaws in any single study. (Fisher, 2005: 128; original emphasis)

However, the simplicity of the concept belies the complexity of the task. On the one hand, bodies such as SCIE face the twin challenges that, in many areas, evidence is simply not available and that the research evidence base is often two or more years behind practice. One R&D centre has estimated that, in order to generate the highest quality evidence from systematic reviews, the time lag between an innovation and its

evidence base could be as long as 12 years (Schrödter et al, 2006). There is pressure then to speed up the evidence cycle.

On the other hand, there is the challenge of managing expectations about what any one review can deliver:

... the reputation of systematic reviews has suffered badly from the foolhardy claims of early advocates who argued that they would deliver pass/fail verdicts on whole families of initiatives (Sherman et al, 1997). (Boaz and Pawson, 2005: 177)

These over-inflated promises continue in the common conflation of the term 'evidence based' with the question of 'what works', damaging not only the reputation of systematic reviews but arguably of the evidence-based movement in general.

In relation to 'evidence-based policy', it has been argued that 'the sheer complexity of evaluative questions that need to be addressed' means that systematic reviews are not and cannot be definitive:

One can review bygone evidence not only to ask whether a type of intervention 'works' but also in relation to 'for whom, in what circumstances, in what respects and why it might work'. For good measure, a review might also be sensibly aimed at quite different policy and practice questions such as how an intervention is best implemented, whether it is cost-effective and whether it might join up or jar with other existing provision. The evidential bricks can be cemented together in a multitude of edifices and thus only modest, conditional and focused advice should be expected from research synthesis. (Boaz and Pawson, 2005: 177)

In relation to 'evidence-based practice' even a portfolio of reviews each aimed at making a contribution to the explanatory whole would struggle because evidence is only one component. Practitioners are required to integrate three sources of information: the best available research evidence, the practitioner's professional judgement of the particular case and the service user's rights, values and preferences (Sackett et al, 2000; Mullen and Streiner, 2004). Even then, exactly how actuarial calculations relate to individual work with people who use services remains difficult to pin down, despite Sackett's oft-quoted definition of evidence-based practice as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett et al, 1996: 71).

Notwithstanding the developments of the evidence base for child welfare, therefore, the explicit use of such formal knowledge cannot provide us with a ready solution to problems of the definition of error:

Evidence-informed practice is, of course, a good thing, so long as the limits of the capacity for formal knowledge to provide answers to everything are acknowledged and the moral and contestable nature of much social work decision making is recognized. (Taylor and White, 2006: 945)

For these reasons, in producing a systems model for child welfare, we consciously employ only a limited use of the language of mistakes, and in place of error talk instead of problematic practice.

Concomitantly, we also place a significant emphasis on identifying good, as well as problematic, practice in the adapted model. In the systems approach formal acknowledgement does tend to be given to the relevance of studying good practice but, in practice, little priority seems to have been given to developing this aspect. This is perhaps linked to the fact that in the fields where the approach originated there is more clarity about what good practice is, so the predominant tendency has been to focus on errors and near misses. Given the limited knowledge base in child welfare, in contrast, it becomes important to focus on good practice, in order to strengthen our understanding of it. Moreover, this focus is also needed as a means of redressing the 'deep negativity' that surrounds the social work profession in particular, 'whereby few have a good word to say publicly about it' (Jones et al, 2007: 1). It holds promise for contributing to recent calls for a dedicated body of work where the notion of good practice 'is theorised and the actual work done showcased' (Jones et al, 2007: 2): 'a critical best practice perspective' (Ferguson, 2003).

3 The pilot case reviews

This project has consisted of trying out the systems approach in practice to see how the engineering and health models needed to be adapted for use in safeguarding and child protection work. In two different inter-agency forums we have worked collaboratively with practitioners to conduct pilot case reviews. In this chapter we provide further details of the R&D methods used, followed by synopses of the two cases that were reviewed.

By the very nature of 'learning by doing', the systems approach itself provided our main set of methods for conducting the pilot case reviews. These were supplemented by the experience of trying to use the model in relation to the two cases and the learning gained thereby about what adaptations were necessary. We have reported on all three of these aspects in the actual case review write-ups that are available on SCIE's website. They are also detailed in the subsequent chapters of this report, through the presentation of the preliminary adapted model as well as details about the process of developing our thinking and difficulties we encountered in using the approach. Providing extensive details of our R&D methods in this chapter would, therefore, be unnecessarily repetitious and instead it is more of a brief sketch and distilled principles that are presented. We hope that this is sufficient to allow readers to make some initial assessment of the reliability and validity of our preliminary model.

Details of the two cases that were reviewed that are presented here include the reason why the cases were chosen, a summary of professional involvement with the family and our judgements about the adequacy of professional practice in them. This is necessary in order to contextualise the illustrations that are presented later in the report. Without such a narrative overview, the reader would be left having to make various assumptions, not least about what sort of cases they were, which professionals were working with the families, etc.

3.1 Research and development methods

3.1.1 The pilot sites

We noted in Chapter 1 that, despite positive interest from Wales and Northern Ireland, both our pilot sites were in England. Both are LSCBs that volunteered to take part after certain of their members, on hearing about the project, expressed interest in the work. They are not, in other words, a sample of any particular kind. Moreover, we are not going to provide an outline sketch or location profile for these pilot sites because this would potentially jeopardise the anonymity of the sites and therefore the participants. Furthermore, for the purposes of adapting/developing the systems model for use in child welfare, the location profiles are of limited interest or relevance. Consequently we refer to the two pilot sites simply as County and City, so allowing a distinction between them.

3.1.2 Ethics

The County pilot case review was authorised by the LSCB within their remit for SCRs under the 1989 Children Act that, all agencies agreed, gave the SCIE team authority to access confidential material.

In City, the research work was given ethical clearance by the London School of Economics Ethics Committee and also gained Research Governance³ approval. The study will not be found on the National Research Register for Social Care as that would involve identifying the location and compromising the anonymity of participants.

To ensure this anonymity, geographic identifiers have been removed, professionals are referred to only by their role and the families by pseudonyms.

3.1.3 The cases

The cases on which we piloted the systems approach were chosen by members of the pilot sites. In County, the case for review was selected by the LSCB members, while in City it was the front-line workers and managers of a social work team based in a maternity hospital who identified the case for review.

The project team requested that the case chosen *not* be one in which a child had been seriously injured or had died because such cases are inevitably very upsetting for the families and professionals involved, and can have legal implications. In light of this, we considered it unethical to use such cases in what were our first attempts at taking a systems approach. Otherwise we set only minimal and distinctly open criteria – that the case be one that they thought had 'potential for learning'. As with the locations, then, the two cases are neither a representative nor purposive sample. It was not by design, therefore, that the cases chosen in both sites were ones in which, at the time of the case review, the child(ren) had been removed from their families and accommodated. Further details on each case are given in Section 3.2 below.

3.1.4 The participants

Ideally a systems methodology requires collaborative participation on the part of staff involved in the case under review in order to learn how they were conceptualising the case and their involvement. Consequently, to minimise the risk of the added complication of reticent or hostile participants in the pilots, participation was voluntary as opposed to mandatory.

³ This involves meeting the specific requirements set out in the Department of Health's Research Governance Framework for Health and Social Care. For further details see www.dh.gov.uk/en/Researchanddevelopment/A-Z/Researchgovernance/index.htm

The project team endeavoured to provide sufficient information about the project and the role we were asking people to play to allow them to make an informed choice. This included providing both written information and the opportunity for a face-to-face discussion with the project team.⁴ In both sites there were workers who, for differing reasons, chose *not* to participate.

In City, the social work team took responsibility for identifying key individuals involved in the case at the time under consideration. One social worker (SW2) was on sick leave; a total of 16 other individuals from five different sectors were identified and 15 agreed to take part. Further details are provided in Table 2. The Health Visitor chose not to participate.

In County, members of the LSCB took responsibility for identifying those members of their own agency who had been involved in the case at the relevant time. In total 17 individuals, from 8 different agencies, became involved in the review. Further details are provided in Table 3. The Environmental Health Officer declined to participate because he lived in very close proximity to the family concerned.

3.1.5 The action research methodology

Methodologically this project was conceptualised in terms of participative action research. This is a method well suited to a pilot study which aims to adapt and develop a method of inquiry but it is also integral to the methodology of a systems approach itself. As indicated in Chapter 2, conducting a systems review is not a mechanistic task. The approach has increasingly drawn on the participative, qualitative research traditions; there is nothing purely objective about the processes of making sense of professional practice by this means. Here, therefore, we need to draw attention to two separate but interconnected aspects of the action research methodology in the pilot case reviews:

- that related to the process or model
- that related to the analysis or sense making in relation to the particular case, that is, the implementation of the model in relation to the specific pilot cases.

Both aspects involved a continual cycle of reflection, learning and adaptation within the review team as well as between the review team and participants.

Within the SCIE review team this continual cycle was facilitated by regular and critical team discussions whether face-to-face, over the telephone or with the use of email. These helped us maintain a critically self-reflexive stand that would have been difficult to attain working alone. The nature of issues raised, debates had and decisions or changes that resulted were diligently minuted. This ensured our learning

⁴ We are not suggesting that participation should always be voluntary. Where case reviews are conducted with statutory authority, participation will be mandatory. However, in such circumstances, it will be equally necessary to try to maximise participants' understanding of the methodology and willingness to speak. This is discussed further in Section 6.5.3.

process and outcomes were captured and this proved vital because we found that we came to take them for granted very quickly; they came to seem self-evident when they had not initially been so. Further details are presented in the main body of the report, such as Sections 5.1.4 and 5.1.5, which relate to our sense making about the particular case and the process or model respectively.

Similarly, various opportunities were created to allow for dialogue between the SCIE team and participants both individually and as a group, as the review team's process of sense making about the case progressed. This began with one-to-one conversations. Subsequently, a preliminary report was drafted and sent to participants before holding an interim meeting to discuss it. Participants had the opportunity at that time, or in a later telephone call or email, to comment on the accuracy of the reporting or to provide additional information that they now saw as relevant. The same process occurred with the draft of the final report which was discussed at a final feedback meeting. In addition, because these were pilot sites, we asked for feedback on the review process itself. Further details of both aspects are found in the body of this report.

3.2 Synopses of the cases

3.2.1 City case

Why was this case chosen for review?

The case chosen by the Social Work Maternity Team involved a young mother, Michelle, and her daughter, Kelly, with whom the team had been involved over a two-year period, since before Kelly's birth. The most recent and final episode of involvement had stemmed from a referral from the nursery concerning bruises on Kelly's bottom. It had led to a concerted multi-agency team effort to gain access to Michelle's house and, ultimately, to the decision to accommodate the child due to serious concerns that the state of the house was impacting on her safety and welfare.

The social workers in this team wanted the case reviewed because, while they agreed with the need for Kelly to be accommodated at this point, they were surprised by the outcome. Up until then they had not considered that this might come to be necessary or that it might have been an option for the child. Consequently, they were keen to work out whether they had missed anything significant along the way that would have changed their understanding of the case. They also wanted to find out whether they could and/or should have done anything differently to improve the outcome for the child and her family.

Synopsis of professional involvement

Michelle had first been referred to Children and Young People's (C&YP) social care services in City when she was pregnant with Kelly. Aged 22, it was her first, and an unexpected, pregnancy. The father wanted no involvement. She had only recently come to City in order to make contact with her birth mother, from whom she had been removed because of sexual abuse by her father, before being adopted at the age

of five. While contact with her birth mother had initially been positive, it later turned problematic and, following the referral, Michelle was re-housed into temporary supported accommodation by the local authority homelessness section.

The case was managed on a 'Child in Need' basis following Kelly's birth. An extensive support package was put in place and many agencies were involved with the family, helping Michelle provide adequate care for her daughter. Initially, daily visits were shared between the Health Visitor, Community Midwife, Social Workers and Home Workers. Later, twice-daily visits by a private agency Outreach Worker took place and were then replaced by daily visits by a C&YP social care Family Support Worker. The Sure Start Public Health Midwife also visited, giving breast-feeding support. The longer-term plan involved a Tenancy Support Worker seeing Michelle weekly in her home to give practical help and a Sure Start Family Support Worker also visiting her regularly in her home with the aim of integrating her into the community and introducing her to new groups. Michelle was re-housed near to the local church as she had requested and throughout, the Reverend and his wife were very involved with the family. Kelly later attended Sure Start Nursery regularly and Michelle attended various Sure Start groups.

Over this two-year period, there were times of increased concern. Three of these led to further referrals to C&YP's social care. On each occasion the referral was passed from the social care Access Team back to the Social Work Maternity Team for a response.

The first referral came from the Tenancy Support Worker, almost a year after Kelly's birth, and was triggered by Michelle's increased distress, dishevelled appearance and the piles of rubbish and over-flowing bin bags that could be seen through the letter box of her home. This led to an Initial Assessment and a Child In Need meeting and a 'shoring up' of the support package.

The second came from the GP eight months later. This reported concerns about Michelle's levels of distress and its potential impact on her parenting capacity as well as bruises on Kelly's back and arm, suggesting that she was inadequately supervised. This led to a Section 47 investigation and a Child Protection Conference focusing exclusively on the reported bruises. The final decision was *not* to place Kelly's name on the Child Protection Register and for professionals to continue to work with the family on a 'Child In Need' basis. However, no work was done to identify a suitable support package and the family received no visits or services afterwards.

The third referral followed two months later and was described briefly above – it came from the nursery and reported a minor bruise observed on Kelly and led to a chain of action that culminated in Kelly being accommodated when, after nine attempts, access was finally gained to the house.

Table 2: Participants in the City case review

	Role
Statutory sector	
Social Care: Social Work Maternity Team	
1	Social worker (SW1)
2	Social worker (SW2)
3	Team manager (SW maternity team manager 1)
4	Team manager (SW maternity team manager 2)
Health: General Practice (GP)	
5	GP
Health: Maternity Services, Hospital	
6	Community midwife
7	Public health midwife
Health: Child Assessment Unit, Children's Hospital	
8	Paediatrician (Paediatrician 2)
Police: Public Protection Unit	
9	Detective sergeant
Environmental Health Services	
10	District officer
Voluntary sector	
Church	
11	Senior minister (Reverend)
Sure Start	
12	Family support worker
13	Safer care manager
Early Days Children's Centre	
14	Manager (nursery manager)
Tenancy Support Services	
15	Tenancy support worker

Conclusions about the adequacy of professional practice and the impact on the child and family

At heart, the City case involves a mother with seemingly serious psychological problems, possibly related to her childhood experiences of abuse and neglect, who had ongoing difficulties in acknowledging and trying to solve them. Many agencies were involved with Michelle and, for two years, she was helped to provide care for her daughter Kelly that was considered adequate by those working with her. The review did not find any obvious point at which significant errors with harmful consequence were made. Indeed, in many ways, the case illustrates the way in which professional practice is more of a balancing act than a clear-cut issue of right and

wrong actions and/or decisions. Specifically, in this kind of case, professionals are treading the line between needing to accommodate a child and trying to support the parents/carers in such a way as to ensure the child's safety and welfare. Good practice involves charting a course between two adverse outcomes – removing a child prematurely and leaving her in danger.

The severity of Michelle's problems was not easy to see when she was pregnant so that her inability to make use of the good package of support services she received to strengthen her parenting capacity could perhaps only be learned through experience – as was done. Even if the Initial Assessment had been more searching, it seems highly improbable that a more thorough assessment during the pregnancy would have concluded that the mother's problems were so severe and unchangeable that the child should have been removed and accommodated at birth. Nor did we find any evidence of a pattern of neglect post-birth sufficient to warrant her being accommodated earlier.

The high quality of relations developed by many workers with Michelle, marked by compassion and dedication, stood out strongly in our analysis. Moreover, the nature of the services and relationships provided by the voluntary sector was in a manner acceptable to Michelle so that she used them well, and consequently she and the child were highly visible. This meant that even small changes were noticed and reported, making it unlikely that Kelly could have experienced significant harm that was unnoticed. There were also quick responses at these times of increased concern involving close collaboration and information sharing. There was so much good practice in the provision of support services that if Michelle's problems had been less complex it seems highly probable there would have been progress, with services able safely to withdraw or reduce their involvement.

The key weakness in multi-agency professional practice was that the complexity/severity of Michelle's problems was not identified earlier despite the necessary information being available. Responses to incidents and crises successfully resolved practical problems but the nature of Michelle's difficulties themselves was never put under scrutiny and emerging patterns were never identified. This would have required professionals to have maintained a higher degree of uncertainty about their assessments and a more purposive approach to the support package that was easier to evaluate. It might have led to a deeper assessment being undertaken, drawing on mental health and learning disability experts, with more attention paid to the mother-child relationship, and a differently targeted, more therapeutic package.

However, it is impossible to say how the outcome would have differed – whether Kelly would have been removed earlier or, if the therapeutic help had been successful, not removed at all. Based on evidence available up until the point of Kelly being accommodated, it is simply not knowable whether, given the appropriate interventions, Michelle would have been capable of developing skills that would have enabled her to avoid the recurrent pattern of the state of her house deteriorating at times of stress. The interventions provided gave support but did not address underlying issues.

A more specific issue of problematic practice identified related to the total absence of social work contact or other agency support following the Child Protection Conference triggered by the GP's referral. Being investigated for physically abusing her child had, predictably and understandably, been stressful for the mother and had caused conflict with her adoptive parents. Given the level of concern raised by the GP about Michelle's levels of distress prior to the Child Protection Conference, it seems likely that this experience would have significantly affected her. We concluded that there is a chance that it precipitated what was the worst crisis Michelle had experienced in two years, leading to the need for Kelly to be removed and accommodated. Closer social work and other agency contact might have averted this. The factors that contributed to this lack of contact making sense at the time are discussed in the section 'What and how much should be shared?' in the next chapter (p 61).

3.2.2 County case

Why was this case chosen for review?

The County case was selected for review by the LSCB after the decision had been taken to remove the two boys from the family and accommodate them. In the subsequent Child Protection Conference, it was decided to put the names of both boys on the Child Protection Register. This was due to the serious concern that the state of the house was impacting on the safety and welfare of the children.

There had been concerns about the adequacy of parenting in this family since the birth of the eldest child 17 years earlier. Over the years, numerous agencies had been in contact with one or more members of this family. In light of the quantity of professional involvement, the LSCB decided it was pertinent to question whether the decision to accommodate the children was timely or whether the extent of the harm suffered or at risk of being suffered by the children and the condition of the house should have been recognised sooner.

Family composition

At the time the two boys were accommodated, the family composition was as follows (see Table 3):

Table 3: Family composition in the County case

<i>Name</i>			
Children	Gender	Age	Nationality
Kim H	Female	17	White British
Darren H	Male	14	White British
Danny B	Male	6	White British
<i>Parents</i>			
Joanna H	Mother	37	White British
Steven B	Father of Danny	44	White British
Paul D	Father of Kim, living elsewhere	Not known	
John F	Father of Darren, living elsewhere	Not known; no contact	

Synopsis of professional involvement

Joanna, the mother, had been known to Social Care Services intermittently since her teens, when she attended a special school for children with severe behavioural problems. The first Child Protection Conference was held soon after her first child Kim's birth with concerns about the physical care of the baby. Another conference was held three years later when Joanna was the victim of domestic violence from her second partner, the father of her second child, Darren. At that time, Kim was placed on the Child Protection Register following allegations that her stepfather was sexually abusing her, but this was not substantiated at paediatric examination and the marital relationship then ended.

In subsequent years there had been numerous referrals to social care by other practitioners about the three children, with varying degrees of response ranging from no action to holding a Child Protection Conference. Concerns generally centred on Joanna's limited parenting skills and the impact on the children. She was seen as a loving mother and very well-intentioned but as not providing consistent discipline or boundaries for the children. Kim was thought to have been given excessive adult responsibilities to fill the gap left by Joanna's limitations and Darren seemed to have reacted worst, with increasing aggression at home towards his mother and his sister. There had also been long-term concerns about Joanna's ability to manage housework effectively. Professional judgements about whether the state of the house was above or below the threshold of acceptability in terms of hygiene and safety changed over time, and often there were disagreements between different professionals. Professional contact with the family rarely involved Steve, Joanna's partner at the time and father to Danny, despite him living in the home. She was said to have explained that he did not like contact with social workers due to having been in care from a young age.

The case review focused on services to the family and multi-agency communication over the two-year period prior to the two boys being accommodated. At the beginning of this time period the case had been reopened to social care following two referrals. One had come from the pre-school concerning Danny who, then age four, had been found alone outside the school with a bruise under his eye. The other had come from the small voluntary organisation whose family support groups Joanna had attended regularly over the years. This expressed concern about the condition of the house in particular, which was described as dirty and untidy. An Initial Assessment was done and the decision was made to work with the family under the category of child in need.

Regular multi-agency meetings were held over an 18-month period, attended by the mother, Social Worker, school staff, the Voluntary Agency Social Worker and the Health Visitor. The mother appreciated these meetings very much. Plans to help her with improving her ability to run the household effectively were never implemented, although many mistakenly thought that the small voluntary organisation was doing this work.

During this period, each child raised concerns for different professionals and received a range of additional services. The eldest daughter, Kim, received treatment for

gastric problems from a paediatrician who referred her to the Child and Adolescent Mental Health Service (CAMHS). There, a psychiatric assessment ruled out anorexia, chronic fatigue and an autistic spectrum disorder and she received counselling for two years, ending just before the boys were accommodated. There was awareness among participants at the multi-agency meetings of the medical services being received by Kim but there was no direct contact between the doctors and this group. Danny, the youngest, meanwhile started school and a needs assessment identified severe developmental delay. He began to receive one-to-one support all day at school. The behaviour of the middle son, Darren, became increasingly violent and destructive at home causing great concern to professionals. Several attempts were made to find some help for him including referrals to the Children with Disabilities Team for respite care, the Child Development Centre for anger management therapy, a befriending service for a befriender in the community, the restorative justice team for crime prevention and the CAMHS for psychological therapy. None resulted in any intervention. He was seen only by a Community Paediatrician who referred Joanna to a parenting skills group but this was ended because of her failure to keep appointments.

Six months before the boys were accommodated, the key social worker left the agency and she recommended the case be closed, considering that there were sufficient other agencies working with the family. The case closure was not communicated clearly to all involved but those who heard of it became concerned. The Paediatrician, the CAMHS Counsellor and the Voluntary Agency Worker expressed concern to social care but got no response until six months later, when a combination of a letter from the voluntary agency and a referral from the CAMHS Counsellor triggered a decision to re-open the case. An assistant social worker made a home visit, was shocked by the state of the house, and with some difficulty persuaded the Team Manager to allocate the case to a social worker. The Duty Social Worker visited the house, contacted the police the next morning, and the children were accommodated directly from school later the same day because the house was considered to be too hazardous for them to stay there.

Table 4: Participants in the County case review

	Role
Statutory sector	
Social Care (then 'Social Services'): Family Support Team	
1	Family support social worker who held the case for most of the period under review (SW1)
2	Deputy manager who supervised SW1 (DM1)
Social Care (then 'Social Services'): First Response Team	
3	Assistant social worker who was on duty and took the referral and made the home visit that led to the children being accommodated (ASW1)
4	Social worker who did the Initial Assessment (SW2)
5	Social worker who took the case from SW1 after the Initial Assessment had been done (SW3)
6	Deputy manager who supervised ASW1 and SW2 (DM2)
Health: Hospital	
7	Community paediatrician 1 (who saw Kim)
Health: Child and Adolescent Mental Health Services (CAMHS)	
8	Child psychiatrist (who saw Kim)
9	CAMHS counsellor (who saw Kim)
Health: General Practice (GP)	
10	GP (for mother)
Health	
11	School nurse
Education	
12	Head teacher, lower school
13	Named child protection officer, middle school
14	Student support centre manager, upper school
15	Child protection manager, upper school
Police	
16	Police officer (who dealt with investigation leading to the children being accommodated)
17	Senior police officer (who supervised the above)
Voluntary sector	
Small Voluntary Agency	
18	Project manager (small voluntary organisation PM)

Conclusions about the adequacy of professional practice and the impact on the child and family

This is a vulnerable family that had caused varying degrees of concern to professionals for almost two decades. The variety and complexity of the needs of the adults and children presents a challenge in terms of service provision. As stated earlier, over the years, numerous agencies had been in contact with one or more members of this family. During the time under review there was evidence of some good inter-agency cooperation and information sharing. Yet the review found that it made little difference in terms of achieving good outcomes for the children, the adults or the family as a whole.

Social services (as they were then called) were centring much of their attention on the mother's issues related to the uncleanliness of the house but these were not actually identified particularly well. Firstly, there was no clarity about whether the state of the house had, in reality, fluctuated over the years or whether it was professional judgements of its acceptability that had varied. Secondly, none of the speculations about the reasons for Joanna's difficulties in running the household effectively were developed or tested. These included:

- a) learning disabilities, although this was contested by IQ tests
- b) misconceptions of acceptable standards and lack of the relevant knowledge, possibly linked to her history as part of a travelling family, but again this was contested
- c) an obsessive-compulsive disorder or psychotic beliefs about what could happen to the rubbish she threw out.

Equally, none of the interventions had clear goals against which they were ever evaluated. Joanna was very appreciative of all the help provided but we found no evidence that she altered her behaviour at all or, therefore, that the children's situation improved. Indeed, there were only very limited assessments of the impact of Joanna's issues on her children, despite the manifestation of health and psychological problems in the eldest child, Kim, and challenging behaviour towards his mother and sister by the middle child, Darren, who was also refusing to eat food prepared in the home.

While the therapeutic help provided by CAMHS seemed to have helped Kim cope with the situation at home, it had done nothing to improve that situation. Darren, in contrast, had become cast in the role of aggressive and troubling young man with behavioural problems that were often wrongly explained, notably by the key social worker, as stemming from Asperger's Syndrome. His needs were never systematically assessed in relation to the kind of parenting he was being provided with. Most of the many referrals for support services for him were unsuccessful, and even successful ones did not lead to sustained service provision. This, the review concluded, had potentially put him on a very poor life trajectory, in which he would be vulnerable to a number of ongoing risks or vulnerabilities (for example, aggression, violence and criminality). Danny, the youngest, we saw as potentially at risk of the same behaviours. While he seemed to have benefited from support at school and at home while young, Joanna's affection for him seemed to have been assumed

to be a safeguard against detrimental effects on him of her problems. There was no assessment of her parenting of Danny as he grew, in the context of his severe learning difficulties and high support needs.

We concluded, therefore, that there had been sufficient evidence that the children were at risk of significant harm and that this should have been recognised, in contrast to the relatively benign assessment that persisted until the boys were accommodated, despite the efforts of several other agencies to raise the level of concern. This recognition might have led to a more thorough assessment and a more purposive approach to the support package that was easier to evaluate. The systemic factors implicated in why this did not happen are detailed in the following chapter. Based on evidence available up until the point of Darren and Danny being accommodated, however, it is simply not knowable whether, given the appropriate interventions, Joanna (and Steve) would have demonstrated capacity for change. Therefore, it is impossible to say how the outcome would have differed – whether the children would have been removed earlier or, if the interventions had been successful, not removed at all.

3.3 What is coming next?

Having provided background material on (a) the development of the systems approach in other fields and (b) our pilot case reviews, the next three chapters present the adapted model that we have developed for child welfare practice. To repeat from Chapter 1, our exposition of this model is in reverse order to the sequence in which it will be used in practice.

Chapter 4 addresses the question 'where do we want to get to?'. It explains the goal of a systems case review, which is to identify underlying patterns of systemic factors that influence practice and generate ideas about improving the work environment so that it is easier for workers to practise well.

Chapter 5 asks 'how do we get there?' in terms of organising and analysing our data. In it we detail how to produce (a) an adapted form of chronology that captures multi-agency perspectives on the case and (b) a table of key practice episodes that identifies the contributory factors that impinged on each.

Chapter 6 is where a review team would in practice begin; it provides the basic data collection methods. Detail is provided on how to engage with two key sources of data: case documentation and the workers themselves through one-to-one conversations. Only lastly do we address the questions of who should be involved and what preparation they will need.

Throughout these three chapters we do not present just the final product in the form of our adapted model. Instead we endeavour to explain how we developed our thinking in the course of adapting and applying the approach to our pilot cases. This includes difficulties that we encountered, in the hope that others will therefore also be able to learn from them.

4 Where do we want to get to? Identifying patterns of systemic factors that contribute to good or problematic practice

A systems case review is a chance to study the whole system and to learn something about how it regularly operates. The goal of a case review using a systems approach is not only to understand why a particular case developed in the way it did (for good or for bad), but to use that particular case as the means of building up an understanding of how both good and problematic practice are made more or less likely depending on the factors in the task environment. This allows ideas to be generated about ways of maximising the factors that contribute to good performance and minimising the factors that contribute to poor quality work. Achieving this goal requires the identification of underlying *patterns* of systemic factors that contribute to good or problematic practice, from the minutiae of case specific details. This is increasingly important due to the emergent properties of complex systems such that, as we explained in Chapter 2, 'latent factors' are harder to predict.

In the engineering and health safety literature, these patterns are often referred to as the 'genotypes' of error, in contrast to the 'phenotypes' of failure. The terms, taken from biology, distinguish the internal blueprint or set of instructions for building a living organism (the genotype) from the outward, surface manifestation (the phenotype). They are used to differentiate (a) the surface description (phenotype of failure) and (b) underlying patterns of systemic factors (generic or genotypical patterns):

The surface characteristics of a near miss or adverse event are unique to a particular setting and people. Generic patterns re-appear in many specific situations. (Woods et al, 2006: 461)

So, good or problematic practice may look different in different cases but the sets of possible underlying causes can be the same and it is these that need to be identified.

In this chapter we address three issues. Firstly, we discuss the process of developing a classification scheme for types of genotypes relevant to child welfare and present our initial typology illustrated with examples from our pilot sites. Secondly, we identify key features of the process of identifying and prioritising these underlying patterns. Lastly, we discuss the formulation of recommendations from the patterns identified.

4.1 Developing a typology of patterns for child welfare

4.1.1 Process issues

While essential, as in all fields, the search for genotypes in child welfare case reviews is far from straightforward. It involves drawing on (at least) two perspectives and knowledge bases (Woods et al, 2007); it requires an understanding of both the language and concepts of 'human performance factors' that are drawn from the fields of psychology and engineering, and the child welfare domain of knowledge.

Clearly, therefore, there is limited scope for simply lifting a classification scheme developed in, say, aviation to use in a radically different area such as Children's Services. Consequently, evolving the beginning of a typology of recurrent underlying patterns appropriate to children's services has been an important methodological part of this project. It has important implications for thinking about how best to collate recurrent concerns from case reviews.

That said, the task is made even more difficult by two factors. Firstly, as we indicated in Chapter 2, there is a huge amount of research into types of error, task differentiation and human performance factors (Munro, 2008). This means there is a vast range of potential variables to choose from. And secondly, this is the least developed area of the systems model in other areas. In health, for example, many reporting systems and investigations only describe errors in terms of their phenotypes: 'they do not go beyond the surface characteristics and local context of the particular episode' (Woods et al, 1994: 13). Classification schemes that are available, therefore, tend to focus more on the contributory factors that influence human performance, that we deal with in detail in the following chapter, rather than on underlying patterns. The potential of learning from other fields is, therefore, comparatively small relative to other aspects of the systems model.

As with the creation of any classification scheme, moreover, decision making is far from a neutral task. Bowker and Starr's (2000) text on classification and its consequences includes a study of the development of a taxonomy in nursing. This demonstrates the influence not only of theoretical assumptions in making decisions about how to classify phenomena but also the moral and political influences on the process. Yet it seems to us that systems models used in the health field in the UK remain surprisingly apolitical in that they do not seem to highlight or address patterns of systemic issues emanating from government that professionals at local level have little, or no, control over. This is surprising given the controversial nature of, for example, nationally set targets and PIs, as well as information and communications technology (ICT) systems being introduced and the high profile coverage of, for example, the perverse incentives particular targets have inadvertently created. In the highly politically and ethically charged world of child welfare, the importance of recognising the role of these political and moral factors is crucial in discussing how to classify patterns in practice.

4.1.2 An initial typology

In our efforts to develop a specific typology of underlying patterns for child welfare, we found the work of Woods and Cook (2001) in the field of patient safety most useful. Instead of focusing on typologies of error, they focus on patterns of human performance factors. This allows for the possibility of identifying patterns of systemic factors that support good practice, that we argued in Chapter 1 is so important in this field. They suggest a three-part categorisation:

- patterns in human judgement;
- patterns in communication and cooperative work;
- patterns in human-computer cooperation. (Woods and Cook, 2001: 5)

This provided a useful starting point but the key practice issues identified in our two pilot case reviews made it clear that the typology required adaptation and expansion.

In terms of adaptations required, in both sites there were examples both of good as well as problematic ways that professionals were working together. It became pertinent, therefore, to focus on *when* patterns of communication and cooperation supported good or problematic practice. This revealed the need to break Wood and Cook's second set of patterns into two, in order to distinguish between patterns of communication and collaboration: (a) in response to incidents/crises and (b) in longer-term, day-to-day work. The category of patterns in human computer operation also needed to be expanded so as to capture not just the influence of ICT systems but also that of forms, assessment aids and other so-called tools. Two other sets of practice issues identified in the pilot sites did not fit into the three-part structure at all. These included patterns related, firstly, to the nature of relations between family members and professionals and, secondly, to organisational factors such as resources and the management system more generally.

Given the above, we ended up with six clusters of patterns of systemic factors that contribute to good practice or make problematic practice more likely, as pertinent for safeguarding and child protection work as a whole. These are detailed below in Figure 8. The typology has been developed from key practice issues identified in the two pilot case reviews and our judgement, based on feedback from practitioners, that they seem to hold broader relevance. It is important to stress, however, that these are first and very tentative steps; even in patient safety, which has a much longer history of using and developing system models, they are still adding detail to individual genotypes as well as adding new genotypes to their typologies of underlying patterns. Our six clusters are not, therefore, presented as comprehensive or definitive but will instead need to be reviewed as more systems reviews are conducted.

Figure 8: Patterns of systemic factors in child welfare: an initial typology

1. Human–tool operation
2. Human–management system operation
3. Communication and collaboration in multi-agency working in response to incidents/crises
4. Communication and collaboration in multi-agency working in assessment and longer-term work
5. Family–professional interactions
6. Human judgement/reasoning

As is clear in the titles, each of the first five clusters highlights one key interaction involving specific elements of the system – the family, the management system, tools and the multi-agency team. The focus is always on the interaction, so treating the interacting elements as a sub-system: family–professional; practitioner–tool etc. In the final pattern – human judgement – there is a focus on how individuals, as

psycho-social systems themselves, reason. Although it is not clear in the names we have given to the six patterns, in seeing how these patterns manifest themselves in practice, interactions with the wider system are crucial since these help or hinder individuals' ability to reason coherently and critically.

Describing them as 'clusters', we hope to indicate that they are high-level categorisations. Each can be broken down further into specific aspects or manifestations of the overarching category. Management systems, for example, include the multiple issues of resources, PIs, priorities etc. In the following section we will illustrate some of these secondary level categorisations from our pilot case reviews. As more systems reviews are carried out, however, a more detailed typology of recurrent issues under each cluster will start to evolve.

In practice, these categories are not rigidly distinct because patterns of systemic factors can overlap in various ways. A specific pattern of human reasoning and pattern of family–professional interaction can reinforce each other in how a particular practice episode was handled. Other contributory factors not highlighted in the clusters can, in practice, also come into play.

The above becomes less cryptic when illustrated with practice examples. So below we go through each type of pattern in turn, giving a general clarification and justification of its relevance, before detailing examples of how they manifest in the County and City pilot case reviews. The different levels of categorisation are summarised in a box at the beginning of each cluster.

4.2 Explanations and practice examples

4.2.1 Patterns in human–tool operation

- The influence of assessment forms:
 - no detail on the quality or depth of assessments, or difficulties faced in completing them
 - discourage documentation of the rationale or complexity behind conclusions drawn
 - encourage factual statements and assertions and discourage the recording of a healthy unease or gaps in understanding
- The influence of the assessment framework:
 - focuses on the assessment of need and discourages articulation of risk factors
- The influence of the case management framework, for example, Assessment, Planning, Implementation and Review (APIR):
 - revision becomes an interruption in the flow of practice

Professional practice is being increasingly influenced by the introduction of tools. Frameworks for the assessment of need and associated electronic and paper forms, such as those for the Initial and Core Assessment and the CAF form, and databases such as the Integrated Children's System, are all examples of such tools. Traditionally, people have tended to see tools as passive objects that help professionals do the same tasks as before, but do them better or faster. Consequently, research,

evaluation and SCRs in child welfare services have tended to focus only on whether or not practitioners are using prescribed tools, for example whether all the sections of a Core Assessment form were completed.

However, the experience from other fields emphasises how tools become active agents in shaping practice so that they are best seen as co-agents, altering the nature of the task the human does. An assessment framework, for example, is more than a neutral format for organising data but offers a framework for organising the assessment that influences the way the family is conceptualised and hence alters the final picture of them that is acquired. The structure of forms with their differently headed boxes, similarly, have transformative effects both on the sense-making process of the form filler and the 'interpretive demands' (White et al, 2008: 12) it places on subsequent readers. It is important, therefore, to consider how people and tools 'interact with each other and, over a period, change each other in complex and often unforeseen ways' (Hood and Jones, 1996: 35), and to examine whether these changes are leading to improvements in practice.

Framing the human–tool operation as a joint system draws attention to their function; it highlights the need to be clear about what they are intended to achieve before one can evaluate their level of performance. For example, are data collection forms such as the CAF or Core Assessment designed to meet the needs of the practitioners who are assessing the needs of the family, or are they designed to provide the information needed by management to monitor services? If they are designed to perform both tasks at once, is this compromising the function of either or both of them? It needs to be studied to what extent these two aims are compatible. Recent research (White et al, 2008) has indicated the incompatibility of the two-fold function of the CAF both as an assessment tool and a mechanism for referral. When used for the latter, it is 'completed and read strategically ... with a mind to available resources and personal accountabilities' (White et al, 2008: 18), thus undermining the aim of the former: the objective, evidence-based identification of need.

Examples of sub-categories of the human–tool pattern are presented below.

The influence of assessment forms

At a local level, there is little choice about what forms to use, since they have been produced by central government, but, in City, it was clear that they played an active role in shaping professional practice and that some of their influences were not constructive. Examples of the kinds of influence we identified are detailed below. The cumulative effect was to convey a greater reliability about the information contained in the forms than was warranted.

No detail was included on the quality or depth of assessments, or difficulties faced in completing them

One way in which the forms influenced practice related to a problematic pattern of communication and collaboration between professionals whereby no detail was shared about the quality or depth of assessments that had been undertaken, or

difficulties that may have been faced in conducting them. In other words, no 'health warning' was provided about the strength of evidence contained or the implications for decision making. As a result even the most blatantly partial and brief assessment was subsequently treated as if it was complete.

Yet rather than being completely within the control of individuals to include or exclude this material, the form itself proved to have an active role. Structured as a series of boxes, each with its own heading and prompts for the writer on how to complete it, the form is explicitly designed to influence what information is included and how it is presented. Pertinently, no space is provided in which to indicate the quality, depth or degree of certainty or uncertainty. The form itself, therefore, seemed to encourage the conflation of two different things: whether the assessment had been stopped or whether it had been completed to a professionally satisfactory standard.

Discourage documentation of the rationale or complexity behind conclusions drawn

A second way in which the forms influenced practice related to another problematic pattern of communication and collaboration between professionals whereby they tended to record, and therefore share, only their conclusions or decisions but not their thinking and the rationale behind their judgements. This is a finding supported by several research studies (cf Farmer and Owen, 1995). While the latter takes more time, it provides a valuable safety mechanism by enabling others to amplify or challenge both the factual accuracy and interpretation of information.

For example, the decision taken at the Child Protection Conference *not* to place Kelly's name on the Child Protection Register was recorded and communicated as *if* it were based on her situation not meeting the threshold for registration. The result was that subsequently the case looked low risk and consequently was not judged as a priority relative to other cases being handled by the social work team at the maternity hospital. As we explained in the synopsis, this meant that rather than receiving the appropriate services after the Child Protection Conference as had been planned, the family received none at all.

In fact the decision not to place Kelly's name on the register had been significantly influenced by the protective measures that Michelle's adoptive father had offered – taking more of an active role in ensuring that Michelle looked after Kelly properly and encouraging them to move back in with him and his wife. Other significant concerns about Michelle's current level of distress and potential impact on her parenting ability and the lack of a complete assessment to date due to Michelle's reluctance to discuss her own history had been problematically minimised.

Yet, as with the quality and depth of assessment discussed above, a closer look at the assessment form itself and discussion with participants revealed that the structuring of the form itself does not explicitly encourage the documentation of how professionals have reasoned to their conclusions or the potential complexity of decisions. There are no section headings or explanatory notes on their completion that request such information.

Encourage factual statements and assertions and discourage the recording of a healthy unease or gaps in understanding

The third illustration of the influence that we identified the assessment forms to be having on practice in City related to a striking discrepancy that was highlighted between formal records and oral accounts by practitioners in the case, a discrepancy that participants indicated was common. Concerns about the mother's level of intelligence, for example, although a significant feature in many practitioners' verbal narratives, were not documented. Discussions with participants suggest that, implicitly if not explicitly, assessment forms encourage factual statements and assertions and discourage the recording of a healthy unease or gaps in understanding – details that would prompt the need to follow up on them. In this case, only what was *already* known to be significant was recorded and not issues or episodes that *might*, with time, have proved to be so, such as the episodes of poor care of the home. Thus the emphasis on the actual and concrete brings with it the risk of ignoring potential concerns.

The influence of the assessment framework

As well as the structure and format of the actual forms, we also identified ways in which the framework (DH et al, 2000) on which assessment forms are based influenced practice.

Focus on the assessment of need discourages articulation of risk factors identified

This influence related to the little, or total lack of, discussion that was included about the mother's weaknesses, as well as misleading information about her strengths.

Discussion of this issue with practitioners indicated that the focus on the assessment of need via the assessment framework and associated forms discouraged them from articulating risk factors that had been identified. They indicated that this was a recurring area of problematic practice. The way that the assessment framework and related forms shaped and altered practice in this respect was described quite graphically by one social worker:

'It gets a stranglehold round you and what you would have written prior to using it about risks, you don't any more, unless you make a special effort.'

This quote can be rephrased in systems terms as describing the framework as making it easy to do the task poorly (with inadequate attention to risk factors) and making it difficult to do it well (requiring 'a special effort').

Influence of case management framework, for example APIR

The final example of patterns of human–tool interaction identified in City implicated the case management framework as having an unhelpful influence on practice.

Revision becomes an interruption in the flow of practice

This related to a problematic pattern of communication and collaboration whereby social care tended to present, and other agencies accept, assessments as comprehensive and definitive, rather than seeing them as ongoing works in progress linked to a clear plan that could be evaluated. This raised concerns that, across agencies, assessment was not seen as a continuous dynamic process but as a discrete stage with a service user.

The influencing tool identified here was the case management framework. With its reliance on flow charts, it seemed to have incidentally reinforced the above approach, with assessment having a fixed box in the flow charts and review, also, falling towards the end of an intervention. It seems that the use of flow charts conveys the impression of setting off on a fixed journey and knowing your destination. Even if written guidance mentions the need to review and add to assessments, the basic picture has already been set so revision becomes an interruption in the flow of practice. Input from the participants suggested that the APIR framework encouraged 'review' to be understood as checking whether a plan had been implemented and not whether it had been effective, or whether, in the light of new information about the family, it was still the appropriate plan.

4.2.2 Patterns in human–management system operation

- Resource-demand mismatch:
 - difficulties accessing expert assessments
 - gaps in service provision
 - threats to preventative services
- Pls and covert organisational messages:
 - trade-offs between competing priorities; overt and covert messages
 - conceptual blurring
- Supervision:
 - threats to supervision in a turbulent environment

The second key pattern highlighted in our initial typology links to management systems. If professional practice is being increasingly influenced by the introduction of tools, it is also increasingly influenced by systems of management. These are made up of various elements. In this section we give examples of three different aspects of patterns of human–management interaction and their influence on practice: (1) resource–demand mismatch, (2) Pls and (3) supervision. Each is prefaced by a more general explanation of why it is useful to consider the patterns of these particular systemic factors in a case review before being illustrated with findings from the pilot case reviews.

Resource–demand mismatch

In the context of children's services, the potential demand is so high that all agencies have to prioritise as they allocate a finite amount of resources (both personnel and financial). A systems review can help to reveal how decisions on priorities and allocations impact on direct work with families. Thus it can provide feedback that

helps senior management to understand the practical repercussions of their own decisions, as well as those of other agencies, so that adjustments can be made if necessary. The pilot cases highlighted three areas of unmet need that had a negative impact on the quality of service that workers were able to provide for families. These are detailed below.

Difficulties accessing expert assessments

In City, the social workers carrying out the assessments of the mother's parenting capacity noted a problem with her intelligence level but were not competent to measure this more accurately or to investigate its causes or consequences. Yet, staff told us that, in their experience, they were impeded from accessing expert assessments because the resources were not available to commission them privately and funding tended to be available only at the point of court proceedings. This is clearly problematic since specialist input at the initial stage of deciding how to help a family would make a significant contribution to the quality of the assessment and linked plan of intervention. Crucially, the degree of unmet need seemed to have been partly hidden from senior management by the decisions of social workers *not* to make requests for specialist assessments when experience had taught them that they were unlikely to be successful. The lack of requests conveyed the misleading impression that there was a lack of need.

Gaps in service provision

A key issue in County was the lack of appropriate help for the teenage son. There was a striking contrast in the quality and quantity of services offered to his elder sister and younger brother. Yet this was not due to any lack of awareness, any shortfall in sharing information or lack of will on the part of professionals. As detailed in the synopsis, there were several attempts to find some help for him but referrals were not accepted. This gap in service provision reflects a national problem; services for children with conduct disorders are under-resourced and referrals of children and young people presenting with emotional disorders are more likely to receive a service than those who present with challenging behaviour or oppositional disorders, such as this boy. The availability and cost of services that engage with family dynamics and the family as a whole is also a national problem, which seemed to have manifest itself in this case.

Threats to preventative services

In City, the nature of the services and relationships provided by the voluntary sector in a manner acceptable to the mother served as a key safety mechanism. The daughter was highly visible in large part due to her regular attendance at nursery, where her development could be monitored and changes linked to possible adverse outcomes were quickly noticed and acted on. The vulnerability of this safety mechanism, linked to resource–demand mismatch, was, however, indicated by confusion over the payment for these nursery sessions and conflicting understandings of prior agreements between social care and the nursery. This resulted in the mother being left with a bill of £300, which she was unable to pay.

Input from participants indicated that this kind of threat to the safeguards provided by the nursery is increasing. We were told that local authorities were restricting the funding of childcare to children on the Child Protection Register and that developments of the Children's Centre were leading to pressure on the nursery to ensure full occupancy. This was making it difficult to get spaces for Sure Start family support team families. The implication is that preventative work with non-child protection families is going to become more difficult, as is responding to families' requests for help, so that a family like this one might not be offered a service in an acceptable way that would allow the child's development to be monitored. Indeed, beyond childcare issues, too, participants indicated that in their experience local authority family support services are only picking up cases in which there are child protection concerns: "Tier 2 families are being disowned". If the prime goal of *Every Child Matters* and the CAF is to increase early intervention services, this is extremely worrying.

With no immediate resolution to the funding issue, in principle, the child's place at nursery should have been stopped. However, the funding problem did not impact directly on the safety of the child because Sure Start staff broke the rules and kept the place open to ensure she had a stable placement. This degree of flexibility at the front line is a good defence against the vagaries of complex rules that have unexpected repercussions in particular cases and illustrates how rule breaking cannot automatically be seen as poor practice since, in this case, it seems to have been in the child's best interests. The benefit of the future orientation that this entailed was underlined by a referral from the nursery to social care, that followed shortly afterwards.

PIs and covert organisational messages

Children's safety and welfare are only two of several goals of the agencies involved in any particular case. The performance management system of targets and PIs creates more short-term, concrete goals that also shape decision making. Therefore, at the front line, practitioners inevitably make trade-offs between competing goals; children's safety is not necessarily the overriding priority in all situations but can be compromised. The performance management system of targets and PIs, therefore, needs to be seen as an active factor when explaining practitioners' established routines. Indeed it is explicitly intended to alter practice (see www.audit-commission.gov.uk/) and clearly has had a substantial impact on it. There are debates about how much the impact of PIs has been beneficial and how much detrimental in the priorities it has encouraged and the perverse incentives it creates (Tilbury, 2004). We do not take sides in that debate but, by including PIs in the typology, stress the need to elucidate the practical impact they have on practice.

Practitioners' decisions about trade-offs are influenced partly by their past experience and partly by the messages that they receive from their organisation and society. A key lesson from the pilot sites has been appreciating the importance of recognising the difference between the overt and the covert organisational messages. Workers tend to be strongly influenced by covert messages and, unless these change, they are likely to sabotage overt efforts to alter practice.

Two examples from the pilot sites of patterns of interaction between practitioners and PIs and associated covert organisational messages are detailed below.

Trade-offs between competing priorities; overt and covert organisational messages

In City, social care staff indicated that they felt strongly that the covert message was that the organisation placed most priority on 'throughput' as opposed to the quality of their work. The pressure that practitioners felt they were under to meet the prescriptive procedures and the system of targets and PIs was mentioned several times – they reported strong covert messages about the importance of meeting PIs relative to meeting a specific child's needs. It was identified, directly and indirectly, as an important driver of the way the case was handled. Allowing assessment forms to be classed as 'completed' when they had serious deficiencies was one example of how such pressure was acted out. The influence of PIs thus overlapped with the influence of forms discussed earlier.

Another organisational message that was influential was the drive to keep as many cases as possible within the 'child in need' category, minimising the number of child protection cases, a categorisation that has significant influence on how the case is framed and handled by all agencies.

Conceptual blurring

A common criticism of the current audit system is that it focuses on the easily measured and on service outputs rather than children's outcomes (Power, 1999; Tilbury, 2004). This design makes it more likely that, in times of pressure, workers will prioritise the completion of tasks that are measured and recorded over the more qualitative aspects of their work the value of which tends to be perceptible only in the longer-term outcomes for the family. The example above from City is a concrete manifestation of this and its negative impact on the quality of practice. There is a PI about completing Core Assessments in a fixed period and bureaucratically there are only two options: completed or not complete. The effect is a conceptual blurring between completed as stopped and completed as in adequately comprehensive.

Supervision

Our third sub-category of human–management system patterns is supervision. The term 'supervision' is usually understood as having several functions: offering case management by senior staff members alongside opportunities for critical reflection and evaluation of the work, support in recognition of the inherent stress factors and the emotional dimension of the work, and educational and training features. Case management is crucial within agencies because of accountability and the audit framework. It therefore tends to take precedence over other elements of the supervision task (Rushton and Nathan, 1996). However, it has been argued convincingly that unless the critical aspects of the supervisor's role are given adequate attention, supervision may deteriorate into a rubber-stamping process leading ultimately to dangerous practice (Hughes and Pengelly, 1997). The inevitable

errors in human reasoning, which we deal with later, may be overlooked and opportunities to challenge situations that may have drifted may be lost.

While a reflective approach to social work should be integral to the work of all practitioners, it is only through the process of supervision that critical and therefore safe practice can be sustained. The theme of retaining reflective practice in social work is a constant one in the literature and has been closely analysed by Bogo and Vayda (1987), who emphasise the dangers of reactive versus reflective practice. A systems review can help to reveal what aspects of supervision are getting prioritised and how these decisions are impacting on the quality of practice.

Threats to supervision in a turbulent environment

Within the agency context of high workloads, emotionally charged work, changing organisational structures and legislative imperatives the critical aspects of the supervisor's role are most vulnerable. Hughes and Pengelly (1997) demonstrate how in a such a 'turbulent environment' both supervisors and supervisees may be prone to endorse each other's approach rather than using supervision as an opportunity to challenge and question assumptions. Such endorsements seem like a supportive way forward in what feels like an unmanageable situation. This was evident in both our pilot sites. Again, the pressure created by prescriptive procedures and the system of targets and PIs was reported to us as highly influential.

4.2.3 Patterns in communication and collaboration in multi-agency working in response to incidents/crises

- Organisational culture around priority setting
- Understanding the nature of the task: overlooking the wider needs of the children in child protection response
- Reserve capacity
- The importance of knowing each other
- Referral procedures and cultures of feedback

Communicating and coordinating work across several agencies and practitioners is known to be a complex task where misunderstandings, omissions and duplications easily occur. Our pilots highlighted patterns in relation to five different aspects of multi-agency working in response to incidents and crises that either made good practice more likely or encouraged problems in working together. These are detailed separately below.

Organisational culture around priority setting

The cases in both pilot sites seemed to indicate that there were clear and shared organisational cultures and values that placed emergency work at the top of professionals' priorities, ensuring all were available to play their part. We had to note in City, however, that the organisational culture around setting priorities is illustrated both by the efficiency of responses to incidents and crises *and* by the family receiving no attention in various other key episodes. When a multi-agency team focuses so completely on an emergency, it has by necessity to leave less urgent cases to wait.

This raised important questions about what guidance was given to practitioners on how to prioritise when the demands of their caseloads exceed the time available, and the responsibility senior management have in helping front-line staff set priorities when, realistically, some tasks cannot be done needs to be established.

Understanding the nature of the task: overlooking the wider needs of the children in child protection response

The distinction between child protection and family support has long been a source of difficulty, not just in allocating cases to the right category but also in the cultural frame of reference that each category tends to trigger. In child protection cases, there is a tendency to focus on the risk of harm but to overlook the wider needs of the children while, in the family support approach, the tendency is the opposite: to focus on the developmental needs of the children and overlook possible short-term and, especially, long-term dangers. Professional practice in the County case illustrated both types of weakness.

In relation to the former, when the case was re-classified as child protection, and a home visit revealed the poor condition of the house, social workers and the police responded to the perceived risk of harm to the children as a crisis. The case was considered so urgent that the dramatic step was taken to remove them directly from school. Yet the grounds for reaching this judgement were not spelled out. What harm might the children suffer if left in a dirty house? How likely was this to happen? How imminent was the risk? The lack of a clear analysis of the nature of the risk contributed to a failure to think through how best to minimise the trauma for the boys.

Neither was information sought from other agencies to inform a wider assessment of their needs. Neither the GP practice of the family nor CAMHS were contacted in the process of deciding to accommodate the boys, to be asked if they had any relevant information. In fact, as recipient of all the medical reports, the GP had an extensive set of information that could have informed assessments at this stage. As a consequence of this crisis focus on the condition of the house, the boys were accommodated without the extent of the emotional neglect being understood. We do not know the subsequent history of the case but there is a risk that this initial mindset of physical neglect may persist as the dominant frame of reference so that inadequate attention is paid to addressing the deficiencies in their emotional care.

The fact that neither agency was told of the decision to accommodate but learned of it from family members suggested serious communication barriers between health and social services. This is discussed further below in the section on inter-agency working in assessment and longer-term work.

Reserve capacity

Organisations that manage a high level of safety share the feature of having reserve capacity in the system and the human workforce to enable them to cope with unexpected circumstances (Transfield et al, 2002). Children's services operate in a very different environment of limited resources and ambitious goals. The case in City

indicated that at the key point of crises, there was sufficient reserve capacity to allow the Sure Start Family Support Worker to get involved with efforts to get into the mother's house, which was important due to her hostility to statutory social workers. Similarly, in County, there was good support for the key workers in social care and the police from within their own professional teams in managing the practicalities of accommodating two boys and tackling the state of the house. The Social Worker involved commented on how good support was when conducting the emergency Section 47 investigation and indicated that this was usual: "colleagues know you can't be in the office making phone calls when out in the field so they help out. They did that efficiently and willingly."

Yet participants in City drew our attention to current budget cuts within the children's centre, leading to cutbacks in some areas other than the nursery, for example, the family support team. With such reductions, it would seem unlikely that a family support worker would be able to be as flexible in the future. This overlapped then with our discussions in the resource–demand mismatch section.

The importance of knowing each other

Good working together in response to incidents in both sites also seemed to be facilitated by the fact that people were operating within a familiar set of procedures with a good, shared understanding of each other's roles. In both sites, we were also told that the fact that most professionals knew each other and that many had good ongoing working relations helped in the communication and collaboration in response to incidents/crises. In City this seemed to minimise conflict and enable a recognition and use of strengths and weaknesses inherent in the relative roles, particularly between the statutory and voluntary sector.

Yet it was also noted that the extent of contact between the social workers based at the maternity hospital and others in the multi-agency team was greater than usual. This was due in part to the city-wide remit of the social work maternity hospital team, which significantly increased the number of other professionals they dealt with and made the development of close working relations difficult. This suggested that there was a strong element of chance in the good working together in response to incidents demonstrated in this case, as opposed to a robust system to support it.

Multi-agency children's services are premised on the assumption that workers are interchangeable but our analysis showed the importance of individuals and interpersonal relations to the quality of working together between people from different agencies.

Referral procedures and cultures of feedback

Safe systems need to accommodate the possibility that referrals or letters conveying increased concern may get lost or, for whatever reason, be wrongly overlooked. In County this happened on four occasions. The systems analysis revealed that there did not seem to be an established culture across agencies of giving acknowledgement of and feedback about action taken in response to referrals, whether by individuals or the multi-agency panels.

4.2.4 Patterns in communication and collaboration in multi-agency working in assessment and longer-term work

- Understanding the nature of the task: assessment and planning as a one-off event or ongoing process?
- Clarity of roles and responsibilities:
 - How much shared responsibility is there?
 - Who is responsible for thinking?
 - What and how much should be shared?
- What barriers and facilitators exist to good teamwork in longer-term case work?
 - Are conflicts of opinion repressed or is there a shared culture in which it is acceptable and even desirable to query each other's assessments?
 - 'Group think'
 - Ascribed and perceived occupational status
 - Overestimating the remit of service provision of different agencies

As noted earlier, our pilot cases indicate the need to distinguish between patterns of communication and collaboration (a) in response to incidents/crises and (b) in assessment and longer-term, day-to-day work. The significant patterns identified were different in each. In the latter, a sub-division of three seemed to capture recurrent issues both from the two pilot sites but also holding broader relevance. These include: (a) understanding of the nature of the assessment task; (b) clarity about respective roles and responsibilities; and (c) other barriers and facilitators to good teamwork. We expand on each of these aspects below and give illustrations.

Understanding the nature of the task: assessment and planning as a one-off event or ongoing process?

In City, good working relations between agencies did *not* result in any change to the Initial Assessment or to the associated Care Plan. There was evidence in this case that social care presented, and other agencies accepted, assessments as comprehensive and definitive, rather than seeing them as an ongoing works in progress linked to a clear plan that can be evaluated. As we discussed in relation to patterns of human–tool interaction, neither the quality nor depth of the assessments nor the difficulties/obstacles in completing them were stressed in summaries written by social workers or queried by other agency staff. There was no discussion of the implications of the strength of evidence contained for decision making. Throughout the two years, what the support package was intended to achieve was never made explicit: whether they expected it to help Michelle develop skills and become a competent parent or whether they thought she would need services to supplement her skills on a long-term basis. Without a clear goal, it would have been impossible to evaluate progress made or the appropriateness of these goals over time and, indeed, this was never attempted. Remarkably similar issues were also apparent in County. While these issues obviously overlapped with our discussions about the influence of the management system and forms, they also raised concerns that, across agencies, assessment was not seen as a continuous dynamic process but as a discrete stage with a service user – an understanding that makes problematic practice more likely.

Clarity of roles and responsibilities

In both the pilot sites, good working together in response to incidents in these cases was facilitated by good working relations between professionals. Yet these good working relations did *not* result in any change to the Initial Assessments or to the associated care plan. This raises questions about how 'working together' should operate in both assessment and longer-term case work, including review. Which agency has the overall responsibility for assessment and evaluation of whether the package is meeting all the family's needs? Is it social care and, if so, what does 'working together' mean? What part, if any, would each of the other agencies consider they played? How much shared responsibility is there? Specifically, who is responsible for thinking? Research in the US has found that increased inter-agency collaboration can *reduce* individual sense of responsibility for the case (Bickman et al, 1997, 1999; Glisson and Hemmelgarn, 1998). These issues will have perhaps an even greater significance as the role of Lead Professional is embedded. We expand on three different aspects of the issue of clarity of roles and responsibilities below.

How much shared responsibility is there?

Official guidance states that assessment should be a joint, multi-agency task. Yet analysis of the cases in both pilot sites indicated that assessments were actually understood as being the job of social care. In City, for example, after both the second and third incidents that led to referrals to social care, leadership of the multi-agency core group and child protection team respectively seems to have been informally delegated to the Social Work Maternity Team. What, then, does 'working together' mean? What part, if any, would each of the other agencies consider they played? In this case, other agencies continued their usual contact with the family but did not add significantly to the assessment or Section 47 process itself. Sometimes basic information was shared but we could find no indication of collaboration in the analytical work involved in interpreting and making sense of the situation (a point taken up further below).

This lack of shared responsibility or collaborative work was also evident in relation to both the task of interpreting the results of assessments completed by social care and evaluating whether the package was meeting all the family's needs.

Cultural divides between health and social/education services

In County, the patterns of communication in the case revealed a significant difference in communication *within* health services or social/education services and *between* them. These divisions in patterns of communication also shed light on patterns in the way that responsibility was partitioned.

The care offered to the daughter by a range of health services, for example, was characterised by regular and detailed communication between those actively involved so that they were all aware of what each other was doing. The GPs of the family members also received all the reports from other medical services. The professionals working in social and education services showed a similar pattern of sharing information and discussing their relative roles in working with family members, although they relied more on verbal communication than written.

However, there were significant omissions when we looked at communication between health and social and education services. At the child in need meetings, the members were reliant on information from the mother about which services were being received, if any, from health professionals and there was no indication that they ever sought permission to contact any medical practitioner. One consequence of this was the haziness around the mother's claim that the middle child had Asperger's Syndrome or Attention Deficit Hyperactivity Disorder (ADHD). Conversely, the Community Paediatrician, Psychiatrist and CAMHS Counsellor were very aware of the problems in the family and saw them as contributing to the daughter's difficulties but did not seek permission to contact social services (until they heard about their withdrawal). Their input might have prompted a rethink of the nature and severity of the family functioning and its impact on the children.

There seemed to be no feeling of shared responsibility and, therefore, no impetus for joined-up working across the health and social/education divide. The Social Worker, for example, explained that she had not focused on the younger son's developmental issues because they were being addressed by others in the health sector, and so were not a focus of concern to her. CAMHS and the Community Paediatrician, on the other hand, seemed to assume that it was social services' responsibility to deal with family problems of which they were aware through their work with the daughter.

In health, there is a long-standing tradition of writing to referrers to update them on their patient 'out of courtesy': "Within health as a referrer you get a letter back." We were told that it is also common practice to have discussions about the case with the referrer, reflecting a shared responsibility. Clearly no equivalent culture of feedback or shared responsibility for thinking was evident in social services from the review of this case. This was linked to a perceived lack of clarity on both sides about which service should take the initiative in contacting the other. Where communication did take place, it was often through 'copying' people into letters addressed to others. This also revealed different traditions resulting in misunderstandings, as some assumed that if they were only copied in, the letter was just for information, not action, while others assumed that the person copied in would read the letter and notice that it requested them to take some action.

Beyond procedural aspects, however, the review also revealed a greater sense of ease in professionals communicating within their own professional worlds where they know each other's roles and speak the same language. Within health, the greater level of consensus on medical knowledge and terminology seemed to facilitate mutual understanding. Speaking across the divide, in contrast, seemed to take greater effort and tended to be done in a more formal way, for example, by writing rather than speaking. Some way out of this impasse will be crucial. Yet the long-standing, cultural focus on the index patient in health poses a challenge to assuming the broader responsibilities associated with safeguarding as opposed to child protection.

Who is responsible for thinking?

Official guidance states that assessment should be a joint multi-agency responsibility. Yet thinking is a strenuous task that most of us avoid if we can, especially when we have lots of other demands on our time. In a work environment

framed by targets and PIs, time for thinking can be hard to measure and, therefore, hard to include in performance management.

As noted earlier, social care staff involved in City indicated that they felt strongly that organisational priority was placed on 'throughput' as opposed to the quality of their work. Workload pressure was also described as creating a 'siege mentality', referred to in the human factors literature as tunnel vision, whereby practitioners tend to make the task manageable by seeing an increasingly narrow portion of their work environment (Dekker, 2002a). This has the benefit of allowing them to stay well focused on one thread in the case but has the weakness of making them slow to notice issues arising outside that narrow focus. In this case, the focus on day-to-day support tended to obscure questions about the long-term adequacy of the emotional and physical care the daughter received.

What and how much should be shared?

Designating responsibility for thinking within collaborative assessment and review processes raises further questions related to communication. What do professionals need to be told in order to be able to work together? Should professionals inform others only of their conclusions or should they also share their thinking and communicate the rationale behind their judgements and decisions? As noted in the discussion of the influence of forms earlier, while the latter takes more time, it provides a valuable safety mechanism by enabling others to amplify or challenge both the factual accuracy and interpretation.

This linked with issues to do with resource–demand mismatch. It also linked to barriers to good inter-agency working, as it requires a shared culture in which it is acceptable and even desirable for professionals to query each other's assessments, which is discussed further below.

What barriers and facilitators exist to good teamwork in longer-term case work?

This is our last sub-category of patterns of communication and collaboration in assessment and longer-term work. Barriers to good teamwork are well documented in the literature and creating safety involves developing systems that take these into account. Four illustrations from the pilot sites are detailed below.

Are conflicts of opinion repressed or is there a shared culture in which it is acceptable and even desirable for professionals to query each other's assessments?

In County, in our interviews with professionals, there were several comments indicating discontent or disagreement with the official assessment and intervention with the family but none of this appeared in the official records. This suggested a culture of covert as opposed to overt conflict, which inhibits good critical thinking about the management of a case. For example, disagreements between the small voluntary organisation worker and others about whether the house was of an acceptable standard seemed to have been resolved by majority rule and/or on the grounds of disparaging personal comments about the dissenter. An alternative approach would have been to attempt to explore *why* the voluntary organisation

worker had reached such a different judgement. This might have brought to light that she was the only one visiting the house. It might also have drawn attention to the lack of detailed recording at previous times of concern which had made it impossible to say whether the condition had fluctuated significantly over the years or whether it was just that different professionals had reached different conclusions about whether it was above or below the threshold of acceptability.

Openly exploring differences of opinion in this way, however, requires a shared culture in which it is acceptable and even desirable for professionals to query each other's assessments. Our review indicated that such a culture did not exist within the core group working on this case. More broadly, it illuminated the way in which systems designed to safeguard against the chance of conflicting opinions being repressed do not work particularly well in practice. For example, if someone is not happy with, or not clear about, decisions or minutes of them, in principle they can have disagreements noted, or go to the social services team manager if such a response does not materialise. However, discussion with participants indicated that, in practice, this did not happen. A third option is for a professional to call a Child Protection Conference themselves but feedback at the interim meeting suggested that this often triggers threats and intimidation: "You'd better have the evidence!".

'Group think'

In contrast to the example above, in City the review highlighted a total lack of conflict within the core group. Yet this too was problematic and also inhibited good critical thinking about the management of a case. The underlying pattern here was 'group think' (Janis, 1982). This is a powerful dynamic that encourages conformity to prevailing points of view. In City, such 'group think' was evident and seemed to have been encouraged by the good working relations that existed between professionals, which became conceptually blurred with good working together.

Ascribed and perceived occupational status

In City, another barrier seemed to be that of 'ascribed and perceived occupational status, occupational knowledge and the importance of that knowledge for care' (Southill et al, 1995). What voices can be heard? Who can talk about what? What does your professional identity allow? In this case, it was notable that the Tenancy Support Worker was the only professional who was *not* surprised by the final episode. She had never felt confident about the mother's progress: "it never got to the point of running smoothly – clinging on with nails, then another crisis". Yet the concerns she had had did not get fed into the multi-agency assessment and review process, even though twice she had brought to people's attention issues related to the state of the house. Being both new to the job and of lower status in the relative hierarchy of child professionals, she found it hard both to articulate her concerns and to get them taken seriously. Furthermore, she did not feel in a position to challenge the group consensus about this family.

This issue was also identified in County. There, information from the small voluntary organisation indicated that it was a common problem that the social work qualifications of their staff were not recognised by statutory social workers because

they worked in the voluntary sector. Consequently, they often felt that they were not treated as equal status professionals and this meant there was a danger of their input being overlooked.

Overestimating the remit of service provision of different agencies

A further barrier to good inter-agency working that was manifest in County was a lack of understanding of the remit of service provision of particular agencies. This was notable both in the overestimation of service provided by the small voluntary organisation and the consistency with which the middle child was unsuccessfully referred to CAMHS.

Input from the small voluntary organisation indicated, beyond this particular case, that social services front-line staff seemed to have no idea about the limitations of a small voluntary organisation or of the specifications of their service level agreement. This, we were told, was compounded by that service level agreement itself not being particularly clear and, therefore, not playing to the strengths of a very small voluntary organisation by providing a clear and realistic remit. Input from CAMHS detailed the way in which they had changed their remit to deal only with mental health issues and no longer with behavioural problems. Yet other agencies either did not seem to be aware of this or did not properly understand what the implications were for them in terms of making referrals.

4.2.5 Patterns in family–professional interactions

- Salience of the mother in social services' involvement
- Classic gendered presentation of problems by family members

Unlike the work of engineering and industry, as stressed in Chapter 2, child welfare professionals do not just act on but interact with the people they are trying to help. Safeguarding and promoting the welfare of children is by necessity a shared enterprise, and social and emotional interactions shape the nature of the work. Consequently, rather than being seen as objects to be managed, children and parents need to be seen as active participants *within* the system, not outside of it. As a result, patterns of family–professional interaction need to be seen as patterns of systemic factors.

When psycho-social case work was the dominant theoretical approach in social work, considerable attention was paid to the relationship, with supervisors helping workers analyse what impact it might have on their reasoning and actions as well as what insight it gave about the functioning of the family. However, in recent years, with the rise of a managerial framework for practice, this dimension has received less attention (Rushton and Nathan, 1996). A techno-rational approach tends to overlook the significance of the specific relationship a worker forms with parents and children and how this affects what information they receive, how they interpret it and how they use it. Yet analysis of child abuse inquiries has revealed the powerful impact of the relationships, often in a destructive way (Reder et al, 1993; Reder and Duncan, 1999).

Reder et al (1993), for example, identified four main themes as problematic in family–professional interaction:

Dependency: when one parent relied excessively on support from professional agencies and experienced crises when their closely involved worker was absent on leave or had left their job.

Closure: when the family shut themselves away from contact with the outside world and with members of the professional network by refusing to open their front door to them, failing to keep appointments and keeping the children away from school or nursery. Usually this occurred intermittently, and it tended to coincide with escalating abuse to the child. We understand closure to be primarily an issue of control, with parents feeling that they had only precarious influence over their lives and attempting to shut out anyone whom they perceived as likely to undermine further that sense of control.

Flight: where families moved home repeatedly, often at short notice and without notifying anyone. This had the effect of distancing them physically and emotionally from their family-of-origin as well as professionals and led to fragmentation of professional efforts to maintain a monitoring role.

Disguised compliance: where parents defused professionals' attempts to take a more authoritative stance by making pre-emptive shows of cooperation, such as by presenting themselves to the social services offices unexpectedly the day before a social worker was due to make a decisive home visit. The family's compliance was only temporary but it was sufficient to persuade workers of their apparent willingness to be more open and therefore kept them at bay.

More recently Brandon et al (2008) have coined the term 'start again syndrome' to describe a pattern of interaction between professionals and families who are well known to social care agencies, sometimes over generations:

One common way of dealing with the overwhelming information and the feelings of helplessness generated in workers by the families, was to put aside knowledge of the past and focus on the present, adopting what we refer to as the 'start again syndrome'. In cases where children had already been removed because of neglect, parental history was not fully analysed to consider their current capacity to care for this child. Instead agencies supported the mother and family to 'start again'. The 'start again syndrome' prevents practitioners and managers having a clear and systematic understanding of a case informed by past history. (2008: 5)

Based as it is on child abuse inquiries, much of the available literature in this area highlights problematic kinds of family–professional interactions. Moreover, it tends to be from the perspective of professionals as opposed to highlighting family members' experiences or points of view. It is important, therefore, to stress the importance in case reviews of both (a) highlighting, where possible, patterns of interaction between families and professionals that support good practice and (b) focusing on family members' perspectives on the kinds and quality of interactions and their effect on the potential effectiveness of interventions.

In the modest but significant collection of studies of the experiences of families who have become subject to child protection interventions, for example, Dale et al (2005) highlighted three main areas of complaint from parents:

- a lack of information given, or opportunity for independent advocacy, means that the child protection system is experienced as arbitrary and opaque
- arbitrary and inconsistent decisions and disproportionate judgements on the one hand, and an inherent negative assessment bias on the other, mean that families feel they are treated unfairly
- families describe a negative interactional style of child protection practitioners who (a) are sometimes discourteous, unpleasant, hostile and cold and b) fail to recognise the emotional impact for families when their child(ren) enter care.

Conversely, the kinds of treatment and interaction that service users and carers would like to expect are also well documented (see, for example, Quinton, 2004; CSCI, 2006, 2007).

Unfortunately, as we were unable to involve family members in either of our pilot sites, the professional bias is reflected in our illustrations from County below.

Salience of the mother in social services' involvement

In County, the compassion felt for the mother seemed to have had a detrimental effect on social workers' assessment of the standard of cleanliness in the house and quality of her parenting, with the children's needs being seen through the lens of the mother's needs. It also contributed to an over-optimistic estimation of her capacity to change because she is well intentioned and likeable.

This is a frequently observed bias in social work with families and creates the danger not just of overlooking the needs of the children and the roles of fathers but of underestimating the risk to those children since risk assessment is based on information supplied by a potential source of danger. Where the mother is well intentioned and likeable it can also lead to an over-optimistic estimation of her capacity for change and extra difficulties separating out judgements about the parenting and the parents. It is a common finding in cases of physical and emotional neglect – that the workers tended to feel compassion for the abuser and that this affected their willingness to describe their actions as abusive (Stevenson, 1998).

Classic gendered presentation of problems by family members

Responses to difficult family situations are often clearly gendered. Girls often assuming a 'helping' mode – taking on extra responsibilities, being supportive and protective of other family members, seeking out help and responding well to efforts to support them. Boys, in contrast, can present very differently – seeking to absent themselves, or being more withdrawn and 'difficult' and/or violent, rather than seeking out help and being grateful. This potentially affects how easy or difficult it is for professionals to engage with them and to understand what is going on for them.

In County, the daughter Kim's response to her family situation was in this classically gendered 'helping' mode. So too was her younger brother Darren's. He tended to either withdraw or fight back, sometimes being violent. The result was that professionals tended to see his behaviour as a problem and to cast him in the role of an aggressive and troubling young man, rather than assessing his needs in relation to what his family was providing for him.

4.2.6 Patterns in human judgement (thinking, reasoning)

- Failure to revise judgements and plans
- Drift into failure
- Attribution error
- Tunnel vision

A fundamental premise that shapes the whole-systems approach to understanding the role of the human operator in error causation is that studies need to be based on a realistic idea of human capacity. Work on human cognitive factors aims to inform our understanding of what standards are likely to be achieved. Designing a safe system means taking into account people's psychological limitations and requires understanding and recognition of the main human errors of reasoning, and building in strategies for detecting and correcting them. It can be argued that many aspects of the innovations in children's services in recent years are intended to provide defences against these human vulnerabilities, for example, the emphasis given to recording, to timely decision making, and the prescribed arenas for case reviews. The important question in a case review, therefore, becomes whether or not these mechanisms worked and why. Four different patterns in human reasoning that emerged from our pilots are detailed below.

Failure to revise judgements and plans

According to the human performance literature, one of the most persistent and important problematic tendencies in cognition is our human slowness in revising our view of a situation or problem. It is one repeatedly found in child abuse inquiries (Munro, 1999). Once we have formed a view on what is going on, there is a surprising tendency to fail to notice, or to dismiss, evidence that challenges that picture.

So in City, for example, initial judgements about the nature of Michelle's support needs and associated care plan continued despite several cues that indicated more serious problems and should have prompted a review of the assessment and plan. The level of professional concern about Kelly's safety and welfare was reduced, it seems, by the mother's participation in services and the child's visibility. These gave strong clues to those most closely involved that there were no serious problems. Against those strong clues, the various referrals about the deteriorating state of the house and the mother's deteriorating mental state were much weaker clues. They were treated as discrete as opposed to continuous, seen in isolation and not located within a longer-term view of Michelle's life.

Given the persistence of this human tendency, creating safety involves developing systems that take this into account. It can be argued that many aspects of the formalisation of child protection work introduced in the past 30 years are designed, in part, to shore up defences against this innate human vulnerability, particularly via review by others, including supervisors, and by other mechanisms such as Case Conferences, involving professionals from other disciplines and agencies and getting input from family members themselves. Consequently, in the City case review our discussion of this pattern overlapped with that of patterns of human–management system operation, particularly supervision, as well as patterns of communication and collaboration in assessment and longer-term work.

Drift into failure

When looked at with hindsight, patterns of professional response to a family can convey an image of complacency or of indifference to the children’s welfare. However, as Dekker (2002b) stresses, this is usually an inadequate explanation. What has generally happened is that deviations from the official procedures have become normalised in the culture as a means of cutting corners to free up time for other tasks. The deviant culture gets embedded and confidence in it grows when there is no major disaster resulting from it, so it looks like a safe and efficient way of coping. Hence there is drift into failure. When an adverse outcome does finally occur and the practice is reviewed by others, the extent of the deviant culture becomes visible. So what, with hindsight, looks like negligence with respect to the official procedure, looked to the workers at the time like the ‘normal’ way to behave in line with what had become the cultural norm as a way of coping with excessive demands.

Practice with families where there is slow, cumulative harm to children’s development rather than dramatic incidents of abuse is particularly vulnerable to ‘drift into failure’ – such as that manifested in County. Many professionals from many agencies made referrals to social services over the years expressing concerns about this family. Responses to referrals were made swiftly and without much reflection, and letters went unanswered if they did not alter the agency response – both strategies that clearly save considerable time and effort. The cumulative effect, however, was harmful because it enabled social workers to hold on to the benign assessment of the case and to discredit new information without giving it due consideration. During the period studied for this review, the social services department was under-staffed and functioning below an acceptable standard, as evidenced by being put on special measures by the Department of Health for a time. The poor practice, therefore, needed to be seen in this stressful context.

Attribution error

The ‘attribution error’ is the tendency to explain behaviour as due to internal personality traits or dispositions without analysing the environment in which the behaviour occurs (Plous, 1993). We tend to make this error more when explaining other people’s behaviour and less when making sense of our own: my anger is an intelligible response to your annoying behaviour; your anger shows your aggressive personality.

In County, it was the mother who seemed prone to making this error in explaining her middle child's problems in particular. She gave them a range of labels that suggested his behaviour was due to problems inside him, thus avoiding consideration of how much they might be due to the family environment and the care she provided. The main social worker strongly accepted the mother's account, while other professionals who knew the son better paid far more attention to the context of his problematic behaviour. This raised questions about the culture within multi-agency meetings for dealing with conflicting opinions that we discussed above, as the differences did not feed into assessments or care plans.

Tunnel vision

Under pressure, people tend to narrow down their focus. This is referred to in the human factors literature as 'tunnel vision', whereby practitioners tend to make the task manageable by seeing an increasingly narrow portion of their work environment (Dekker, 2002b: 124). This has the benefit of allowing them to stay well focused on one thread in the case but has the weakness of making them slow to notice issues arising outside that narrow focus. We mentioned earlier how, in City, the focus on day-to-day support tended to obscure questions about the long-term adequacy of the emotional and physical care the daughter received. This is a classic manifestation of tunnel vision. Such handling of the case was reinforced by patterns of multi-agency working in which, as we detailed earlier, shared responsibility was minimal and by the influence of the covert organisational messages linked to PIs that workers understood as prioritising throughput over quality.

4.3 Identifying and prioritising patterns

The typology outlined above provides a framework for the identification of patterns of systemic factors linked to either good or problematic practice. It is made up of six clusters of patterns in:

1. Human–tool operation
2. Human–management system operation
3. Communication and collaboration in multi-agency working in response to incidents/crises
4. Communication and collaboration in multi-agency working in assessment and longer-term work
5. Family–professional interactions
6. Human judgement/reasoning

It is not a prescription of the kinds of issues that *should* be found in any particular case review. Some patterns will be more significant in some case work than others and some may not feature as explanatory factors at all. Selecting which are highlighted and which are ignored is an empirical task. This should be influenced both by the nature of front-line practice in relation to the particular family whose case is being reviewed and by practitioners' opinions about how widespread the issues are beyond the particular case under review. Lessons from the health field also suggest prioritising those with the greatest importance for the safety of *future* children's services delivery.

However, our experience suggests that none of the above is straightforward or easy. Firstly, a systems approach creates a problem of boundaries that a typology will never solve because the theoretical premise means that the boundaries of a review are inherently ambiguous, and nothing is ruled out by default. Therefore, the review team needs to find their own boundaries in order to keep tasks to a manageable size in order that they can be completed in the available time and are fit for purpose. Many of our discussions at this stage of both pilots, arguably quite rightly, veered into deep discussions about the general direction of recent national policy and implications for the caring professions, etc, but we had to accept that we should not try to cover everything. Of a whole raft of different patterns of systemic factors encouraging either strengths or weaknesses in professional practice, we had to select just a few.

Secondly, far from being a neutral and objective enterprise, we found that different issues stood out to differing extents for different members of the review team and for different participants depending on their identity, positioning etc in relation to the case. This resonates with Woodcock and Smiley's (1998) study, that found that the more senior the position of the safety specialist, the more likely they were to focus on front-line issues as opposed to systems issues emanating from further up the hierarchy. This difficulty is exacerbated by the overlapping nature of the clusters of systemic factors. While they are separated in our typology for pragmatic purposes of clarity, as the examples above demonstrate they actually overlap in multiple ways.

Both points highlight the fact that key patterns did not and will not simply fall out of the case review of their own accord. Instead, choice and judgement are involved in their identification and prioritisation. This underlines the fact that this stage is (a) creative and (b) dependent on good background knowledge of the area. So there can be no mechanical process for formulating deep causes or prioritising them. Questions of how to ensure both sufficient methodological consistency and transparency at this stage, therefore, remain crucial. A key element of this, we suggest, is the provision of sufficient detail of the analysis of the whole case in order that the basis from which patterns have been selected is accessible and readers can, in principle, make alternative selections.

Formulating the findings of case reviews according to this typology holds promise for the collation of review findings by allowing a clear and useful differentiation of the kinds of issues being identified. As more systems reviews are done, therefore, it will become clearer which aspects are particularly troublesome or successful at local, regional and national levels.

4.4 Formulating recommendations

The identification of underlying *patterns* of systemic factors that contribute to good or problematic practice should lead, at the very least, to the identification of issues that need further exploration and, where possible, to the generation of ideas about ways of maximising the factors that contribute to good performance and minimising the factors that contribute to poor quality work. This distinction is important; it highlights that the recommendations that came out of our pilot systems reviews did not all meet the management literature's ideal of being SMART (specific, measurable,

accountable, reasonable and timely). Instead, they took on three distinct forms that are usefully distinguished (see Figure 9).

Firstly, there are recommendations of the kind that people have come to expect from case reviews and inquiries. These concern issues for which the solutions (a) are clear cut and straightforward in nature and (b) can be implemented at a local level. The issue of the differing understandings between health and social/educational services of what it means to be copied into a letter rather than being directly addressed, discussed earlier, illustrates this well. There is a clear need to create a consistent rule across agencies in order to avoid misunderstandings, and this is what we recommended in County.

Secondly, there are recommendations that cannot be so precise because they highlight weaknesses in practice that the multi-agency team needs to review in the light of other constraints on their work. It cannot be assumed that there is spare capacity. For example, more attention in supervision to detecting errors in reasoning requires more time; can that be obtained by cutting back on some other tasks? In other words, in relation to these issues, any potential changes will need to be evaluated against the other requirements of the system. As it is unlikely that the review team will be cognisant of all the demands and priorities of the agencies constituting the LSCB this is a task more properly done by the senior management. Consequently, our recommendation in City was as follows: that the importance of critical review in supervision, relative to the other demands on a manager's time, needs to be established both in C&YP social care and across other agencies.

The experience in our pilots highlighted the usefulness of involving participants in discussion of how best to resolve competing demands and priorities. For example, participants in City suggested that it might be useful to consider ways of separating out the critical appraisal aspect of supervision by, for example, having particular meetings where it is the explicit goal to look for evidence or questions that are being overlooked and/or consider rival or alternative explanations. It was suggested to us that these might be provided on a monthly basis to individual staff and undertaken by someone other than their manager. Consequently, we recommended that the Board might want to consider whether such supervision would be useful for multi-agency teams involved in long-term work with particular families, as well as individuals.

The third category of recommendations includes those that point to issues that need detailed development research in order to find solutions, although those solutions would then have wide relevance to children's services. For example, the difficulties in capturing risk well when completing Core Assessments indicate a need to research how widespread this problem is and, if necessary, experiment with alternative theoretical frameworks and/or forms structures, formats and possibly software.

As our three-part structure above implies, a key lesson from our pilot sites has been appreciating the need to identify *where* in the system change can be initiated. Increasingly, child welfare services are shaped by government prescription so that local autonomy is significantly reduced. This mirrors the way that procedures and audit have reduced individual workers' autonomy.

Figure 9: Three different kinds of recommendation

1. Issues with clear-cut solutions that can be addressed locally
2. Issues where solutions cannot be so precise because of competing priorities and inevitable resource constraints
3. Issues that require further R&D in order to find solutions that would need to be addressed at a national level

5 How do we get to identifying patterns? Producing a narrative of multi-agency perspectives and a table of key practice episodes and their contributory factors

If the end point of a case review using a systems approach is the identification of underlying *patterns* of systemic factors that contribute to good or problematic practice, how do we get there? How do generalised patterns relate to the analysis of the particular case that is being reviewed? This chapter goes back a step to deal with the organising of data and analysis of the case itself, from which the patterns are subsequently abstracted. Specifically, we present two different aspects that feed into the identification of patterns: (1) the construction of an adapted form of chronology that we call multi-agency narratives/perspectives and (2) the identification of key practice episodes and their contributory factors.

We detail these three parts of the organisation and analysis of the data separately and consecutively. In practice, however, they are not discrete stages; they are neither sequential nor procedural and do not proceed in a linear fashion. Rather than steps or stages, therefore, they are better thought of as parts in a creative and iterative, as opposed to linear, process.

5.1 Rethinking 'chronologies': capturing different local rationalities

Chronologies have a long history as an integral part of the conduct of child abuse inquiries. Yet recently, questions have been raised about their purpose and value:

... if chronologies are not simply another task to be completed during a serious case review, more attention is required to how they are compiled and used.... It is important that compiling an integrated chronology does not become an end in itself and a separate process from the rest of the [review]. (Rose and Barnes, 2008: 48)

At first glance, the purpose and value might seem self-evident – to verify the facts of the child and family's history and the contacts with, and interventions by, different agencies. Yet how resilient are these 'facts' under (intellectual) interrogation? And how useful are they for learning from and improving front-line practice?

5.1.1 What is a chronology for? A key part of the working method

A key premise of a systems approach is that, in order to build up an understanding of how factors in the work environment make good practice more or less likely, we need to escape the hindsight, bias and try and understand how things looked to people *at the time*. As explained in Chapter 2, a systems approach presupposes that even actions that, with hindsight seem problematic or mistaken, at the point when they were taken actually seemed like the sensible thing to do. In order to be able to understand how they seemed sensible, then, we need to understand the so-called mindset of people involved at the time, or their 'local rationality'. This is a

crucial step before we can begin to identify and analyse the ways in which different and overlapping factors influenced them to see it in this way and not another, with whatever consequences for their decision making, action or inaction. Capturing people's local rationalities is, therefore, the prime use of the 'chronology' and it is a critical part of the working method of the review process. In many respects, its inclusion as a coherent whole in the final report is only of secondary importance to its use in the review process itself.

5.1.2 How is it compiled? Highlighting the diversity of professionals' perceptions

If the purpose of the 'chronology' is to capture the local rationalities of participants in the case, this has major implications for how it is compiled. We need to go beyond the basic factual detail of who was involved, why and of what their involvement consisted, to capture how different professionals were seeing and understanding the case and their involvement as well as that of others. As we will explain in detail in Chapter 6, how people were seeing and making sense of evolving situations cannot be ascertained from documentation alone but requires relatively in-depth interviews with those individuals.

In our pilot sites we were quite startled at exactly how differently numerous agencies/professionals could view the same family. This included even the most basic details, such as the age of the mother in City – some professionals were dealing with a 'young mum', a 'teenage mum', while others were dealing with a woman in her mid- to late twenties! Clearly such different ascriptions of her age altered the perception of the case and therefore the management of it. It was linked with equally differing perceptions of the underlying reasons for the problems she was having, linked to views of her ability/learning disability and mental health. Going through this shock was a salutary experience; once you start to pay detailed attention to people's different points of view, any confidence in a singular chronology rapidly begins to crumble.

The diversity of professionals' perceptions of the families and what problems they were thought to have was also a key theme in County. For some workers practical issues of parenting dominated while others were more concerned with the emotional care provided. Opinions on individual family members also diverged: the daughter was seen as having a number of psychological and behavioural problems by the Community Paediatrician and CAMHS Counsellor but as being well adjusted and coping well by the Social Worker.

Far from being an oddity, the nature of different agency involvement with families and the nature of different roles within agencies or professions mean this diversity of professional perspectives will invariably be the case. They approach the case with a specific purpose relating to their agency/profession and as a result each practitioner is highly likely to characterise the child(ren) and/or parents/carers differently, as well as the concerns they have, although differences can range from being slight to radical. What the world looked like for each will differ depending on what information was available to them, what was capturing their attention, what bodies of knowledge and experience they drew on to make sense of things, the goals they

were trying to achieve and the conflicting priorities they were juggling. Moreover, this means the same episodes or events will not have the same significance to everyone; they may feature differently in different people's stories or while they feature in some people's, in others they may not feature at all. The family's perspective may of course be altogether different again.

Even the most basic premises of people's narrative are not necessarily equivalent. Social workers tend to talk in terms of 'cases' and to structure accounts of their involvement around the pre-established aspects of their practice, including assessment, intervention and review, and the specific 'landmarks' associated, including home visits and different kinds of meeting, whether Child In Need or Network Meetings or Case Conferences, etc. Yet families who find themselves and their lives being articulated through this framework for the first time tend to struggle; for them it can be a disconcerting experience. For teachers too, who engage with a particular child or young person as a pupil or student and meet them on a daily basis, over a period determined by the education system, this temporal and narrative framework is often alien. With the range of people potentially involved with a particular family expanding now that safeguarding is 'everyone's business', the diversity of the interests and conceptual frameworks used in making sense of families and professional involvement, and the consequent diversity in their basic descriptions, can only increase.

Consequently, as noted in Chapter 2, it can be 'a major fault to assume that we all share the same picture of reality' (Gano, 2003: 60). Moreover, this is far from purely an academic pre-occupation but a key aspect of the complexity of multi-agency working on the ground. As such, there is a need to collect data of this kind systematically in the course of a review. Even when professionals use the same words, they may mean quite different things. There cannot, therefore, be one single objective account or chronology. Instead, in a systems approach the review team somehow needs to capture and structure multi-agency and professional perspectives on the family and professional involvement, as well as, ideally, incorporating the perspectives of children and parents/carers themselves.

In order to highlight this focus, we spent time thinking of alternative names to 'chronology' because this is generally used to refer to the compilation of a single account of the case history, often focusing mainly on the easily described features such as when meetings were held or letters sent but not revealing the different perspectives of those involved. We began by calling it a 'multi-agency overview' but decided that still implied too much of a consensus of perspectives. 'Multi-agency perspectives' or 'multi-agency narratives' seem more apt descriptions, although this excludes families, which in our pilots was the case.

5.1.3 Implications for writing style and substance

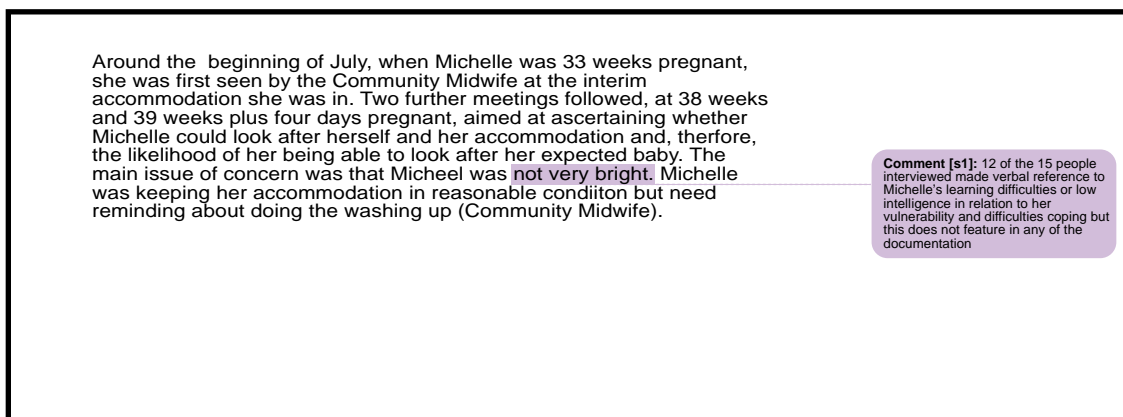
Going beyond the basic factual detail of who was involved, why and of what their involvement consisted, to capture how different professionals were seeing and understanding the case and their involvement has certain implications for what is included in the written account and the style in which it is written.

This expanded focus emphasises the importance of identifying where descriptions come from; there is a need to be transparent about the sources of evidence. This includes noting where key perspectives are missing, such as in City where a key social worker was off on long-term sick leave and unable therefore to take part in the review. It also becomes important to identify where significant discrepancies between sources occur as well as points about which even basic information is unavailable:

... discrepancies in accounts or meaning attached to events in the agency chronologies are as important as gaps or missing information. (Rose and Barnes, 2008: 48–9)

A key issue for the review team at this stage is to remember that the aim is not to judge the practitioners but to understand the differing local rationalities. To this end in City we found it useful to mark emerging questions and issues using the 'comment' function in the Microsoft Word programme as this kept our judgements physically separate and aided us in making them explicit (see Figure 10).

Figure 10: Use of Microsoft's 'comment' function: an example



In practice, there is of course an enormous choice of literary styles through which one might accomplish this task. In both pilots we were rather conservative. We specified the sources of evidence, for example, in square brackets in the text but otherwise employed quite a pseudo-factual manner of exposition. We used the past instead of the present tense and used the language of those in the case in descriptions but, because we had only interviewed professionals, this was in the professional languages. With hindsight we could have broken further from social work chronology-writing traditions. Further thought and experiment would therefore be beneficial in this area.

5.1.4 Review team's susceptibility to human errors of reasoning

Compiling these differing views of the world in relation to a particular case is not as easy as it might sound. Standardly, chronologies tend to identify and document events, developments, changes, episodes and agency involvement in a child's life in chronological order as they happened to the child. By this means, the impact of these developments on a child over time can be seen and responded to. Some will

note the source of the information or judgement about a family but many will report details as if they were an objective account. For those with a social work background particularly, the habituation of thinking of and producing 'chronologies' as objective and factual is well entrenched, and breaking out of this framework is likely to be difficult.

The recurrent tendency to want to assert what *really* happened, or *the* reality of the situation, has to be continually managed. So at the early stage of the case review in City, we found ourselves gaining the impression and talking about the mother as if she really did have a low IQ. We had to pull ourselves up and refocus on how professionals were *perceiving* her problems, highlighting to ourselves that while most people thought she did have a low IQ, others did not.

It is important to emphasise that throughout this process, review team members are as susceptible to the recurrent errors of human reasoning that we discussed in Chapter 4, as practitioners are in their work.

In the City review, for example, at one point we found ourselves describing the mother as 'reluctant' to discuss her psychological problems. Critical team discussions enabled us to spot the attribution error this entailed – explaining her behaviour as due to internal personality traits or dispositions rather than being related to external context. Subsequently we rethought the issue in terms of the interaction between the mother and others, that is, as situational, as opposed to being in her psyche in some way: she was reluctant to discuss the problems with these specific workers at this particular time.

Similarly, when putting together the multi-agency narrative for City, we realised that initially different team members had strikingly different recollections of the level of concern that practitioners had had about the state of the family's home. Specifically, the member of the review team who wrote up the initial draft omitted the small voluntary organisation's perspective and associated actions that, pertinently, differed significantly from the view of the Social Worker, which had come to dominate the way the case was handled. This seemed to relate to the fact that it had been other members of the team who had interviewed the small voluntary organisation worker. Therefore, it probably reflected the common 'availability' error, in that the data that are more vivid comes more readily to mind, so the actions and perspectives of those people we personally interviewed play a bigger part in our picture of the case than those interviewed by other people, despite the fact that transcripts of all interviewed had been read.

A systems investigation, therefore, needs to build in strategies for identifying and rectifying these predictable errors. In the main, these will draw on basic social sciences research methodologies for avoiding confirmation bias (Silverman, 2000), such as continually going back to re-examine the 'raw' material, like interview transcripts, in order to test emerging interpretations. The use of qualitative software programmes often proves beneficial. We also found working as a team extremely helpful.

5.1.5 Structuring the material

From any professional's point of view, the standard chronology is an idealised version of events constructed with the benefits of hindsight; it obscures more of professional activity than it reveals. Yet abandoning its singular, omnipotent perspective raises a new set of problems for the task of writing it down. The amount of material to be included significantly increases once differing perspectives are acknowledged and accumulated. How, then, to present such a large body of information in a way that helps the reader understand the ensuing analysis of practice?

Some narrative structure is required and yet this is not straightforward. Any attempt to order the material into something more readable involves selecting some aspects of the case as more deserving of attention than others. Any mode of description, therefore, has transformative effects; there can be no neutral narrative. Even a long stream-of-consciousness type of account would necessarily omit a multitude of details and, by its very rambling nature, obscure connections and relationships between people and over time. The point is that if it is accepted that the aim of a chronology is not a misguided attempt at neutral objectivity, there is a need to justify what gets written and how. It becomes important, then, to articulate how choices are made and to think deliberately about their relevance in a particular review.

We have chosen here *not* to offer a standardised framework for structuring different perspectives in a case review. A standardised or preferred model would make it easier to compare across a range of case reviews; readers would become familiar with the layout. However, it would obscure the fact that there are always other possibilities and that the one finally chosen inevitably reflects aspects of the interpretation of the case. Below we summarise the choices we made in our two pilot case reviews, reflecting on the strengths and weaknesses. Their relevance in relation to other reviews will need to be thought about deliberately and we encourage creativity and innovation in producing alternative models.

In City, we used a single story line covering all family events and agency contacts. This was reasonably straightforward for, as we described in Chapter 3, the family was small, consisting of only the mother and her young child. Professional involvement too was relatively easy to report since it only covered two years. We chose to structure the narrative around the four referrals to C&YP's social care/social services. This seemed important because it was at these points that the multi-agency professionals came together as a team, when they were otherwise working independently. However, it also led to something of a social work bias. What would the story of the case have looked like ordered around those episodes that Sure Start or the local church deemed most pertinent? If we had interviewed the mother or her adoptive parents, a radically different ordering again might have been possible.

As well as deciding on the key plot structure, we also thought a lot about the temporal sequencing of events in the narrative. For the purposes of case management and decision making there are very good reasons to orient the chronology temporally around the child. However, for the purposes of learning about professional practice there may be benefits to documenting things and events as

they became known to a particular professional as opposed to when they occurred in the life of the family. We opted, therefore, to present the story in chronological order from professionals' perspectives.

The above worked well for the case reviewed in City that involved only a mother and one child, and two years of professional engagement. However, attempts to use the same organising principle of a single story line presented significant difficulties in County. Here, as we summarised in Chapter 3, the case involved multiple family members and long-term engagement involving several agencies, spanning 17 years, with family members having some shared professional contacts but others being exclusive to them individually. A single story line covering all family events and agency contacts, therefore, seemed too long and unstructured, with attention moving from one family member to another or from one agency to another on a purely chronological basis, so that continuity of story lines would be lost and the reader would be left with all the work of trying to identify themes within the long, fragmented, account.

Instead, therefore, we first attempted deploying a two-dimensional structure to order our account. This summarised each individual family member's contacts with agencies, and then summarised each agency's contacts with family members. This gave a coherent picture in a series of snapshots but not an overall single picture. It was also decided to put the family members' stories first as an indication of their importance. The disadvantage of this format is that it underplays the relationships between family members or agencies and it obscures what events in different members' lives happened at the same time. With some families' histories, revealing the time sequence may be very important. For example, the mother's new pregnancy may coincide with the five-year-old's bad behaviour at school or the father's increased drinking. However, in this family, there seemed no obvious clusters of significant issues. Subsequently, we reflected on whether the ease with which it was possible to report each agency's involvement in isolation was, in fact, symptomatic of the relative independence of their work with this family, despite the occurrence of a number of professionals' meetings over time.

5.2 Identifying key practice episodes and contributory factors

Constructing the multi-agency perspective is one element of ordering and analysing data from the case under review that feeds into the identification of underlying patterns of systemic factors that influence good or problematic practice. The second aspect is the identification of key practice episodes from that narrative and the exploration of the contributory factors that influenced professional performance in each. This includes making judgements about the adequacy of the thinking and action in each episode. This can be assessed by looking at the wider picture – at what information could or should have been used to inform the process – and considering whether its use might have led to a different outcome. We deal with these three different parts separately below:

- Identifying and describing key practice episodes to analyse
- Judging the adequacy of practice in those episodes
- Identifying contributory factors that influenced performance.

Lastly, we share our learning about how best to structure and lay out the above material.

5.2.1 Identifying and describing key practice episodes to analyse

We stated earlier that the process of compiling the chronology is a crucial part of the working process of the review team. As the basic factual details of the case are established and the local rationalities of those involved are developed, different episodes will be highlighted by different practitioners, as well as parents/carers and children, as significant to understanding the way the case developed and was handled. The review team will therefore have been building up a picture of which points in time require further attention and analysis.

We have termed these 'key practice episodes'. This draws methodologically on the work of Charles Vincent and colleagues at the Clinical Safety Research Unit at Imperial College London (Vincent et al, 2000; Taylor-Adams and Vincent, 2004). In the engineering model of a systems approach, once the chronology has been established, the investigation team identifies 'active failures' in the process – slips or lapses of judgement leading to departures from standard practice or procedures. Vincent opted instead to use the more general term 'care delivery problems (CDP)' (Taylor-Adams and Vincent, 2004: 6) to describe unsafe acts, and found this helpful because in healthcare:

... a problem often extends over some time and is not easily described as a specific unsafe act. For instance a failure of monitor of a patient may extend over hours or days. (Taylor-Adams and Vincent, 2004: 6)

This was useful to us as clearly practice issues usually also extend over periods of time in child welfare. Yet the formulation is still focused only on problems, excluding the possibility of highlighting good practice. Therefore, we chose a more neutral label of 'key practice episodes' in order to allow for the identification of both good and problematic practice.

The term 'key' emphasises that these are a selection of episodes and do not form a complete history of the case. This will not usually be feasible either in terms of time available for the review or space available for its write-up. Moreover, it would probably not be advisable either because some selection is necessary to ensure the pertinence of the focus of analysis for understanding the way the case was handled. Key practice episodes are, therefore, selected by the review team. The term 'key' also refers to the way that they seem to be points at which actions were taken that had a decisive effect on the future course of the case, an effect sometimes positive and sometimes negative.

In both our pilot sites, the selection was largely based on interviewees' views of what episodes were significant. These were also described in the language of those involved in the case and, because we had only interviewed professionals, this was in the professional languages. The choice of key episodes was also supplemented on the basis of the review team's judgement. In the absence of direct input from family members, we used basic standards of courtesy, respect and fair process to

highlight episodes that we deemed significant from family members' perspectives. If we had interviewed family members, it is possible and even likely that they would have identified significantly different key episodes than those identified either by professionals or by us, and described them in significantly different language. This reminds us again of the impossibility of a neutral account of practice and the importance of articulating how choices are made.

The selection of key practice episodes, then, inevitably involves judgement. Consequently, it becomes important to be explicit and transparent about the reason for an episode's selection as well as providing a brief description of what it involved. This reason will involve the use of hindsight and the review team's understanding of the case over all to judge the significance of a key practice episode, that is, how it influenced or might have subsequently influenced actions and decisions and the way the case was handled (see Figure 11).

Figure 11: Identifying and describing key practice episodes: an example

Key practice episode

Referral from Tenancy Support Worker to social care (Part Two, 11-15 August 2005)

Description

On a visit to Michelle's house, through the letter box the Tenancy Support Worker saw piles of rubbish and overflowing bin bags. She met Michelle as she was leaving, who said she could not cope with Kelly on her own and needed more support.

Significance

Triggered at least in part by the state of the house, new information was available that might have led to a rethinking of the assessment of Michelle's needs and risk factors to the child.

5.2.2 Judging the adequacy of practice in those episodes

We have made much of the need to highlight good practice as well as problematic areas in a systems case review. Expanding the focus of analysis to include not only episodes that manifest problematic practice but also ones that reflect good practice produces the need to be explicit and transparent about the review team's judgements about the adequacy of decisions and actions that make up each particular episode. This is important to ensure basic clarity by distinguishing positive and negative assessments. However, it is also necessary because of the limitations of the knowledge base in child welfare, discussed in Chapter 2, which means firstly that judgement is required and secondly that there is no necessary consensus.

The adequacy of the workers' judgements and decisions are not assessed against an abstract, idealised standard. Instead, they need to be assessed by looking beyond the individual episode to the wider picture of the case as a whole. It is helpful, for example,

to consider what information was or should have been used to inform the process. The review team needs to consider how the use, or ignoring, of available information actually influenced, or potentially might have influenced, subsequent episodes for the better. In our pilot case reviews, we found that each key practice episode tended to include both good and problematic elements of practice. As opposed to a one-off judgement, therefore, it proved more useful to break the episode down into smaller constituent parts and make our judgements of each part explicit. This is illustrated in the distinction between a) and b) in Figure 12 below.

Ultimately a judgement needs to be made on how a particular episode was linked to outcomes for the child(ren) and family – whether, in a good practice episode, it was linked to a good outcome, or in a problematic practice episode it might have led to a different and better outcome. In other words, the review team needs to be clear in differentiating practice that contributes to poor outcomes and poor practice per se. This distinction is important because practice that contributes to poor outcomes may be good practice. Conversely, poor practice may not lead to a poor outcome. (Continuing with the example used in Figure 11, this is illustrated in Figure 12.)

In the process of analysing these episodes, we clarified for ourselves that responsibility for the judgements of standards of practice lay with the review team alone, and although ideal, it was not strictly necessary that participants agreed with them.

Figure 12: Judging the adequacy of practice in key practice episodes: an example

Breakdown and reviewers' judgement

4a. Good practice is notable in many aspects at this point. The Tenancy Support Worker picked up Michelle's deterioration and the state of the house quickly and was also prompt in making a referral to social care. She contacted other relevant professionals to share her concerns and gather any other relevant information. She demonstrated great perseverance in her efforts to meet with Michelle in her house and persevered with this even after making the referral to social care. When her concerns escalated with the passing of time, she was pro-active in calling social care to reinforce her prior referral. Good working together between the Tenancy Support Worker and Sure Start Family Support Worker is evident.

4b. Problematically, the state of the house was *not* stressed in the referral. The Tenancy Support Worker stressed instead that Michelle was not coping and was saying that she required more support.

5.2.3 Identifying contributory factors that influenced performance

The third aspect of this part of the analysis involves the identification of contributory factors that influenced the performance of each key practice episode. Here, review team members have to draw on the local rationality of participants as a means of identifying which factors influenced them to see the situation in this way and not

another, with whatever consequences for action or inaction. However, the analysis is also facilitated by a list of contributory factors that we have drawn up as relevant to safeguarding and child protection practices. As will be described further in Chapter 6, this list is used in the one-to-one interviews with participants to prompt interviewees in their thinking and aid them to consider issues that they have not spontaneously raised. This means that, by the stage we are describing now, the data are already partly classified by interviewees.

As with the identification of key practice episodes, in developing a framework of contributory factors for child welfare, we drew methodologically on the work of Charles Vincent and colleagues at the Clinical Safety Research Unit at Imperial College London, specifically the framework of contributory factors influencing clinical practice that they developed (Vincent et al, 2000; Taylor-Adams and Vincent, 2004) (see Table 5 below). This draws on and extends Reason’s model of active and latent errors discussed in Chapter 2, classifying error-producing conditions and organisational factors in a single broad framework of factors affecting clinical practice (see also Vincent et al, 1998).

Table 5: Framework of contributory factors influencing clinical practice

Factor types	Contributory influencing factor
1 Patient	Condition (complexity and seriousness) Language and communication Personality and social factors
2 Task and technology	Task design and clarity of structure Availability and use of protocols Availability and accuracy of test results Decision-making aids
3 Individual (staff)	Knowledge and skills Competence Physical and mental health
4 Team	Verbal communication Written communication Supervision and seeking help Team structure (congruence, consistency, leadership, etc)
5 Work environmental	Staffing levels and skills mix Workload and shift patterns Design, availability and maintenance of equipment Administrative and managerial support Environment Physical
6 Organisational and management	Financial resources and constraints Organisational structure Policy, standards and goals Safety culture and priorities
7 Institutional context	Economic and regulatory context NHS executive Links with external organisations

This framework distinguishes seven factor types ranging from 'patient factors' at the top to 'institutional context factors' at the bottom. Each factor type is conceptualised as being cumulatively influenced by the subsequent factor type. So while 'individual factors', which include knowledge, skills and experience of each member of staff, will obviously affect their clinical practice, each staff member is part of a team and therefore the way an individual practices is also influenced by 'team factors'. For each factor type, or level of analysis, a more detailed list of its components is provided. In our pilots we used this list with only slight adaptations (see the interview schedule in Chapter 6). Participants were given the opportunity to offer alternative factors but, in practice, all could be classified within this set of categories, suggesting that it is a useful list to use.

Subsequent to the pilots, however, we have done further thinking about the relevance of this framework for understanding factors influencing front-line practice in safeguarding and child protection work and made several modifications. Firstly, we have found that it is helpful to group the factors in three different ways according to the level and location within the world of child welfare from which they originate. This involves distinguishing between:

- front-line factors
- local strategic level factors
- national government level factors.

This seems important because it reflects the power structure of the child welfare system in its broadest sense and so helps to clarify where responsibility for the different factor types lies. With such responsibility clearly comes the power and authority to modify or change them if necessary. It also seems necessary in view of the level of central government involvement in the operational details of practice.

Adding this high level of categorisation had implications for both the designation and ordering of factor types. In Vincent's model, for example, 'task and technology factors' includes the following components:

- task design and clarity of structure
- availability and use of protocols
- availability and accuracy of test results
- decision-making aids.

The equivalent components in child welfare originate from differing levels in the system. While protocols are usually specified at the local strategic level, decision-making aids such as the framework for the assessment of need (DH et al, 2000) is decided at a national government level. Similarly, the 'design of equipment' that in the health framework is a subsection of the 'work environment' factor type, in child welfare would have to include ICT systems such as the Integrated Children's System that again is dictated from the national government level. Our typology of different factor types has, therefore, been modified.

Throughout the course of the pilot case reviews, we have also been able to specify in more detail likely components of the major factor types when applied to child

welfare scenarios. These are presented below in Table 6. For clarity we separate these out but theoretically it is the cumulative interaction that it is important to highlight and, therefore, in practice the different categories overlap.

As with the typology of patterns of practice discussed in Chapter 4, this list is not comprehensive. It has been developed from contributory factors identified in the two pilot case reviews and our knowledge of child welfare more broadly. As more systems reviews are carried out, the different levels of the framework will need to be assessed as to their usefulness and adapted as necessary. More detailed specification of the components of the major factor types will no doubt also emerge.

Table 6: Framework of contributory factors influencing front-line practice

Factor group according to level/location	Factor types	Contributory influencing factor
Front-line	Aspects of the family that influenced a worker's thinking about a case and action	<ul style="list-style-type: none"> • Nature of the problem(s) – complexity and/or seriousness and availability of suitable services; strength of knowledge base/level of professional consensus on diagnostic categories and possibilities • Duration of problems; well known to services or not • Problems as self-identified and/or designated a problem by others • Manner of problem presentation, for example, help-seeking or hostile • Willingness to engage • Nature of relationship between professional and family member(s) • Availability for meeting • Number of children • Size of family; number of significant adults involved • Complexity of family dynamics • Communication issues and language • Personality • Social factors – history • Gender • Age • Sexuality • Ethnicity

Table 6: continued

	Personal (staff) aspects	<ul style="list-style-type: none"> • Knowledge, skills and expertise • Mindset • Human reasoning • Attentional factors (what were they doing when they were not doing something else) • Illness, tiredness, burnout etc leading to their not being able to work to optimal standards • Motivation • Personality • Social factors – history • Interactional style
	Aspects of their role	<ul style="list-style-type: none"> • Frequency of contact with the family • Location of contacts, for example, going into family home or not • Focus of their concerns
	Conditions of work	<ul style="list-style-type: none"> • The general atmosphere surrounding the case • Staffing levels and skill mix • Workload • The timing, for example, shift patterns or busy time of year • Administrative support • Managerial support • IT/computers
	Own team factors	<ul style="list-style-type: none"> • Issues related to getting help, advice or support • Supervision • Communication, both written and oral • Differences of opinion within the team • Issues around team operations, for example, mixed messages • Team culture • Accepted/usual/routine practices • Capacity/workload • Skills/experience mix • Strength of knowledge base/level of professional consensus on diagnostic categories and possibilities

Table 6: continued

	Inter-agency/inter-professional team factors	<p>As above and also:</p> <ul style="list-style-type: none"> • Relative hierarchies; status and hierarchy • Language • Clarity of relative roles • Information sharing • Personal relationships and history (knowing each other or not) • Nature of working relationships (good–hostile) • Group dynamics • Cultures of communication across boundaries • Inter-agency culture and accepted practices • Culture of dealing with conflict – covert or overt
Local strategic level	Organisational culture and management (of individual agencies and multi-agency system as a whole)	<ul style="list-style-type: none"> • Financial resources and constraints • Resource allocation • Organisational priorities • Organisational structure • Organisational culture • Thresholds • Local policy • Local procedures • Standards and goals • Safety culture and priorities • Mixed messages • Availability of services; gaps in service provision • Clarity and adequacy of commissioning arrangements • Staffing decisions/allocation
National government level	Political context and priorities	<ul style="list-style-type: none"> • Government policy • Government guidance • Management system and regulation: PIs • Tools: assessment framework and associated forms; ICT systems

Figure 13: Identifying contributory factors for a key practice episode: an example

Contributory factors

4a. Quick pick up of deterioration and perseverance

Role (tenancy support): the Tenancy Support Worker was actually going into the house (groups did not notice as quickly; the Health Visitor hadn't been since May).

Human reasoning: the Tenancy Support Worker had general feelings of unease about the case before hand; Michelle had called her in a panic various times in the month prior.

Inter-agency: the Tenancy Support and Family Support Workers had sought each other out previously for informal discussions about the case.

4b. No mention of state of house in referral

Human reasoning (people tend to stress the issues that they think others will respond to): the Tenancy Support Worker's previous efforts to share her concerns linked to the state of Michelle's house had not got anywhere.

Personal (new worker): still new to her job, the Tenancy Support Worker was bowing to the greater experience of professionals in the identification of the prime concerns of this case as opposed to challenging them.

Inter-agency (relative hierarchies): her lower status in the relative hierarchy of professionals compounded the issue of inexperience, to minimise the likelihood that she would think of going against the grain of how the case was being understood.

Identical to factors relating to disregarding incident involving the house (2e)

Inter-agency (information sharing): the Tenancy Support Worker still did not know of prior incidents involving the state of Michelle's house (Butlins, post-birth).

Human reasoning (The information available to people changes their interpretations): the Tenancy Support Worker did not attribute greater significance to the state of the house relative to Michelle's distress, as nothing in the information available to her flagged it up as significant.

Continuing with the example used in figures 11 and 12, an illustration of the identification of contributory factors is presented in Figure 13. As this shows, the categorisation of contributory factors is not clear-cut. The fact that the Tenancy Support Worker's previous efforts to share her concerns about the state of the house had got her nowhere could be categorised as a 'human reasoning' factors, but equally as an 'inter-agency' factor.

5.2.4 Layout

As with structuring the multi-agency perspectives, deciding how to structure the three different aspects involved in this part of the analysis is not simple. In our pilots we used a three-columned table, illustrated below (Table 7).

Table 7: Layout for table of key practice episodes

Description of key practice episode and significance with hindsight	Breakdown and reviewers' judgement of adequacy of practice	Contributory factors (Why did it make sense at the time? What helped? What hindered?)

The second column contained sub-sections for each of the constituent parts and the review team's judgement of each part. Where their judgements of adequacy were multi-faceted, we found that each part often had its own contributory factors. So these had to be distinguished using subheadings within the contributory factors cell that summarised the problematic or good issue. An illustration is provided in Table 8.

In comparison with the narrative alternative, we found this table format made the distinction between the different parts of the analysis clearer. Listing the contributory factors aided clarity. Altogether it was more concise. Moreover, repetition across different episodes stood out strongly. This related to both repetition of types of good or problematic factors and their contributory factors, as well as repetition of contributory factors that influenced a range of different aspects of practice. We made this clearer again by specifying where factors in one episode were repeats of an earlier one.

There are of course also drawbacks to this layout. In some ways it is not very reader friendly. The way that cells cross over multiple pages, for example, means that sometimes reading across columns involves going back a number of pages. It may be that it is useful in developing an analysis because it makes it clear to all involved *how* judgements are reached. However, once it has been used in the interim meeting to check interpretations with participants, it could then be re-drafted in a more precise and user-friendly manner.

As with producing the narrative of multi-agency perspectives, structuring of these episodes is not necessarily straightforward. In both our pilots, we found it useful to mirror the structure that we had used for the adapted chronology. So in City, key practice episodes followed each other chronologically through the singular story line. In County, in contrast, we drew up key practice episode tables for each child individually, noting overlaps in time where they were significant. We also constructed a table that dealt primarily with services offered to the mother but in which we also considered the extent to which the case was conceptualised as a family problem rather than as a set of individuals with varying needs.

Table 8: Identifying key practice episodes and contributory factors: an example

4	Key practice episode and significance	Breakdown and reviewers' judgement	Contributory factors
	<p>Referral from Tenancy Support Worker to social care (Part Two, 11–15 August 2005) On a visit to Michelle's house, through the letter box the Tenancy Support Worker saw piles of rubbish and overflowing bin bags. She met Michelle as she was leaving, who said she could not cope with Kelly on her own and needed more support.</p> <p>Significance Triggered at least in part by the state of the house, new information was available that might have led to a rethinking of the assessment of Michelle's needs and risk factors.</p>	<p>4a Good practice is notable in many aspects at this point. The Tenancy Support Worker picked up Michelle's deterioration and the state of the house quickly and was also prompt in making a referral to social care. She contacted other relevant professionals to share her concerns and gather any other relevant information. She demonstrated great perseverance in her efforts to meet with Michelle in her house and persevered with this even after making the referral to social care. When her concerns escalated with the passing of time, she was pro-active in calling social care to reinforce her prior referral. Good working together between the Tenancy Support Worker and Sure Start Family Support Worker is evident.</p>	<p>Quick-pick up of deterioration and perseverance Role (tenancy support): she was actually going into the house (groups did not notice as quickly; Health Visitor had not been since May). <i>Human reasoning:</i> she had general feelings of unease about the case before hand; Michelle had called her in a panic various times in the month prior. <i>Inter-agency:</i> the Tenancy Support and Family Support Workers had sought each other out previously for informal discussions about the case.</p>
		<p>4b Problematically, the state of the house was not stressed in the referral. The Tenancy Support Worker stressed instead that Michelle was not coping and was saying that she required more support.</p>	<p>No mention of state of house in referral Human reasoning. People tend to stress the issues that they think others will respond to: the Tenancy Support Worker's previous efforts to share her concerns linked to the state of Michelle's house had not got anywhere. <i>Personal (new worker):</i> still new to her job, the Tenancy Support Worker was bowing to the greater experience of professionals in the identification of the prime concerns of this case as opposed to challenging them. <i>Inter-agency (relative hierarchies):</i> her lower status in the relative hierarchy of professionals compounded the issue of inexperience, to minimise the likelihood that she would think of going against the grain of how the case was being understood. Identical to factors relating to disregarding incident involving the house (2e) <i>Inter-agency (information sharing):</i> the Tenancy Support Worker still did not know of prior incidents involving the state of Michelle's house. <i>Human reasoning. The information available to people changes their interpretations:</i> the Tenancy Support Worker did not attribute greater significance to the state of the house relative to Michelle's distress, as nothing in the information available to her flagged this up as significant.</p>

6 What data do we need and how is it best to collect it?

In Chapter 5 we presented details on the organisation and analysis of data about the case under review. This included (1) constructing an adapted chronology that highlights different agency and family perspectives and (2) producing a table of key practice episodes that identifies factors in the work environment that supported good practice or influenced problematic decisions and actions. Both are necessary in order that underlying patterns of systemic factors that help and/or hinder front-line workers can, subsequently, be highlighted. By clarifying what is done with the data in a systems review, in the way that has been described, we hope to have made clear what kind of data is needed. In this chapter we go back another step in the case review process to discuss methods the review team should use in order to gather the appropriate kind of material to allow for the different parts of analysis described in the report so far.

The relevant material necessary for a systems analysis does not come ready labelled and its collection is, therefore, more than a supermarket sweep for items on a shopping list. So we begin by clarifying the participative and interpretive nature of data collection in a systems review and the continual dialogue needed between different sources. Next we outline what is involved in ascertaining material from two specific sources of data: (1) from participants directly through interviews and (2) through the selection of case documentation. This is followed by a discussion of the importance of feedback meetings with participants in the course of the review. We end with suggestions about decision making related to who should be involved in a case review and the preparation they need, as well as the make-up of the review team.

6.1 Data collection as an ongoing, participative, interpretive process

Going beyond the basic factual detail and understanding the way practitioners viewed the situation and their own actions is central to discerning the interactive effects of different parts of the system. Consequently, as a method of reviewing professional practice, a systems approach is of necessity very much in the participative, qualitative research tradition. The reviewer(s) can no longer stand outside, or indeed above, those actually involved and identify causal links themselves. Instead, the key means of access to the workings of individuals and systems is through the experience of those involved.

There are two important sources of data relevant to this kind of understanding – the written documents of different agencies and interviews with key staff, as well as service users and carers. Yet neither data source provides a consensus view. The documentation of different agencies may conflict in the basic factual details presented or it may have a very different focus. Similarly, as described in Chapter 5, we found to our surprise that the notion of a neutral, objective account of practice quickly disintegrates as soon as you start hearing narratives from different people's points of view; even the seemingly most basic facts such as a person's age can be

contested. There is no necessary consensus as to the key practice episodes that determined the way the case was handled either for better or for worse, and which therefore would be beneficial to understand in more detail.

The review team, therefore, requires data that compare and contrast different accounts, exposing and exploring both overlaps and discrepancies between the various sources of data – whether between participants' respective accounts, between different agencies' documentation or between particular documentation and any particular account. The task of the review team is to ascertain how the two sources interact, that is, how one can help make sense of the other. It involves critically appraising documentation in light of participants' narrative as well as further questioning staff about their narratives in light of information the documentary sources reveal.

Yet data collection is inevitably a cumulative process because it is simply not possible to gather and digest all the relevant material at one and the same time. In the course of data collection the review team is only *gradually* able to build up a picture of the basic factual detail of the case and local rationalities of those involved and identify key practice episodes that influenced the way the case was handled and require further exploration. This poses a challenge for identifying overlaps and discrepancies and gathering data that allows for their exploration, because the order in which we become aware of things also influences our subsequent interpretations, questions and avenues of exploration.

Whether we access the documentation before holding interviews or vice versa and the order in which we meet and speak to individuals will inevitably influence the data we collect. What we see as significant varies depending on what we have already found out; data, as we said earlier, do not come pre-labelled. Particular documents do not have intrinsic value as data; their relevance is relative to other documents and/or people's accounts and the review team's emerging interpretation. There is no way round this. Data collection is an interpretive enterprise. Our division of data collection in this chapter from the analysis in Chapter 5, while useful for presentation purposes, is false: the analysis begins in the course of data collection as opposed to after it; making sense of the data happens in the course of their collection and is an ongoing process.

In the course of successive conversations and/or accessing the paperwork, new information will continually be coming to light against which we have to rework our developing overview and analysis. We will realise that we have omitted an important data source, be it document or person, or that we have incomplete information from a particular data source because certain questions and issues have only just become apparent and, therefore, could not have been explored earlier.

In City, for example, talking about the Child Protection Conference, professionals had all told us that it had been triggered by bruising found on the child. At that stage of the one-to-one conversations we had had no reason to query this. However, accessing the documentation afterwards showed that while the bruises had indeed been the focus of the conference, the actual referral had raised far higher levels of concern about the mother's level of distress and possible impact on her parenting.

Consequently, certain questions suddenly became pertinent, that we did not realise and could not have realised were significant questions previously and had not, therefore, raised in the one-to-one conversations. Why, for example, did social workers respond only to the bruises and what systemic factors had influenced this focus?

Conversely, in County, speaking with CAMHS staff and looking at their documentation revealed that that they had made a referral to social services about which we had heard nothing from social services themselves, nor found any reference to in their records. Unravelling this mystery of the disappearing referral proved difficult but eventually revealed the involvement of a new multi-agency forum, the multi-agency allocation panel, which required that we speak to new people and engage with new documentation. It also became necessary to go back to workers who we had already spoken to with new questions. The result was a whole new key practice episode that, without such follow-up, would otherwise have continued to go overlooked.

Such examples highlight that data collection, whether through conversations with individuals or accessing and selecting documentation, is not a one-off event but instead an ongoing process requiring interpretation on the part of the review team at every step of the way. The choice of seeing the multi-agency documentation before conducting conversations with participants or vice versa is arbitrary; whichever order it is done in brings its own biases, of which the review team must be continually aware. Consequently, there will often be the need to return to both participants and documentation in order to follow up. For some individuals, a second conversation may be necessary.

6.2 One-to-one conversations

If a systems approach attempts to avoid the benefits of hindsight in reviewing professional practice, then we need data that allow us to build a picture of how things looked to people involved, at the time they were involved. This includes data that allow us to identify key episodes that influenced the way the case developed and was handled, for further analysis. The review team needs a sufficiently detailed picture of the circumstances of these key practice episodes to help with the task of identifying contributory factors that influenced performance. One-to-one conversations with key staff, as well as with service users and carers, are the most important route to obtaining this kind of detailed data.

As stated in Chapter 5, how people were seeing, making sense of and reacting to evolving situations cannot be ascertained from documentation alone. We noted in Chapter 4 that the review process in City highlighted a striking discrepancy between formal records and oral accounts. This contrast means that if we had relied only on documentation, we would have got a seriously distorted picture of multi-agency involvement with these families. We would have learned little of the 'local rationality' of the different professionals, or which factors contributed to their actions and/or decisions.

As indicated above, however, there is also a secondary purpose to speaking with participants. This is to link their individual narratives with the emerging overview of the case provided through other people's accounts as well as different agencies' documentation. In the course of the conversation, the review team also needs to explore with participants both overlaps and discrepancies as well as the adequacy of their actions and decisions in light of the wider picture of the case as a whole.

The detail presented below represents our experience and learning from conducting conversations with practitioners and not with parents/carers or children and young people. We discuss the involvement of children, young people and their parents and/or carers further in Section 6.5.1 below.

6.2.1 Preparation for participants

At the point when people are contacted about speaking to the review team about the case on a one-to-one basis, it is important that the purpose of the conversation is made clear. To this end, we have consciously chosen to refer to these as 'conversations' as opposed to interviews. Within a qualitative research framework they clearly are interviews but in a safeguarding children context the term has connotations of formal, fact-finding, bureaucratic or even legalistic endeavours. As the review team is not setting out to collect evidence, using traditional research terminology is likely to be unhelpful. Alternatives common in the field of social work include 'talk with you about' or 'have a conversation about'. This seems better to reflect the aims of these meetings with individuals in a case review, which are both to understand each individual's story of the case and their role in it, and their perspectives on critical points and contributory factors, and to discuss these further in light of the emerging overview. We also found that it was useful that this conversational style be reflected in written communication with participants, as illustrated below (Figure 14).

Figure 14: Excerpt from letter to participants: an example

One-to-one conversations

We will be contacting you shortly to try and arrange a time to talk with you one-to-one about the case. The main purpose of this conversation is to get your view of what was going on in and around this case, how you understood your role or the part you were playing and your perspective on what aspects of the whole system influenced you as a worker.

It is also a chance for us to share with you something of our emerging overview of the case so that together we can begin explore any differences between your own view and other accounts that we have been told. Sharing the wider picture of the case as a whole also gives us the opportunity to work out together with you, whether your judgements and actions were good or problematic. As we explained previously, discussing differences of opinion and judging the adequacy of people's judgements and actions is not about criticising or blaming anyone. Instead it is a necessary step in order that we can better understand what factors in the work environment support or hinder you in doing a good job.

The prospect of having one's practice put under the microscope can, understandably, cause anxiety. It is advisable, therefore, that participants are allowed to have a supportive friend or colleague present if they would like to. Their role is to support the participant and not contribute in substantive terms to the conversation. Ideally, therefore, the friend/colleague should not be someone who was involved in the case. It must not be the participant's line manager as this runs the risk of severely limiting how free the participant will feel to speak openly about their own or others' actions/decisions and the work environment.

In our pilot sites people reported that they were more willing to discuss the intimate aspects of their practice with us than in a traditional case review because they knew we were trying to understand not criticise. Organisational endorsement of and senior management support for this emphasis should, therefore, also be re-emphasised in the course of organising the conversations.

Lastly, issues of confidentiality also need to be clarified. It needs to be made clear that interim reports will draw on the content of individual conversations and that these will remain confidential to participants in the review. In final reports that might be made public, participants need to be assured that geographic identifiers will be removed, professionals referred to only by their role and the family by pseudonyms.

In terms of how participants should prepare for these conversations, in the course of our pilots we discovered that it is better not to give rules. Specifically, we suggest that the review team should not prescribe whether or not people should bring or refer to the case files. This allows people to bring their own approach and professional norms, which become a further data source, throwing light on both individual and sometimes wider team cultures relating to the value of paperwork.

6.2.2 Preparation for review team

We found it useful to have two members of the review team take part in the conversations. This allowed one to take the lead in listening and taking notes, recording 'subtle points that may otherwise be overlooked' (Taylor-Adams and Vincent, 2004: 11), with the other having a more interactive role, taking the lead in responding and asking questions either to get the participant to elaborate or to prompt their thinking. We also learned that there are significant benefits to the same two people facilitating all the conversations. This allowed for the overview of the case to be developed more quickly in the course of successive conversations and, consequently, overlaps and discrepancies to be pursued in the course of conversations, thereby minimising (although not eradicating) the need for follow-up.

In order for participants to participate openly and honestly in the conversation it is necessary that they invest a certain amount of trust in the reviewers. This can be difficult in the context of a perceived 'blame culture' and the associated anxiety and defensiveness potentially raised by case reviews. It is particularly important, therefore, that the style in which conversations are facilitated should be relaxed and conversational and demonstrate genuine curiosity and openness. If we are asking participants to trust us enough to speak to us in detail about the intricacies of their

work, we need to respond in such a way that shows we are indeed worthy of such trust. This involves responding respectfully to whatever a participant tells us.

Starting from an open, curious and respectful position in relation to each participant is not necessarily straightforward. In our pilots there were times when we found ourselves quite damning in our judgement of a person's actions, on the basis of what we had heard from other people or ascertained through documentation – 'how could s/he have been so stupid?!' This, of course, reflects a classic attribution error whereby the relevance of circumstances to a person's decisions or actions is underplayed. It is important, therefore, that as review team members actively remind themselves] that although we may have read documentation pertaining to a particular person's involvement, and heard about them and the part they played from conversations with other participants, before we speak to them, we cannot begin to know how the world looked from where they were standing, how things seemed through their eyes. This is a key aim of the conversation.

Linking a particular individual's account with the review team's developing overview is not necessarily an easy or comfortable task either. Querying the accuracy of parts of their narrative, indicating information that was available but that they seemed to have overlooked, or sharing a conflicting account of the same episode, can be seen as challenging the very version of events that we are asking the participant to share. Moreover, it runs the danger of exacerbating pre-existing conflict between individuals and/or agencies. So the review team needs to be sensitive to the timing of these interjections. We found that it worked better to instigate dialogue connected to the overview perspective on the case towards the end of the conversation, only after the account from the participant's own experience and perspective had been fully explored. The manner in which queries are brought up also needs attention. It needs to be done in a non-threatening way that makes clear that the aim is not to criticise but to enable better understanding.

In the face of all the above, in both our pilot sites we were struck by how un-defensive participants were and, indeed, how eager they were for an overview of the case and to be able to see and review the part they played in the context of the bigger whole. Without exception, all told us that they enjoyed the chance to talk and reflect on their own practice in such detail. It is important, however, that reviewers check with participants at the close both how they have found the session and how it has left them feeling about themselves and/or the part they played.

During the course of interviews in our pilot sites, we were surprised at how easily and quickly we continued to be 'sucked in' to people's individual stories each time. Over time this became something of a disconcerting and unnerving experience; it left us feeling somewhat fickle as we changed our empathy, sometimes quite radically, depending on to whom we were speaking. This leads us to think that it is useful at the start for the review team members to be cognisant of what an unusual enterprise it is that they are undertaking. Rarely do we have the chance to view the same story from so many different people's perspectives and the review team needs to remember what a privilege that is.

6.2.3 Conversation structure

The structure of the one-to-one conversations that we have developed is adapted from models provided by Dekker (2002a) and Vincent (Taylor-Adams and Vincent, 2004). A summary can be found in Table 9. Reflecting the different aspects of organising and analysing the data covered in Chapter 5, there are distinct elements of the conversation. It is not strictly necessary, however, to move through these areas in order. Through our pilots we found that as we got more experienced in facilitating the conversations, we increasingly allowed the participant to structure the conversation more themselves, while we used the framework as a checklist and prompt to ensure all aspects were covered at some point, although not necessarily in a set order.

Table 9: Conversation structure summary

1	Introduction	<ul style="list-style-type: none"> • Purpose of the conversation • Confidentiality and ethics • Outline of the structure
2	Overview	<ul style="list-style-type: none"> • A brief description of what happened in this case and the part you played
3a	'Turning points' or 'key practice episodes'	<ul style="list-style-type: none"> • What do you think were crucial moments in this sequence, when key decisions or actions were taken that you think determined the direction the case took or the way the case was handled?
3b	'Mindset' and 'local rationality'	<ul style="list-style-type: none"> • What did you think was going on here? • What was behind your thinking (reasons but also emotions) and actions at the time? • What information was at the front of your mind? What was most significant to you at this point? What was catching your attention? • What other things were occupying you at the time? • What were your main concerns? What were you tossing up at the time? Did these concerns clash at all? Were there any conflicts? Were some dismissed, others prioritised? • What were you hoping to achieve? • What options did you think you had to influence the course of events?
4	Contributory factors	<p>What were the key factors that influenced how you interpreted the situation and how you acted at the time? In what ways? Prioritise aspects that were most significant.</p> <ul style="list-style-type: none"> • Aspects of the family • Aspects of your role • Conditions of work/work environment • Personal aspects; your own team factors • Inter-agency/inter-professional team factors • Organisational culture and management • Wider political context • Other

5	Things that went well	<ul style="list-style-type: none"> • What things relating to the case went well? • What do you think you or others did that was helpful/useful? And what factors supported/enabled it?
6	Queries from the overview perspective	–
7	Suggested changes	Off the top of your head, having thought back on this case and your role, are there any small, practical changes that you can think of, that would help you/staff do a better job?
8	Summing up	<ul style="list-style-type: none"> • Have we got your view of the case?
9	Reflections	<ul style="list-style-type: none"> • How have you found this session? Do you have any comments or questions? • How do you feel now, about yourself and your role, after this discussion?

The start of the conversation is, however, not negotiable. It should always begin with an unstructured session where participants are encouraged to 'tell their story' about the family and why and how they were involved with them. As noted previously, different people have different kinds of engagement with families, for different purposes, so they have different types of story to tell and their narrative frameworks will also differ; social workers are likely to talk about the family as a case whereas teachers and workers from faith groups will probably not. It is important, therefore, that participants are given the chance to tell the story in their own terms.

At this point, the review team should not be concerned with the accuracy of the participant's overview of the case and their involvement, but instead be focusing on ascertaining as much detail as possible of the local rationality – how the particular participant was seeing and making sense of what was going on as the situation evolved. Which family member(s) was their primary focus? What aspects were they focusing on? What were their main areas of concern? How were the children and/or parents/carers characterised? What were they hoping would be achieved? If a participant chooses to refer to case documentation here, and starts with too narrow a report based only on the written record, they will need to be encouraged to amplify the story from a more personal perspective.

From our experience, first-line managers' narratives tend to mirror those of their front-line staff, giving the impression of first-hand knowledge of families based on direct contact with them. That is, they do not seem to focus explicitly on their management roles and responsibilities related, for example, to supervision, budgets and PIs. If this impression holds more broadly, the review team needs to encourage managers to talk about their specific roles and responsibilities and provide a detailed enough picture so that the influence of specific contributory factors such as PIs, resources, supervision etc can be identified.

The semi-structured part of the interview only starts once the participant's own account has been given. This focuses initially on asking the participant to highlight

what, from their perspective, were key practice episodes. In our pilots we found that participants had often already highlighted these in their original narrative. These episodes can be described variously as 'turning points', significant moments', 'crucial points' or 'critical junctures'; they are points in the story perceived as being significant in determining the direction the case took and/or the way the case was handled. Due to the tendency we all have to highlight episodes that influenced the case in a negative fashion, it is important that the review team ask specifically about things that went well, so prompting the participant to think about what they or others did that was helpful or useful. This is particularly so in cases where the family has not flourished, where details that raised the level of concern are more likely to be recalled than if better outcomes had been achieved.

Secondly, and for each of these episodes, the review team needs to help the participant to describe their perception of the circumstances in sufficient detail in order that they can then identify contributory factors that influenced performance. Between the first and second practice site, there seemed to be a considerable increase in our ability to elicit and make sense of contributory factors. It is essential that review team members familiarise themselves with how these concepts can be applied in child welfare scenarios. The purpose of the list of contributory factors being available to participants is to prompt them in their thinking. As we became more experienced in facilitating the conversations, it became possible just to use this list towards the end in order to ask for assistance in re-categorising what they had already said using different language, and to prompt them to consider any issues that had not spontaneously been raised. It might be valuable to keep a record of what issues tend to come to mind readily and to see if there are any common themes.

As stated above, queries and questions from an overview perspective should only be raised toward the end of the conversation, after the account from the participant's own experience and perspective has been fully explored.

In our pilots we allowed one-and-a-half hours per conversation. This seemed long enough to allow for a sufficiently detailed discussion and short enough not to tax either review team members' or participants' concentration.

The importance of transcribing

In County, contemporaneous notes were made by one of the two SCIE team members who took part in each conversation, as well as audio recordings. We then transcribed all the one-to-one conversations. This was extremely time-consuming so in City, we experimented with a short-cut for capturing the content of one-to-one conversations. Instead of transcribing each interview, we went straight to filling in the data extraction form, so capturing the significant data from the conversations as identified from contemporaneous notes. These were completed as soon after the conversation as possible and the audio recordings were used for clarification where there were disagreements between SCIE team members and also for quotations.

On reflection, however, this is potentially too distorting because it reflects our picture of the case at the time so omits what might be crucial counter-evidence. Without transcriptions, we ended up having to go back to the conversation notes

and recordings to test our emerging interpretations and avoid confirmation bias. It seems, therefore, that some form of transcription is essential, even if a precise word-for-word replica is not necessary. How this can be done most time- and resource-effectively requires further consideration.

6.3 Documentation

Records, reports, letters and other forms of documentation from all the different agencies are another important source of data in a systems case review. Unlike the more personal accounts of different agencies' involvement produced through conversation, documents provide the formal record of professional involvement according to different agencies. They need to be seen, therefore, as complementing the material produced through one-to-one conversations but as they produce data of a different nature, one cannot be a substitute for the other. Instead, as stated earlier, the task of the review team is to ascertain how the two sources interact, that is, how one can help make sense of the other.

To the question of which documents to select, therefore, there is no easy answer; it is not something that can be prescribed. Instead, the process of selection is part of the process of making sense of the multi-agency working in the case under review. In the process of going through sometimes large stacks of paperwork of any particular agency, the review team must be continually relating the contents to other agencies' documents as well as participants' accounts. Consequently, the selection will need to be readjusted as the review team's picture of the case changes over time. Below we give some examples of the ways that documentation proved useful in our pilot sites. Given the limitations outlined above, however, these are illustrative and there is no claim that they are exhaustive.

Firstly, in both case reviews documentation provided a vital check on the accuracy of the basic factual details of the chronology. This can be necessary in terms of the details of any individual agency's involvement because people's individual accounts are likely to be influenced both by lapses in memory and in being remembered through the filter of knowing what happened later in the case. Secondly, separate agency sources also provide a check on the accuracy of any one agency, thus identifying gaps or mistakes in understanding that need to be further explored in order to get to the bottom of why they happened. The missing CAMHS referral mentioned above is such an example.

Documentation also proved a useful source of data for going beyond the basic factual detail, in a variety of different ways. In County, accessing the paperwork of different agencies gave significant insight into the cultures of communication both within and between sectors – as described in Chapter 4, as an illustration of patterns of communication and collaboration in assessment and longer-term work. Documentation from the different agencies revealed dramatic omissions in communication *between* health and social and education services, an issue that was followed up in conversations.

In both sites, documentation also provided useful comparative data relative to oral accounts, which shed light on what is included and what becomes written out of

the formal record, and to what effect. This gave us an indication of the dynamics of multi-agency working that needed to be further explored. In County, for example, as described in Chapter 4, whereas our conversations with professionals had raised several comments indicating discontent or disagreement with the official assessment, accessing the documentation revealed that none of this appeared in the official records. This suggested a culture of covert as opposed to overt conflict, which inhibits good critical thinking about the management of a case, which was confirmed when following the issue up in conversations.

A final and important example of how documentation proved useful in going beyond the factual detail of professional involvement to understand the intricacies of multi-agency working relates to the patterns of human–tool operation discussed in Chapter 4. In City in particular, critically appraising children and young people’s social care documentation gave us evidence of the way in which tools, such as the Core Assessment form, were actively shaping practice in problematic ways.

6.4 Sharing drafts and holding meetings to discuss the analysis

We have stressed above the way in which data collection in a systems approach is an interpretive enterprise, which therefore requires the active participation of participants and open dialogue between them and the review team, including going back to follow up on issues that emerge only after the conversations have been conducted. Yet in the previous chapters we also made much of the point that the task of the review team in bringing the disparate accounts provided by people and paperwork into an overview perspective constitutes yet another level of interpretation. The review team’s account, like those of practitioners, can never be neutral as it will be neither comprehensive nor objective. Thus we have stressed the need for transparency both of sources of evidence in the adapted chronology and creative reflexivity in the choice of narrative structure and style. So, too, we highlighted the need for clarity about the reasons for selection of each key practice episode and of the judgements of the adequacy of practice contained within them. Lastly, we highlighted the need for choice and judgement in selecting and prioritising which patterns of systemic factors are the focus and which are ignored.

All these issues have implications for the relationship between participants and the review team in a systems case review. Instead of the process of making sense of the case happening, as if by magic, behind the scenes and being presented at the end as a *fait accompli*, it needs to be much more of a joint and co-owned process. So the dialogue that begins in one-to-one conversations and necessary follow-up needs to continue throughout the course of the review, both with individuals but also, importantly, with the multi-agency group as a whole.

Given the iterative, as opposed to linear, nature of this process there is a need to check with individual participants the accuracy of both the adapted chronology and the table of key practice episodes and the contributory factors, and ascertain whether any key details and/or connections have been overlooked. Beyond that level of detail too there is also the need to check with participants the review team’s preliminary analysis of key themes running through the case in terms of what worked well, where problems have been revealed and contributory factors in the intra- and

inter-agency systems that helped and/or hindered. This is an important part of the process leading to the identification and prioritisation of key *patterns* of systemic factors that contribute to good or problematic practice that, as explained in Chapter 4, is not a mechanical task. Instead, the review team needs to have open discussions with the multi-agency group about whether the issues identified seem appropriate or whether other more important ones have been overlooked. They also need to find out from participants whether these issues are relatively unusual and unique to this case or if they hold broader relevance because they are a common occurrence. In relation to common features of good or problematic practice, more in-depth discussions need to be initiated to further the review team's understanding of the contributory factors and the implications in terms of helpful changes that could be implemented.

6.4.1 Staging the dialogue

Achieving this dialogue involves both sharing draft reports for individual comment and meeting as a multi-agency group for discussion. Input both from individuals and from group discussions should feed into subsequent drafts of the report. Learning from our pilots suggests that there are benefits to organising working together between the review team and participants in a three-stage process, as detailed in Figure 15 below.

Figure 15: Suggested stages of the dialogue with participants

1. Preliminary report

Individual comment
Preliminary group meeting

2. Interim report

Individual comment
Interim group meeting

3. Final draft report

Individual comment
Closing meeting

As with the structuring of the different perspectives in the case, however, it is difficult to offer a standardised framework for either the content or structuring of these different reports or meetings. To do so would obscure the fact that, to a large extent, what is possible at different points will vary depending on the details of the iterative process of data collection and analysis itself, influenced by the nature of the case and professional involvement, and the working methods of the review team. Moreover, there will always be alternative ways of proceeding. Therefore, we recommend instead that creativity and innovation are required in terms of approaches, in order for us to learn how to make best use of these meetings and what kind of reports best facilitate useful dialogue. Some of the learning from our pilots is detailed below.

6.4.2 Individual comments on draft reports

Given the time pressure that participants are likely to be under we suggest that the review team should be as flexible as possible about the way they accept feedback from participants on draft reports (see Figure 16).

Figure 16: Excerpt from letter to participants: an example

We are happy to receive your feedback in any form – you can send comments by email or post or the use of the 'track changes' and 'comments' function in the actual document. If you would rather speak to someone, then please email me so that we can arrange a convenient time. We will listen and respond to your input respectfully.

Many participants took advantage of being able to pick up the telephone to ask for clarifications and discuss issues, even when they had also given their feedback in written form.

If any changes are agreed to the report, it is only polite to send the individual the edited version where changes resulting from their input have been made.

6.4.3 Group discussion meetings

In our pilot sites, group discussion meetings lasted two hours and we chose to hold them over lunchtime to increase the possibility that participants could attend. We were delighted with the turn-out to meetings in both sites. People's willingness to come seemed to indicate that the meetings served an important function in making concrete their joint ownership of the process.

Review teams must be consciously aware, however, that most participants have only extremely limited time either to read or reflect on draft reports prior to meetings. So great thought needs to go into how to present the developing analysis to make it as easy as possible for participants to quickly get to grips with the issues. We tried to structure clearly and tightly the focus of discussion so as to maximise people's chances of giving useful input in a restricted period of time. Often we chose to discuss fewer issues in more detail rather than attempting to cover everything.

In City, for example, the interim group meeting focused on two key issues related to multi-agency assessment practices: (a) the culture of rethinking prior assessments and (b) multi-agency input into and ownership of assessments and family involvement. This raised important issues that participants had not previously indicated in their one-to-one conversations, including the covert organisational message of the relative importance of throughput over quality, as well as difficulties workers experienced in expressing feelings of unease and of talking about risk that were used in the illustrations of patterns of systemic factors in Chapter 4.

6.4.4 Farewell meeting

Our experience suggests that the review team should offer to hold a final farewell meeting to mark the close of the case review. This provides an opportunity for participants to hear about the way in which senior managers or the LSCB have reacted to the findings of the case review and any decisions about action to be taken as a result.

It also allows the review team to thank participants and reaffirm the value of their contributions. It is a valuable chance for the review team to get feedback from participants about the *process* of the systems review and suggestions for improvement. Key questions might include:

- Did we explain the systems approach to you well enough? What issues were confusing to you?
- We were trying to make this a joint exercise but to what extent did we succeed?
- Is there anything else you would like to tell us about your experience of taking part or how we could improve the process?

The last, and perhaps most important function, however, is to mark the close of the case review. After what is quite an intense level of engagement in the process, as one of our participants put it, it is "nice to finish something off" (school nurse).

6.5 Who should be involved and what preparation do they need?

The final methodological question that we deal with here is that of who should be involved in a systems case review and what kind of preparation they need. This would of course be one of the first questions to be dealt with when using the model in practice. We discuss the involvement of the family first before turning to decisions related to professionals.

6.5.1 The family

We noted in Chapter 2 that one can deliver a pizza but not safeguarding services, because achieving good outcomes requires the constructive engagement of the intended recipients. In terms of the theoretical premise of a systems review, it would be nonsensical not to include families. Rather than being seen as objects to be managed, children and parents therefore need to be seen as active participants *within* the system, not outside of it. However, this raises practical complications in terms of how parents and children are best involved. Despite our initial intentions, unfortunately we were not able to involve parents or children in either pilot case review. We have not therefore had any empirical data with which to ground development of this aspect of the model.

Ideally reviewers would need to understand and value parents'/carers' and children and young people's perceptions of events and processes to an equal extent that they do practitioners'. This means ascertaining parents'/carers' and children's stories about themselves and why and how professionals were involved with them, their local rationality and their perspectives on key practice episodes and the contributory

factors that influenced the way in which they were handled. This is a considerable level of detail to request and would need to be made clear to families in the initial invitation. Some may decide that the level of detail requested oversteps the mark in terms of balancing their right to privacy against their right to be heard. Where family members accept the invitation, there will need to be attention to the quality of process that recognises the potential emotional impact of taking part, and the need for skill and compassion in dealing with any distress that results.

For families with whom there is ongoing professional involvement, there will be a need to draw out the implications of the review not just for future safety but for families' current situations and the present work of staff engaged with them. This will not be straightforward because while a systems review can identify where in the system the problems lie, it does not necessarily provide absolute or immediate solutions. Some weaknesses in practice need to be reviewed in the light of the other constraints of the system; others require further research in order to find solutions, which would then have wider relevance; neither will be of much immediate use or consolation to families.

The question of whether families can be involved in the interim and final feedback meetings would seem to turn on whether the professional system sees them as inside or outside the system.

6.5.2 Agencies and individuals

Ideally, all personnel involved in the case or part of the case under review, from whatever sector and/or agency and at all levels within organisations, should be involved in the review. However, as the majority of cases run over a significant period of time, this will often not be realistic. Consequently, judgement will be required as to whose roles and contributions were most significant. These judgements link to the identification of key practice episodes that, as we have explained above, are not necessarily self-evident at the beginning of the review, but instead emerge gradually over time. During this process, then, the review team may realise that it has omitted an important agency or person. It seems likely that at the initial stage the categorisation of 'key staff' will reflect organisational cultures and formal procedures, and that it is only when you look more deeply that it becomes possible to identify staff who were key to the family as opposed to the professional system.

At the initial stages of the review we found it useful to enlist the help of the front-line staff involved with the family in identifying who the key staff were. This proved very productive for identifying front-line staff but less so for identifying their first-line managers. Given the importance of first-line managers' involvement for identifying patterns of systemic factors related to PIs, resources, supervision etc the review team might consider the involvement of the first-line manager of each front-line staff member involved.

6.5.3 Preparation for professionals' involvement

Methodologically, a systems review has much in common with participative action research. The review team should be aiming to make it as much of a joint exercise

as possible and the quality of the learning depends largely on the extent to which participants are prepared to engage openly and actively in the process. To this end, it is vital that participants are given a thorough introduction to a systems approach before the case review begins, in order that they understand the aims of the approach, what it entails and the part they are being asked to play.

Our pilots suggest that an introductory meeting including all key staff initially identified is the best means of providing this introduction to the aims and methods. Background reading (for example, Munro, 1999, 2005) can also be useful but it can be no substitute for a face-to-face meeting between participants and the review team. The latter gives participants the opportunity to ask questions and seek clarifications about the aims and methods, as well as checking what reassurances there are in the face of any reservations or cynicism they may have about the focus really being on learning and not blaming. Our experience suggests that it is important at this early stage that the review team clarifies that 'no blame' does not mean that there will be no judgement of individual practice in a systems review, nor that no change will be required of participants. Instead, as discussed in Chapter 1, good as well as problematic practice will be highlighted as the necessary first step to exploring systemic factors that help or hinder people in their roles.

Beyond explaining the theory and practice involved, however, meeting face-to-face before the case review process also serves other important functions. Firstly, it manifests in a very tangible fashion the difference between a systems approach and traditional reviews. Standard reviews tend to be top-down and the workers whose practice is under scrutiny tend to be minimally involved, if at all. Rarely are they given the final review report or made aware of its findings, let alone have a chance to comment on them. Through this first meeting, in contrast, participants actually get to meet the review team members and this gives a strong initial indication that they, and their judgements, will not be aloof and anonymous. Through the review team modelling the nature of the relationships and dialogue with participants that they want to develop in the course of the review, participants too get to make something of an initial judgement of whether and how much they feel they can trust them. Secondly, by bringing all the participants together at the start, this initial meeting also serves to foster a group identity and therefore the possibility of building a feeling of joint ownership, across agencies, of the review process and findings.

6.5.4 The review team

For a full case review we suggest that a team of people is required which minimally should involve two. The amount of work involved is likely to be too much for any one individual. Moreover, critical dialogue between team members is an invaluable safeguard against the common errors in human reasoning that can impede the quality of the analysis, discussed earlier.

There are some benefits to the review team being made up of people who are independent of the organisations whose practice is being reviewed. In our pilots workers' active and open participation seems to have been aided by the neutral 'outsider' status of the review team. However, the drawbacks of choosing people independent of the agencies is that they will know very little of the basic contextual

details related to local structures, policies and practices. Developments in health suggest that it is useful to include someone with knowledge of the affected system(s) but they must not have been involved in the incident (see Vincent, 2006). The suggestion is that these should be people in senior management or clinical positions. Yet, Woodcock and Smiley's (1998) study, mentioned in Chapter 4, found that the more senior the position of the safety specialist, the more likely the specialist was to provide human error-type attribution as opposed to identifying factors in the situation that contributed, suggesting this is not a problem-free solution.

It is also likely to be helpful for the team of individuals to come from different professional backgrounds, so reflecting, at least to some degree, the key professions involved in the case under review. In our pilots, social work was the professional background of most of the review team members and this seems to have biased us towards being better able to conduct closer scrutiny of the social workers' practices than that of other professions.

The key point is that the idea of a totally neutral review team is a fantasy due to the inevitable range of personal and professional understanding and vested interest of any one individual.

7 Ways of implementing the model

In health, ways of implementing a systems approach to learning are often presented as two-fold. A distinction is made between incident-focused methods and continual learning processes. The former include a range of methods for investigating patient safety incidents; the latter predominantly focus on systems for reporting incidents that could have or did lead to harm to a patient or patients. As stated in Chapter 1, however, the way that the systems approach has tended to be used should not be confused with its logic; it is not inherently incident-driven. Theoretically, it can be used as a means of learning from any professional practice.

As in many sectors of children's services, practice is categorised according to the particular family or 'case'; therefore, we have presented the initial model for a systems approach for use in learning from professional practice in relation to a particular case. Consequently, discussing how this model might be implemented in this chapter, rather than highlighting 'incident-focused methods', we focus firstly on 'case review methods'. We draw out both the kinds of cases that might usefully be subject to a full investigation before considering how quicker and simpler use of the principles of the approach might be incorporated into day-to-day practice in relation to any particular case.

Only secondly do we address continual learning methods whereby the systems approach can be implemented. Putting reporting systems and feedback loops in second place in this way is a conscious and significant decision. Experience in health has led some to criticise the over-emphasis in that sector on reporting over and above analysis:

Incident reporting lies at the heart of many initiatives to improve patient safety.... New risk management and patient safety programmes – whether local or national – rely on incident reporting to provide data on the nature of safety problems and to provide indications of the causes of those problems and the likely solutions. Incident reports by themselves, however, tell you comparatively little about causes and prevention, a fact which has long been understood in aviation. Reports are often brief and fragmented; they are not easily classified or pigeon holed. Making sense of them requires clinical expertise and a good understanding of the task, the context, and the many factors that may contribute to an adverse outcome. At a local level, review of records and, above all, discussions with those involved can lead to a deeper understanding of the causes of an incident. Surprisingly little attention, however – and even less funding – has been given to the key issue of incident analysis.... With vast funds being sunk into the research and development of reporting and tracking of incidents, it is perhaps time to pay more attention to the ultimately more important – but greatly neglected – issue of incident analysis. (Vincent, 2004: 242–3)

Given the very early stages of development of this approach in child welfare, these issues are highly pertinent. As we will clarify, developing a reporting system at this stage would be dangerously premature.

7.1 Case review methods

In the previous three chapters we presented an initial model for a systems approach for use in case reviews in children's services. We stated in Chapter 1 that although one has to have a reason for conducting an inquiry or case review regardless of the method of learning used, that trigger does not necessarily need to be a specific adverse event happening to a child – their serious injury or death – although, in practice, such events are currently often the trigger for in-depth reviews.

SCRs in England and Wales and Case Management Reviews (CMRs) in Northern Ireland, then, form one important sub-category of case reviews. They are unique in that they are a specific legal requirement under the Children Act 2004 and accompanying Regulations. This legal requirement is one that LSCBs in England and Wales and Area Child Protection Committees (ACPCs) in Northern Ireland are obliged to fulfil. Their practical importance leads us to begin with outlining how a systems approach can be used in meeting these legal duties. We deal firstly with how the systems model we have presented here fits with the English government's *Working Together* guidance (HM Government, 2006) for SRCs and Ofsted's criteria for their inspection. Subsequently, we consider other potentially useful triggers for a case review.

7.1.1 How does the model fit with *Working Together* guidance for SCRs and Ofsted's inspection criteria?

Congruence of purpose and the focus of analysis: learning not blaming through answering the 'why?' questions and highlighting good practice

The systems model is congruent with the aims of SCRs, as laid out in paragraph 8.3 of *Working Together* (HM Government, 2006), which focuses not on an adversarial and forensic investigation but on learning about the way in which local professionals and organisations work together in order to identify lessons that can be acted on to improve inter-agency working and better safeguard and promote the welfare of children. It is explicitly stated that SCRs are not inquiries into how a child died or who is culpable (HM Government, 2006, paragraph 8.4).

Key to this learning is an emphasis in the guidance on analysis of practice that gets behind what happened to understanding why it did so:

Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened *but why*. (HM Government, 2006, page 175 on 'Analysis of involvement' in the 'Management reviews' box; emphasis added)

... look at how *and why* events occurred, decisions were made and actions taken or not taken. (HM Government, 2006, page 177 on 'Analysis' in the 'LSCB overview report' box; emphasis added)

Answering these 'why' questions is presented as necessary in order to:

... look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made. (HM Government, 2006, page 174, paragraph 8.22 on the aim of individual management reviews)

As this quotation indicates, the guidance indicates that learning from front-line practice necessitates focusing not only on individuals but also on the practices of the organisations involved. There is also a significant emphasis on highlighting good practice as well as problematic practice that can be improved (see HM Government, 2006, page 176, 'Management reviews' box and page 177, 'LSCB overview report' box).

The guidance, then, gives clear stipulations about the purpose of SCRs, the focus of analysis and the organisational as well as individual practice to be scrutinised. All these match the focus of a 'no blame' systems approach that aims to understand the complex webs of causality that influence practitioners' actions and decisions on the front line for better or for worse.

Providing an explicit methodology for how to achieve those ends

The guidance also specifies various aspects of the process, which we will discuss shortly, but first it is important to stress what the guidance does *not* provide. It does not prescribe detail on *how* to actually go about the analysis; it gives no suggestions of models or methodologies to be used.

This is an important issue and one highlighted in two recent reviews of SCRs from England. Sinclair and Bullock's study of SCRs undertaken between 1998 and 2001 (2002) included a focus on the SCR process itself. Specifically they aimed to highlight whether the new guidance produced in December 1999 had led to any discernible changes in the nature of reviews and identify what helped and hindered the process. Obstacles to the quality and, therefore, the value of SCRs included that:

... the sophistication of the review process was often reduced by the limited experience among ACPC members of analysing diverse evidence and by *the lack of a methodology for sifting important information from the rest*. (Sinclair and Bullock, 2002: 54; emphasis added)

The subsequent biennial review of SCRs from England between 2001 and 2003 continued the focus on the effectiveness of SCRs and exploration of factors influencing the case review process. Rose and Barnes (2008), the authors of this review, noted that:

... overview reports could appear ignorant or unquestioning of the most fundamental issues that were a matter of record in the reports. This was not about the research team apportioning blame or suggesting that some events might have been predicted but about *wanting more rigorous exploration of the detail of practice* through the process of the overview. At times it was as if agency reviews and their accounts were accepted without challenge by the review panel or the reviewer.... This suggests that *some more attention needs to be given to how the*

process is undertaken and how the narrative about the circumstances is presented in the overview report. (2008: 84; emphasis added)

This suggests that the issue of the quality of analysis, linked to questions of the methodology used in the review process, remained unresolved.

The most recent review (Brandon et al, 2008) did not focus on process issues so no more up-to-date information is available. Yet further information should be forthcoming from reviews of Ofsted's evaluations. They have recently produced a benchmarking scheme to clarify and share with LSCBs the criteria by which they evaluate and rank SCRs as outstanding, good, adequate or inadequate reviews. This makes clear that the quality of analysis, including its systematicity and rigour, is of great importance. This is evident, for example, in the distinguishing aspects of an 'inadequate' SCR, which includes that:

The extent to which practice at individual and organisational levels is analysed openly and critically ... is inconsistent across agencies. There are gaps in information which are not fully explained.... The overview report ... lacks rigour in its examination of the facts and explanations of how and why events occurred and actions or decisions by agencies were or were not taken. The use of the benefit of hindsight by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events is not convincing. (Ofsted, 2007: 4)

Further details are provided in Table 10.

The systems model, therefore, supports the implementation of *Working Together* guidance by providing LSCBs with an explicit methodology for *how* those conducting SCRs can accomplish the prescribed aims. This will support LSCBs and Children's Services Authorities (CSAs) to attain positive inspection results. It provides a structured and systematic process that, as in health, 'can help to ensure a comprehensive investigation and facilitate the production of formal reports when necessary' (Taylor-Adams and Vincent, 2004: 1). Moreover, it is one premised on an explicit theoretical framework that explains the rationale for the data collection and analysis methods proposed. It would, therefore, also be of benefit to LSCBs as commissioners of SCRs by providing clarity about the nature of the work required, against which the quality can be judged.

Table 10: Ofsted's evaluation criteria related to systematicity and rigour of analysis

Descriptors	Judgement			
	Outstanding	Good	Adequate	Inadequate
Open and critical analysis of practice at individual and organisational levels	By all agencies	By all agencies	By most agencies	Inconsistent across agencies
Explanation for gaps in information	Fully explained	Fully explained	Identified and explained	Not fully explained
Examination of the facts	Rigorous	Rigorous	Included	Lacked rigour
Explanations for how and why events occurred and actions or decisions by agencies were or were not taken	Convincing	Credible	Credible	Lacked rigour
Use of benefits of hindsight and evidence from research to judge whether different actions or decisions by agencies may have led to an alternative course of action/events	Deftly	Appropriately	Appropriately	Not convincingly

Source: Adapted from Ofsted (2007)

Promoting a culture of learning: supporting the need to secure full and open participation and advancing the active involvement of staff

Working Together stipulates the need 'to secure full and open participation from the different agencies and professionals involved' (HM Government, 2006, page 178, paragraph 8.32, bullet 3). In order to get the maximum benefit from the review process in terms of learning lessons from them, the guidance also recommends that people should:

... as far as possible, conduct the review in such a way that the process is a learning exercise in itself, rather than a trial or ordeal. (HM Government, 2006, page 179, paragraph 8.34, bullet 1)

According to Ofsted's descriptors, the quality of the process of the SCR, as distinct from the quality of the findings, is the key distinguishing factor that marks out an

SCR as outstanding in their evaluations. The review has to be conducted in such a way that it 'promotes a culture of learning'.

As with the methods of analysis discussed above, however, neither *Working Together* nor Ofsted specify in any detail *how* either of these aspects might be accomplished. The systems model, therefore, also supports LSCBs in this aspect of the process. It provides a tested participative method that facilitates joint ownership of the review process by multi-agency workers, so helping dissipate any potential fear of blame and encouraging open and active participation by workers.

The model builds on the possibility noted in the guidance of interviewing staff in the course of individual management reviews (IMRs) (HM Government, 2006, page 175, paragraph 8.27); as we have seen, one-to-one conversations with key staff lie at the heart of a systems investigation. The model provides clarity about the kind of data needed from these interviews as well as a conversation structure to help the reviewers obtain it. It also advances the degree of participation by going beyond the stipulation to provide 'feedback and debriefing for staff involved' on completion of each agency management review, in advance of the completion of the overview report (HM Government, 2006, page 174, paragraph 8.23). Instead, a systems approach allows participants themselves to play an active role in the development of the analysis, prioritisation of key findings and identification of solutions. The model enables review teams to achieve this by providing a suggested three-part structure for multi-agency group discussion meetings and opportunities for participants to comment on consecutive draft reports. This process will also ensure, as stipulated in the guidance, that LSCBs 'ensure that contributing organisations *and individuals* are satisfied that their information is fully and fairly represented in the overview report' (HM Government, 2006, page 177, paragraph 8.29, bullet 1; emphasis added).

How does it fit with the two-part process of IMRs and an overview report?

Current guidance requires that each relevant service undertakes a separate IMR and that these are subsequently brought together and analysed in an overview report that is commissioned out to a person independent of all agencies/professionals involved. SCIE's model is *not* premised on such a two-part process and there are, therefore, various possibilities of how it might fit with the procedure specified in the guidance.

The model can be used in the conduct of the overview report analysis

The systems model can be used to produce the overview report, building on the IMRs. We have one worked example of this (although it was not part of the SCIE project). It is important to note that this would change significantly the nature of the task of producing an overview report from a paper-based exercise to one requiring direct engagement with staff via one-to-one conversations and feedback meetings and, consequently, increase the work involved.

The benefit would be that it would allow a detailed review of the actual *working together* of the different agencies, improving the quality of the data and analysis thereby. This is pertinent because the lack of cross-referencing across IMRs and

investigation of connections/contradictions in overview reports is one of the key problems that Ofsted is identifying in its evaluations. The SCIE model raises the question of whether this problem is integral to the two-part process; if our aim is to learn lessons about the working together of multiple agencies, how sensible is it to premise the investigation on single agency reviews conducted in isolation from each other? Anecdotal evidence from overview report authors suggests, for example, that they can experience frustration that the information they are provided with via IMRs does not allow them to explore gaps or contradictions between different agencies' accounts. Furthermore, the commissioning arrangements do not allow (in time or money) for them to supplement the information provided by IMRs through further data collection of their own. Use of the systems model would, therefore, also benefit both commissioners and authors by providing clarity about the nature of the work required, including the purpose and the process, against which the quality could be judged.

The guidance provides an outline format for the presentation of the overview report (see Table 11). The different aspects of the systems model can easily be fitted into this structure, especially as the guidance allows for flexibility because 'the precise format depends on the features of the case' (HM Government, 2006, page 176, paragraph 8.28).

Table 11: LSCB Overview Report structure

	Section	<i>Working Together</i>	Systems model
1	Introduction	<ul style="list-style-type: none"> a) Circumstances leading to the review b) Terms of reference of the review c) Contributors and nature of their contribution d) Review panel members and overview report author 	No change
2	The facts	<ul style="list-style-type: none"> a) Genogram of family, extended family and household b) Integrated chronology of organisational and professional involvement, including each occasion child was seen and their wishes and feelings sought and expressed c) Overview summarising what relevant information was known to professionals regarding parents/carers, perpetrator and home circumstances of the child 	<ul style="list-style-type: none"> a) No change b) and c) contained in multi-agency narratives, that may throw up different understandings of the 'facts'

Table 11: continued

3	Analysis	<p>a) How and why events occurred, decisions made and actions taken or not</p> <p>b) Whether different decisions/actions may have led to alternative course of events</p> <p>c) Examples of good practice</p>	<p>a), b) and c) all contained in table of key practice episodes of good and problematic practice and identification of contributory factors</p>
4	Conclusions and recommendations	<p>a) Summarise lessons drawn for local policy and practice</p> <p>b) Detail recommendations for action</p> <p>c) Highlight lessons drawn for national policy and practice</p>	<p>a), b) and c) all contained in patterns of underlying systemic factors influencing good or problematic practice and associated recommendations</p>

This option could mean, therefore, that much of the work currently done as part of IMRs would become part of the task of the overview report authors (as becomes clearer in the following section). The guidance would seem to allow for this as it encourages consideration of whether ‘any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate’ (HM Government, 2006, page 172, paragraph 8.12, bullet 3). There are also implications for the timing of IMRs. They would most sensibly be written not before but after the multi-agency analysis has been completed. Consequently, at the beginning of the case review, a reduced form of IMR that provided only the basic factual detail of an individual agency’s involvement and left the in-depth analysis and recommendations to the overview authors would be preferable.

Fitting with the suggested outline for IMRs provided in the guidance would require that the authors cross-reference with the overview report in order to avoid unnecessary duplication. The IMRs might usefully highlight any single agency implications raised in the overview report. The outline, however, is provided as a guide as opposed to a strait-jacket because, as explained in the guidance, ‘each case may give rise to specific questions or issues that need to be explore, and each review should consider carefully the circumstances of individual cases and how best to structure a review in the light of those particular circumstances’ (HM Government, 2006, page 175, paragraph 8.27).

The model can be used to guide the conduct of each IMR

The second option is that the systems model could be used to guide the conduct of each IMR. The guidance provides an outline format intended to guide the preparation of management reviews, which includes:

- a) constructing a comprehensive chronology of involvement by the organisation and/or professional(s), summarising briefly decisions reached, the services offered and/or provided and other action taken

- b) analysing that involvement by assessing whether judgements made or decisions taken were good or could be improved and, in relation to the latter, identifying why things happened as they did
- c) identifying lessons to be learned in terms of good practice and ways in which practice could be improved and implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources
- d) making recommendations for action.

These are wholly compatible with the systems model. The question still remains as to whether the practice recommended in the guidance on IMRs is achievable. Are individual agencies in a position to accomplish these tasks *before* the *multi*-agency perspectives have been clarified and working *together* has been analysed? Also, might it be difficult for individual practitioners to believe in the 'no blame' approach to an intensive scrutiny of their practice when it is conducted by senior personnel within their own agency?

The guidance, as noted earlier, is not specific on who should conduct IMRs, specifying only that 'each relevant service should undertake a separate management review' (HM Government, 2006, page 174, paragraph 8.18) and that it should be commissioned by a senior officer in the organisation (HM Government, 2006, page 174, paragraph 8.22). Common practice seems to be that each is done in-house, by a member or members of the individual service. As noted in Chapter 5, however, our pilots suggest there are significant benefits to the same people interviewing all key staff involved in the case. In the course of interviewing any individual professional, the interviewers are simultaneously identifying connections with other individuals' interviews, that is, cross-referencing across agencies, identifying connections and/or contradictions to be further explored. There is, therefore, a case for arguing that SCIE's model would best fit with one team, preferably of independent personnel, conducting both stages of the review. This suggests that the first option, above, using the systems model to produce the overview report, will be more fruitful than this second option of using it in IMRs.

Recommendations

Translating findings into recommendations for action

Guidance for both IMRs and the overview report specifies that the final step involves drawing out the implications of lessons identified through the SCR for improving ways of working and translating these into recommendations for action. In their study of SCRs undertaken between 2001 and 2003 Rose and Barnes highlighted problems in this process of translating findings into recommendations and action for change:

... recommendations did not always follow from the findings. There were obviously divergent views at this point about whether the operational difficulties or failures that had been identified were the result of systemic problems requiring more holistic solutions or the result of individual error – acts of either commission or omission. These different perspectives were not always explicit in

the recommendations and some reviews contained elements of both. What was marked was the emphasis in the recommendations on reviewing or strengthening existing procedures or developing new procedures. This was supported by the views of some respondents that the systems were adequate but the problem was one of staff compliance. There was less emphasis than might have been expected on issues of management, supervision, staffing resources and staff knowledge, skills and experience. The organisational context, which in some agencies at the time was undergoing major change, resulting in disruption and discontinuity in staffing, also rarely featured in issues to be addressed. (2008: 88)

The subsequent biennial review by Brandon et al (2008) did not study the recommendations formulated in the SCRs from 2003 to 2005. So, while their report does make clear that details of contributory systems factors were available in the overview reports (see Section 5.6 'Agency context and "organisational climate"', (Brandon et al, 2008), it is not evident whether or how these were linked to the lessons learned or recommendations.

The systems model, therefore, supports the formulation of recommendations by linking them to the initial typology of underlying patterns of systemic factors that contribute to either good or problematic practice, presented in Chapter 3. This makes explicit that individual and systemic issues are not mutually exclusive and highlights the benefits of focusing on the interaction of factors. The identification of generic patterns of systemic factors and analysis of other inter-acting contributory factors allows for reflection on pathways and obstacles to modifying them. This generates ideas for how the work context and inter-agency working can be strengthened in future. While still tentative and not comprehensive, this typology provides a useful basis for discussion about the kinds of findings to be highlighted. It has the additional merit of helping to remedy the current lack of fit between the findings and recommendations of SCRs.

Highlighting national-level, as well as local-level, implications

Working Together specifies that recommendations should be highlighted not only for local policy and practice but also for national policy and practice:

... if there are lessons for national as well as local policy and practice, these should be highlighted also (HM Government, 2006, page 177, 'LSCB overview report' box, 'Conclusions and recommendations' section)

The systems model aids this task firstly through the provision of contributory factors grouped according to the level and location within the child welfare world from which they originate. Table 6, presented in Chapter 5, distinguishes between front-line, local strategic and national/government-level factors. This helps to clarify where responsibility for the different factor types lies and concomitantly the power and authority to modify or change them if necessary. Secondly, as detailed in Chapter 4, we suggested that the recommendations linked to patterns of systemic factors fall into three distinct kinds that are usefully distinguished. This included specifying solutions that can be addressed locally and ones that would need to be addressed at a national level.

In their study of SCRs undertaken between 1998 and 2001 Sinclair and Bullock (2002) noted that participants were 'less sure about the way in which lessons for national policy and practice were being drawn out or disseminated' (2002: 54). A similar theme emerged in the subsequent review of SCRs by Rose and Barnes, who note that 'none of those interviewed thought that enough value was being gained from the reports nationally' (2008: 74). In view of the level of central government involvement in the operational details of practice this is worrying. However, as noted in Chapter 4, the formulation of recommendations linked to the typology of patterns of systemic factors holds promise for facilitating the collation of review findings and this holds for their collation at a national level. Having recommendations for issues at a national level clearly identified and pre-categorised according to type would significantly aid the authors of the biennial review of SCRs in identifying themes and trends to which the government should respond.

Distinguishing kinds of recommendations

Guidance for both IMRs and the overview report specifies that recommendations should be 'few in number, focused and specific, and capable of being implemented' (HM Government, 2006, page 177, 'LSCB overview report' box, 'Conclusions and recommendations' section). This is mirrored in Ofsted's descriptor of this aspect, summarised in Table 12.

Table 12: Ofsted descriptors concerning recommendations

	Outstanding	Inadequate
IMRs	Areas for changes in practice are clearly identified and supported with measurable and specific improvements	Some areas for changes in practice are identified but are not always supported with measurable and relevant recommendations for improvement
Overview report	Lessons to be learned, nationally and locally, are specific and supported by achievable recommendations for improvement and a comprehensive action plan for implementation	Some lessons to be learned, nationally and locally, are identified but not always supported by specific recommendations for improvement and a comprehensive action plan for implementation

The systems approach, however, raises some important queries about stipulations that recommendations should all be SMART. In trying to be so specific, SMART recommendations run the danger of failing to take account of the wider organisational context and competing priorities. The proliferation of procedures without considering their cumulative effect on practice is a good illustration of such narrow, short-sighted recommendations. Our approach leaves the final responsibility to LSCBs to decide how the recommendations can be implemented in the light of their overall resources and other priorities. Given the inspection criteria, therefore, in SCRs we advise LSCBs to make very clear the reason why areas for change or achievable recommendations for improvement are *not* identified.

Concerning the challenge of how to make effective use of the lessons being drawn from SCRs, particularly about good practice, and turning them into sustainable improvements in safeguarding practice, Rose and Barnes suggest that:

There would seem to be some support for the argument of creating more space and time between the completion of a review and handling its aftermath before beginning a more measured process of responding to the lessons learned. At the moment the two processes often seem conflated.... This would suggest that during the process of the case review a more strategic approach should be taken to drawing up recommendations and action plans ... a distinction [should be] made between those recommendations requiring immediate action and those that present new issues or reinforce themes identified in previous reviews that should be taken forward within a broader framework of change and improvement. (2008: 80)

A systems approach would seem to support this argument and add to it, by highlighting that some new issues may need detailed development research in order to find solutions. Other new issues will need to be considered in the light of the other demands and priorities of the agencies constituting the LSCB before recommendations can be identified.

Time scales

Guidance specifies that SCRs should be completed within four months and this is feasible using the systems model, if the team is able to devote sufficient time. The need for interim and final feedback meetings necessarily places constraints on very fast progress. However, the guidance does permit a degree of flexibility in complex cases.

In Chapter Eight of *Working Together*, the government makes the recommendation to 'make sure that tragedies are not the only reason inter-agency work is reviewed' (HM Government, 2006, page 179, , paragraph 8.35, bullet 1). In line with this, we turn now to consider other possible triggers for case reviews.

7.1.2 Other possible triggers for case reviews

Finding out what happened when a child dies is a basic human right, now enshrined in the Human Rights Act 1998 (cf Rose and Barnes, 2008: 77). There is arguably also a moral as well as a legal responsibility to try to understand more about the circumstances which might lead to the occurrences of a child's death or their serious injury (cf Brandon et al, 2008: 10). Yet there is also a long history of debate about whether learning from tragedies is the best way of understanding how well or not local inter-agency systems are working to safeguard and promote the welfare of children and making changes to lead to improvement.

Firstly, there is the argument that, as the old adage goes, 'bad cases make bad laws'. Secondly, despite guidance to the contrary, opportunities for learning from any good practice in the case tend to be overlooked in the context of a tragedy. As Stanley and Manthorpe point out in relation to public inquiries:

... it is difficult to point to positive messages about what works. Yet examples of good practice are evident in many reports. (2004: 38)

Lastly, there is the 'well-known capacity' for SCRs and public inquiries 'to provoke fear and defensive, risk-averse practice' (Stanley and Manthorpe, 2004: 38). So what other triggers could usefully instigate a case review using a systems approach?

The problems with 'near misses'

Rather than restricting case reviews to incidents of child death or significant harm, many LSCBs now seem to be setting up systems for the review of what are colloquially referred to as 'lower-level' incidents and/or 'near misses'. This mirrors developments related to the development of the systems approach in health where the range of patient safety incidents are differentiated according to the severity of harm caused: no harm, low, moderate, severe, death (see Bostock et al, 2005, Appendix D).

It also reflects the first phase of SCIE's work in adapting a systems approach for child welfare in which the need was identified to develop an equivalent language for safeguarding work. The tentative proposition for the equivalent of 'patient safety incident' in health was a 'safeguarding incident':

A "safeguarding incident" results in harm or potential harm due to professional agencies' failure to keep a child safe, rather than from neglect or abuse by family members, for example. Like a "patient safety incident", a "safeguarding incident" also covers near misses that have the potential to lead to serious harm but have been prevented or have occurred but no serious harm was caused. A "safeguarding incident" refers to an action combined with a potential or actual negative outcome. (Bostock et al, 2005: 17)

In SCIE's Report 06 (Bostock et al, 2005) the benefits of learning from 'free mistakes' or 'near misses' *before* harm is caused to children, were particularly promoted.

As in health, a 'near miss' was defined as practice in which:

- 1) something could have gone wrong but has been prevented, or
- 2) something did go wrong but no serious harm was caused. (Bostock et al, 2005: 15)

Various difficulties were, however, also identified in developing a grading system for adverse incidents in children's services and particularly in distinguishing the category of 'near miss' in child welfare. On the one hand, there was the difficulty of capturing longer-term consequences of interventions. On the other hand, the research carried out with practitioners and service users indicated that incidents identified by practitioners as 'near misses' were often experienced as harmful and damaging by service users and carers (see Bostock et al, 2005, Chapter 4 for more details).

A further set of difficulties that has emerged more clearly in the current phase of the work relates to the limitations of the knowledge base in child welfare, discussed in Chapter 2. Defining a 'near miss' presupposes consensus about what should

have happened and what counts as a deviation, error or mistake on the part of a professional. It also assumes that the link between that deviant action and the potential negative outcome can be reliably made. Yet both of these are problematic in the field of child welfare. Poor or even tragic outcomes for service users may or may not be the result of professional action or omission and we do not, even in theory, know how to work with abusive or neglectful parents to make them resilient and competent parents in all cases.

The case we were given to review in City made these difficulties in using the 'near miss' categorisation of triggers for review even more tangible. In relation to work with this family, there had been speculation among practitioners in the site that one or other of the definitions of 'near miss' (given above) were true. On the one hand, many practitioners involved with the family during the time under review, expressed their fears about what might have happened to the child if the state of the home, which led to her removal, had not been discovered when it was – definition 1, something could have gone wrong but has been prevented. This fear was reinforced by a feeling that it was only by chance that the state of the house had in fact been discovered when it was. On the other hand, others involved during the time under review as well as some professionals who had been involved with the family subsequently, felt that the child should have been removed earlier but that luckily no serious harm had been caused by the delay – definition 2, something did go wrong but no serious harm was caused.

On the face of it, however, prior to the review process, there was little evidence to indicate either any specific serious risks to the child or the need for her removal earlier. Before reviewing the case in detail, therefore, this could be no more than speculation. Consequently, rather than a 'trigger' for review, whether or not this case was a 'near miss' is more appropriately a question for the review to answer. There was still the possibility that this case was an example of *good* practice: a deteriorating situation being competently identified before any serious consequence to the child.

This example serves as a graphic illustration of the problems involved in achieving a sufficiently high consensus and inter-user agreement in the identification of 'near miss' cases for review and, therefore, consistency of use of the category to trigger a case review just between professionals. Indeed, the disagreements between professionals in this case are not the only possible ones. Families also have a point of view. The mother in City might have contested the categorisation on other grounds again. She might not have seen the removal of her child as a 'near miss' at all but, in her eyes, as an adverse outcome and perhaps even one that could and should have been avoided.

Linked to the above, it is also worth remembering that good practice involves charting a course between two adverse outcomes – leaving children in danger and removing them prematurely. If our triggers for case reviews focus only on the former, we shall distort the reality of the practice complexity. The effect would be to highlight outcomes that reflect badly on professionals but undervalue outcomes that are unjust to families, such as removing a child on insubstantial grounds.

More fruitful triggers

Given the contentious nature of both 'error' and 'harm', outlined above, we would suggest that the use of such typologies, including 'near misses', as triggers for case reviews in child welfare is premature and unlikely to be helpful. For reasons argued above, judgements about the quality of practice and its links to outcomes for children and families are best clarified through the review process itself and not beforehand. So what alternative triggers are there that might serve us better?

A case might be chosen for review, for example, because of the outcome for a child, irrespective of professional competence. These might be negative outcomes – recognition of the level of neglect a child is suffering or a decision to remove a child or noticing that the family has not changed significantly in a number of years. There are also strong arguments, as indicated in Chapter 2, for focusing on positive outcomes - a particularly successful case or one considered to represent routine or normal impact or change.

Alternatively, a case review might be triggered not by outcomes but on the basis of the experiences and perspectives of those involved. We could identify cases in which professionals or the family were surprised by the nature of the outcome – they had not seen it coming. This was another common way in which professionals in City categorised the case that we were reviewing; they had not foreseen their work culminating in the child being accommodated and this led them to question whether they had missed anything along the way and whether they could or should have done anything differently. A second option would be cases that families and/or professionals are particularly pleased with, for whatever reason.

'Case review fatigue' (Axford and Bullock, 2005: 52) has been identified as a common weakness of the current approach and there is research to suggest that it is:

... better to have a good review accompanied by a lot of after-thought on a smaller number of cases than a scant and soon forgotten inquiry on all of them ... a deeper analysis of each case can go beyond the platitudinous and indicate its own important lessons. (Axford and Bullock, 2005: 52)

This seems an important issue for LSCBs to consider.

7.2 Incorporation of the case review model into day-to-day work

7.2.1 The systems model

Experience of using the London protocol (Taylor-Adams and Vincent, 2004) for systems analysis of clinical incidents in health in England has shown that it can be used in a variety of settings including hospitals, primary care settings and mental health units, and in many different ways beyond a full-blown incident investigation. These different formats for its use include:

It can be used for quick 5 or 10 minute analyses, just identifying the main problems and contributory factors. (Taylor-Adams and Vincent, 2004: 2)

A clinical team might use the method to guide and structure reflection on an incident, to ensure that the analysis is full and comprehensive. (Vincent, 2006: 112)

The protocol could also be used for teaching, both as an aide to understanding the method itself and as a vehicle for introducing systems thinking. (Taylor-Adams and Vincent, 2004: 3)

This alerts us to the possibility of implementing the model in child welfare in other ways than case reviews. Our pilot case reviews suggest two obvious possibilities.

Use of the model to review the way a particular current case is being conceptualised and handled

Waiting for an incident in child welfare before reviewing the way a case is being conceptualised and handled is often too late to avert an unintended outcome, as already discussed in previous chapters. Each of our pilot sites, however, suggested specific triggers that could usefully invoke the use of the systems model in relation to current and ongoing work, to facilitate a constructive multi-agency review and revision of assessments and plans. This would be the equivalent of case discussions that are routinely held in parts of the health sector but for which there is neither an established culture nor accompanying forums or policies in social care.

The model could be used to guide reflection, for example, starting by highlighting the inevitably differing perceptions of different agencies involved. Examination of these differences would need to explore whether they contribute new dimensions to understanding of the family or reveal misunderstandings that need to be rectified. Subsequently, the identification of key practice episodes could be used to identify patterns of problematic practice and their contributory factors so that those within the control of the multi-agency group could be addressed. These might include patterns of human reasoning and patterns of multi-agency working. The reflection could be facilitated by the multi-agency group itself, or run as a group supervision session, led by an outsider either from one of the participating organisations or an independent person.

The case reviewed in County suggests that one useful trigger to invoke the use of the systems model in relation to current and ongoing work would be with cases that are unchanging for a considerable period of time. It is possible that the review might conclude that interventions are working as effectively as possible in preventing a deterioration but it may be that a deeper scrutiny will unsettle the existing picture of the involvement and introduce new possibilities for intervention.

The case reviewed in City suggests a different trigger. Here, the case was not 'stuck' but, as noted in Chapter 4, at various points different professionals had strong feelings of 'unease' about the case: "it never got to the point of running smoothly – clinging on with nails, then another crisis". Yet these concerns were not documented in the formal records and nor were they shared. Consequently, they did not feed into the multi-agency assessment and review process, due to a variety of contributory factors. Feelings of unease about a case might, therefore, be a second trigger to invoke the use of the systems model in relation to current and ongoing work as a

means of reflecting on where these feelings come from and what they might mean and, indeed, whether they are valid.

A longer list of 'trigger' points might usefully be developed.

Using the model as a routine part of practice

A second possible use of the model in day-to-day work would not involve a particular trigger, but instead would involve incorporating particular aspects as a routine part of practice to aid ongoing critical appraisal and review. A checklist of common errors in human reasoning, for example, might aid critical review in professionals' meetings. If a systems approach is widely implemented then professionals will get familiar with this framework and it might be adaptable to ongoing case supervision and discussion.

Incorporating the approach into people's day-to-day work has the potential for allowing them to get used to the approach and to value it. This might make its use in the stressful times of SCRs potentially easier. It would also allow it to be used positively, to aid the creation of safety and prevent things going wrong.

7.3 Continual learning methods

We stated in the introduction to this chapter that continual learning methods in health have focused predominantly on systems for reporting incidents that could have or did lead to harming a patient or patients. We quoted Vincent's criticism of this emphasis to the detriment of focus on methods for analysis. He is also critical of the British medical incident reporting system itself, listing as its weaknesses:

- No standardized, operational definition of incident,
- Coverage and sophistication of local incident reporting systems varies widely,
- Incident reporting in primary care is largely ignored,
- Regional incident reporting systems undoubtedly miss some serious incidents and take hardly any account of less serious incidents,
- No standardized approach to investigating serious incidents at any level,
- Current systems do not facilitate learning across the NHS as a whole. (Vincent, 2006: 59)

These details suggest that the taxonomy was inadequately formulated before this system was put into operation.

Other research suggests that this is not unusual. Wallace and Ross (2006) warn that most currently used accident investigation systems and minor event reporting systems have been built backwards:

In other words, the methodology for gathering the data was set up, then the database to order the data, and then the taxonomy to order *these* data.... Certainly one needs *some* raw data at the beginning (which might be a very small number of reports, discussions with process engineers, or observations of plant activity). As soon as information starts to come in, discussions should commence with the staff who have to use the database to create a workable

and database-specific taxonomy which may of course use lessons learned from other taxonomies, but the fundamentally unique aspects should never be ignored. (Wallace and Ross, 2006: 60)

This suggests that while developing a similar reporting system in child welfare may look appealing, extreme caution is required in order to proceed only as quickly as theoretical developments permit. As our discussion above of the contentious nature of both 'error' and 'harm' and the inherent difficulties of defining a 'near miss' suggest, this is as yet not far at all and indeed perhaps never will be. Moreover, we have also suggested that there is as much good reason for considering the development of a theoretically grounded taxonomy of good practice, as there is for one of error or near miss.

It seems highly likely, therefore, that a premature rush to instigate a reporting system would lead to the amassing of a mountain of diverse reports, each classifying incidents in idiosyncratic ways and providing varied details about the context. Such unstructured data would be hard to analyse in any reliable way so that the reporting system would soon fall into disrepute and disuse since it could not produce any valuable lessons.

Instead, individual agencies and LSCBs might usefully consider alternative kinds of feedback loops that focus on the patterns of systemic factors that contribute to good or problematic practice, identified in Chapter 4. Continual learning processes would require feedback loops that enable a continual mechanism so that senior management can be readily informed of weaknesses in the system as well as new, emerging problems, as they become apparent to front-line staff, in order to be able to learn from them.

8 Conclusion and next steps

8.1 Recapping

Methods of learning are central to efforts to improve outcomes for children and families. They are the means whereby current problems in service provision can be identified in order that solutions can be sought. To date, a key aspect of such efforts has been through the inquiry into a tragic death of a child from child abuse or neglect. Yet,

... the findings are familiar and repetitive over more than two decades, giving rise to the questions: why do such significant errors continue to be made? Why do interagency coordination procedures not identify such failings more effectively at an earlier stage? (Dale et al, 2005: 53)

Engineering and other high-risk industries have developed the 'systems approach' to learning specifically to get to the bottom of 'why' accidents occur. It is also used preventatively to identify strengths and weakness in routine work so that so that steps can be taken to strengthen practice before a tragedy occurs. The approach has also been taken up in the health sector. Understandably, therefore, and on an international scale, there is increasing interest in how the approach might be used in the field of child protection and child welfare.

Transporting approaches across fields of practice is, however, a notoriously fraught process, in which sensitive adaptations are invariably required to take account of significant differences between the domains. In this report, we have presented initial steps in that process. Based on participative action research pilot case reviews, we have presented a preliminary model of a systems approach adapted specifically to suit the nature of multi-agency safeguarding and child protection work for use in case reviews.

Below we highlight what seem to be two of its more radical features compared with more traditional approaches, before discussing the 'next steps'. We conclude with a brief end note on the importance of opening up discussions about methods of learning used in case reviews more generally.

8.1.1 Practice-based evidence and practice-based system change

The importance of 'nearness to practice' has been discussed in relation to the kind of research needed for building up the knowledge base in social work and social care practice. SCIE (see Marsh and Fisher, 2005) has argued for the importance of 'practice-based evidence' as opposed to 'evidence-based practice':

... social care needs research that can be used in practice. It needs research that begins and ends in practice: that begins with practice relevant questions, and that ends with relevant material that can be applied to practice. (2005: 13)

Given this, the argument continues, 'we would ideally want the engagement with research production to rise as the closeness to practice rises' (Marsh and Fisher, 2005:

16). In reality, however, practice-based evidence is lacking and the nearer you are to practice the less likely you are to engage with the research production process.

The systems approach highlights the importance of 'nearness to practice' not only in relation to the kinds of learning produced through research but also through case reviews. Woods and Cook (2002) warn of the need to avoid 'the psychologist's fallacy'. The phrase was originally coined by the 19th-century psychologist William James, and refers to the fallacy that occurs:

... when well-intentioned observers think that their distant view of the workplace captures the actual experience of those who perform technical work in context. Distant views can miss important aspects of the actual work situation and thus can miss critical factors that determine human performance in the field of practice. Understanding technical work in context requires (1) in-depth appreciation of the pressures and dilemmas practitioners face and the resources and adaptations practitioners bring to bear to accomplish their goals, and also (2) the ability to step back and reflect on the deep structure of factors that influence human performance in that setting. (Woods and Cook, 2002: 139)

The common belief that senior personnel understand the experience of the front-line worker, therefore, is a serious error because once we are out of front-line work we will become out of date with the nuanced changes in the factors influencing performance.

The systems model of learning that we have presented starts and ends in the 'swampy lowland' (Schon, 1987: 3) of professional practice. As a participative, multi-agency approach grounded in the realities of front-line practice, it holds great potential for producing the practice-based evidence that leads to practice-based systems change that is necessary for improving outcomes for children and their families. The contrast with current approaches to case reviews in this regard is striking, as Figure 17 below illustrates. By the time we get to biennial reviews of SCRs, commissioned by the Department for Children, Schools and Families in England, we are four steps away from the complex realities of front-line practice and the people actually involved. These are based on multiple overview reports, which are each based on internal management reviews, each based (in the main) on case documentation.

Figure 17: Current approaches to case reviews and distance from practice

Review of serious case reviews

↑ ↑ ↑ four steps removed

Overview report

↑ ↑ ↑ three steps removed

Individual management reviews

↑ ↑ ↑ two steps removed

Case documentation

↑ ↑ ↑ one step removed

Complex of professional practices

Speaking in general terms about the systems approach and its findings, one of the participants from our pilot sites said:

'This way of carrying out reviews does feel much more empathic both to professionals and family, also more wide ranging and about normal human behaviour rather than endless policies and procedures – were they present, and who didn't follow them? The recommendations feel much more constructive and practical – they aim to address real difficulties of shop-floor workers – not to make a whole lot more work developing new processes almost for the sake of being seen to do something.'

With this, she highlighted what we think of as the 'nearness to practice' of the systems approach.

8.1.2 Power and accountability

The systems approach raises some fundamental questions about traditional views on accountability, power and control. In the systems approach, the front-line worker's actions are seen as, in part, due to factors in the wider system that influence the nature of the task s/he is expected to carry out and the conditions in which it can be performed. This raises the question of how to apportion accountability and responsibility. Is the front-line worker only, in part, accountable, and how do we measure the size of that 'part'? How do we apportion accountability when causation is conceptualised as diffused throughout the many layers of the system? Who has the power to produce improvement? It is possible that the heroic worker of exceptional talent can defy the adverse pressures to achieve high standards but it

might be more effective on a wider scale if a senior manager re-designed the task so that is easier for the average front-line worker to do it well.

Besides the questions about moral and legal accountability for performance, the systems approach also raises queries about the limitations of a top-down approach to implementing change and improvement in the system. The 'command and control' model of management assumes that senior management has not only the authority but also the power to dictate how policies should be implemented throughout the organisation. The systems approach, however, draws attention to the complexity of the causal network so that it seems implausible to claim that senior managers can see all the potential interactions of their instructions with the other factors outside their control that are influencing front-line performance.

In children's services, where so many agencies with varying priorities are interacting, the possibility of predicting in advance how change in any one agency will interact with other agencies seems very remote. The commands sent out from senior management will be interpreted with some degree of variation on different layers in the system because they will interact in unexpected ways with other processes influencing practice. Social care management, for example, may set certain procedures for their staff but they depend, in practice, on cooperation with police officers whose senior management may be introducing other changes that affect their interactions with social workers. This argument about complexity strengthens the need for a systems approach to studying how organisations are functioning and the need for feedback loops that encourage good communication between all layers in a system. That is not to say that fulfilling such a need will be easily achievable, as we discuss below.

8.1.3 Challenges to the hierarchy

Feedback from participants at our pilot sites highlighted potential obstacles to the take-up of this model:

'I suspect that some senior professionals from agencies almost like the more inquisitorial nature of SCR with lots of recommendations about procedures and new policies. The "blame" aspect while not supposed to be a feature probably does satisfy to some extent.'

'I would have some fears about this approach being adopted in such a collaborative way by a formal case review – not sure that organisations are really willing to listen to the real views of professionals about why they think things may have gone wrong, and make changes to organisations rather than just the workers involved.'

'Not hopeful about the agency. Still feel because of performance indicators they will value throughput above quality.'

This scepticism is a useful reminder of the challenge that a systems approach poses to top-down approaches not only to management but also to government and,

consequently, to the full hierarchy of children's services. It requires opening up lines of communication and accountability from the bottom all the way up to the top.

In his preface to the second edition of *System failure: Why governments must learn to think differently*, Chapman writes that in the first edition he omitted 'the biggest obstacle of all – namely the presumption of knowing best' (2004: 12). We need to ask, therefore, whether this presumption underpins the current child welfare reform agendas in the different countries of the UK. Attention has been drawn to the extraordinary rhetorical potency of the English government's reform agenda:

The appellation 'Every Child Matters' applied to both the Green Paper and the Children Act 2004 offers an incontrovertible moral imperative. Who could possibly dispute that *every child matters*? Thus the reforms have drawn upon a linguistic repertoire that constructs changes as an ethical imperative for professionals working with children and young people. (Peckover et al, 2008: 378)

The question is whether this linguistic repertoire also reflects an over-confidence on the part of government ministers and senior civil servants about how to achieve the admittedly laudable aims. Any such knowing best runs the danger of shutting the door to learning about unintended consequences of different aspects of their reforms or to adapting or changing them accordingly. Recent research, for example, about the ways that ICTs are being mobilised, for example, via the Integrated Children's System, are changing ways of working in unexpected and unhelpful ways (Bell et al, 2007; Lifting the Burdens Task Force, 2008). Such findings do not challenge the ultimate goals of policy and practice but indicate that there is a need for modifications in how they are achieved.

8.2 Next steps: continual R&D to refine the model

In the course of this project we have been struck by the high level of interest in the systems approach. Some LSCBs have already used the method of their own accord; many others have been in touch because they want, or are planning, to, but need further information and help with putting it into practice (we discuss this further in the following section). We hope that this report will be of use to this growing community. However, we stress again that what we have presented are preliminary first steps in the development of a systems model for child welfare. There is an urgent need, therefore, for a shared mechanism for learning from each other in the use of this model in order that it can be further refined and developed. SCIE is keen to have discussions with interested parties in how this might be accomplished.

A UK systems network of some kind would usefully contribute to a growing international community of people interested in pursuing this approach to learning. Developments are taking place in Australia and in Illinois, US, and there is interest from the Bavarian state in Germany as well as Norway.

8.3 End note: the importance of methods

This report is proposing a new model for conducting case reviews and this raises the question of what it would replace. Yet it is in fact quite difficult to find out what

methods are currently used. Through the course of this project, we have come to wonder with amazement at the lack of either transparency or public discussion and debate about the actual methods of analysis used in case reviews in children's services. It is standard practice in research for any report on a study to contain a 'methods' section, explaining and justifying the choice of methods used. Such a culture is lacking in SCRs. It seems to be rare, for example, for report authors to provide any detail about the approach they have taken or its relative strengths and inevitable weaknesses. Both descriptive and reflective papers about case review methods in journals are, similarly, rare, as are accompanying conferences. Practice guidance, moreover, is only just starting to be created and shared, for example, the Swindon SCR process guide (www.swindonlscb.org.uk/lscb-index/lscb-general-about/lscb-aboutus-scr.htm) and Newcastle's SCR protocol and handbook (www.newcastle.gov.uk/ssacpc.nsf/a/protocol?opendocument). Our impression, however, is that these tend to focus on the processes, roles and pro formas as opposed to discussing the rules or methods to follow in the difficult intellectual task of making sense of why things happened as they did.

When compared, for example, with the transparency, guidance and numbers of papers published and conferences run on systematic review methods in the fields of social work and social care, education and criminal justice, the difference is staggering. It is all the more bewildering given the practical importance of reviews in children's services. There is a statutory obligation in the UK to conduct SCRs when a child is seriously injured or killed, and the impact of public inquiries has been a major influence on the way services have developed.

The community of people involved in both commissioning and conducting case reviews is large and contains a wealth of experience. As we conclude this report, therefore, we would like to urge all those involved to talk and write about their experiences and reflections on the methodologies that they have used and the kinds of learning achieved thereby. At a minimum, we hope that this report will help to open up these kinds of discussions.

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*Learning together to safeguard children:
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