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Messages from elsewhere about reviewing serious cases: What's in it for Scotland? Key messages and actions from the seminar (Seminar report)

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SHORT PAPER

Messages from elsewhere about reviewing serious cases: What's in it for Scotland?

Key messages and actions from the seminar

SEMINAR DETAILS: 15 SEPTEMBER 2011, EDINBURGH
 SEMINAR HOSTS: The Multi-Agency Resource Service (MARS)
 Scottish Child Care and Protection Network (SCCPN)
 The University of Edinburgh Child Protection Research Centre¹

OVERVIEW ABOUT THE SEMINAR

In September 2011 the MARS/SCCPN and the University of Edinburgh/NSPCC Child Protection Research Centre¹ hosted a seminar in Scotland for practitioners and those involved in policy development related to child protection. With input from experts – Dr. Sheila Fish and Dr. Sharon Vincent – the seminar explored approaches to reviewing cases of child death and serious abuse – specifically looking at approaches in New Zealand, Canada, Australia, the USA and a Systems Approach being developed in England. Delegates were then invited to reflect on these approaches in order to distil learning and implications for Scotland.

TERMINOLOGY

Serious Case Reviews (SCR) is a term usually applied to reviews conducted when a child has suffered serious harm or died as a result of neglect or abuse. In Scotland, the term used is Significant Case Review (SCR) and need not comprise just one significant incident². Child Death Reviews (CDR) is a term usually adopted for reviews conducted when a child has died, irrespective of the cause, and would include those who have died as a result of neglect and abuse. CDRs are not applied in Scotland. As the seminar highlighted, there is wide variety in the extent to which SCRs and CDRs are conducted in countries outwith the UK.

In addition to reflecting on approaches for conducting individual reviews, this seminar also looked at how these reviews are then assessed or analysed *across* a state or country in order to identify wider trends and generate learning. In Scotland, SCRs are commissioned by Child

Protection Committees (CPCs). In England and Wales, this responsibility lies with Local Safeguarding Children Boards (LSCBs).

SCOTLAND: BACKGROUND

This seminar was designed to build on the work of the Short Life Working Group's report *Significant Case Review (SCR): Developing Best Practice*, the MARS/CLiCP¹ Conference on Significant Case Reviews held in 2010 and the work of Sharon Vincent conducted while at the Child Protection Research Centre. Unlike England, Wales and Northern Ireland, there have been no Scotland-wide analyses of Significant Case Reviews. In 2010 the Scottish Government accepted recommendations to improve SCR consistency and practice; this included a recommendation to commission analysis of SCRs undertaken in Scotland since 2007. At the time of this seminar, clear steps to implement this analysis were not yet manifest. The event provided an opportunity for delegates to explore approaches adopted in other countries, and to identify possible actions for taking forward this agenda.

SPEAKERS

Dr Sheila Fish of the Social Care Institute for Excellence (SCIE) has been involved in developing and implementing a particular **methodology** for reviewing cases including serious cases – a **Systems Approach**. She spoke to the principles and applicability of this model.

Funded by a Leverhulme Scholarship, **Dr Sharon Vincent** has been conducting a six-country comparison learning from how child death reviews are conducted. She presented initial findings from four countries specifically highlighting **differences in approach**, the use of **national database** systems and **themed reviews**.

¹ The University of Edinburgh/NSPCC Child Protection Research Centre was previously known as The University of Edinburgh/NSPCC Centre for UK-Wide Learning in Child Protection (CLiCP). This name features on publications and seminar material produced between 2007 – 2011.

² For further information, refer to "Protecting Children & Young People: Interim Guidance for Child Protection Committees for Conducting a Significant Case Review" (2007).

PRESENTATIONS: A BRIEF SUMMARY

A SYSTEMS APPROACH FOR CASE REVIEWS: A POSSIBLE APPROACH FOR SCOTLAND?

**Learning Together to Safeguard Children:
commissioning case reviews and serious case
reviews using a systems approach.**

**DR. SHEILA FISH, SENIOR RESEARCH ANALYST & HEAD OF
LEARNING TOGETHER, CHILDREN'S SERVICES TEAM, SOCIAL
CARE INSTITUTE FOR EXCELLENCE (SCIE)**

BACKGROUND

The Systems Approach was originally developed in the engineering sector as a way of conducting reviews following serious accidents. Using an in depth reflection on organisational context and decisions *at the time*, this approach is focused on ensuring the right kind of lessons can be learned in order to mitigate future risks.

In terms of learning from child deaths in England to-date, despite clear review processes, it has been difficult to identify and integrate learning that is transformative.

“There is an overwhelming sense that there is too much emphasis on getting the process right, rather than on improving outcomes for children, of the process being driven by fear of getting it wrong, of practitioners and managers feeling more criticized than supported by the process, and that the Ofsted evaluations do not support learning” Sidebotham, et al. 2010. Learning from SCRs. Report of a research study on the methods of learning lessons nationally from SCRs. London: Dept for Education.

Since 2004 work has been conducted by SCIE to explore how this Systems Approach model can be applied to case reviews and SCRs in England – this has included looking at the NHS which has a longer history of using a Systems Approach in its reviews of organisational practice through Root Cause Analysis. The adapted model is called Learning Together (Fish, et al. 2008).

ABOUT THE APPROACH

A methodological heart underpins a Systems Approach to review – more specifically, it is based on an established and theoretically informed understanding of human performance. It recognises that within an organisation, most harm is not deliberate or a result of incompetence, but takes place because of latent conditions in which accidents happen. Rather than becoming fixated on the mistake, this approach seeks to

identify the conditions that, in the extreme, are ‘accident opportunities’ (making it harder for people to do good quality work), and those that are more likely to result in helpful and safe actions. When appropriately implemented, a systems approach affords the opportunity, described as lacking to-date, to “reflect on and learn from deeper issues in the systems, attitudes and practices of the organisation and individuals within it” Sidebotham et. al. 2010

SCIE has introduced flexibility into how the model can be implemented, however, the key principles remain static and these include:

- Avoiding hindsight bias and aiming to understand how professionals saw and made sense of things at the time
- Appraising and explaining key practice episodes so as to identify what was influencing workers so that their actions seemed sensible at the time – the contributory factors.
- Going beyond the case specific findings and using a single case to get a ‘window on the system’ (Vincent 2004) in order to identify general strengths and weaknesses across the system.

Applying these principles requires the case review process to be multi-agency and collaborative from the outset – including by speaking directly to those involved to understand what was influencing their decisions *at the time*. In line with qualitative research principles, reviewers endeavour to start with an open mind in order that the focus is led by what they actually discover through the review process. This replaces terms of reference that have a specific focus of analysis before the review process has begun

ABOUT THE FINDINGS

Rather than prioritising what was most important *in the case*, the approach remains focused on *organisational learning needs* by identifying current strengths and problematic areas. It involves determining what is most important for the safety of systems for current and future work with families.

Findings from these case reviews identify current vulnerabilities in multi-agency system reliability. The findings are presented as issues for the commissioners to consider as well as challenges from which LSCBs can decide how best to respond. Rather than identifying new issues, the findings provide a more detailed, nuanced understanding of the underlying problematic issues. Additionally, because of the methodology, they usually

provide professionals, including those on LSCBs and in member agencies, with opportunities to think differently about the issues and how they might be tackled.

Significant positive feedback has been received from those involved in being trained in, and delivering, this method of review, including:

- the positive impact for professionals in being brought together in a guided reflection/learning process
- the usefulness of putting a research framework around the process and how this brings rigour to the review
- the quality of insights about what is getting in the way of good quality work with families.

In addition to finding ways to implement this approach more widely in England, SCIE are also exploring how best to measure the longer term impact of this approach.

SOME CONSTRAINTS AND CAUTIONS

The Systems Approach must be proactively applied with skill and expertise – it “does not work itself”. To be effective there is a need to cultivate a set-up where skills and expertise of those leading case reviews can be accrued and implemented over time. The English Government has funded SCIE to run a training and accreditation programme and so initiate this process.

In policy terms there is support in England for this approach – particularly in the light of the *Munro Review of Child Protection in England* which has recommended that LSCBs be required to use a systems methodology for SCRs and be encouraged to initiate a broader range of learning activity than that triggered by poor outcomes. This looks set to remove the implicit methodological constraints in previous statutory guidance in England (for conducting SCRs). This policy change occurs at a time of financial austerity when there is increased pressure to show that any investment in organisational learning is good value for money.

Further information: For detail on the Systems Approach to case reviews in England (Learning Together) including practitioner/social care films, reports, guides and pilot evaluations, visit: www.scie.org.uk.

CHILD DEATH REVIEW IN AUSTRALIA, NEW ZEALAND AND NORTH AMERICA: INITIAL FINDINGS AND IMPLICATIONS FOR SCOTLAND

DR. SHARON VINCENT, SENIOR RESEARCH FELLOW
THE UNIVERSITY OF EDINBURGH/NSPCC CHILD PROTECTION RESEARCH CENTRE (NOW AT: SCHOOL OF HEALTH AND WELLBEING, THE UNIVERSITY OF WOLVERHAMPTON)

BACKGROUND

Content for this presentation was drawn from an ongoing study titled: “Preventing Child Deaths: Learning from Review”. The overarching aim of the study is to pool knowledge in relation to child death review across countries to further understanding of how and why children die, and to identify good practice in order to inform policy and practice around prevention. Using a case study approach with documentary analysis and interviews with key informants, the study looks at what data is collected, the main risk factors highlighted in the data, how child deaths are reviewed, to what extent review is congruent with a public health approach, and whether review has been effective in reducing child deaths. This presentation highlighted approaches adopted by Australia, New Zealand, Canada and the USA in relation to child death review, in order to identify some general messages for Scotland.

WIDER ANALYSES OF CHILD DEATHS

Australia, New Zealand, the USA and Canada all have processes for reviewing individual child deaths, and conduct wider analyses at country and/or state level. Some key differences exist in the legislative basis, who undertakes the review, the focus of the reviews, funding and family involvement.

DATA SYSTEMS

Both the USA and New Zealand collate data at a national level. In the USA, 36 states input into a national case registry system which now holds information about 88,000 child deaths. New Zealand based their data system on the USA system but every health board inputs its data on child deaths directly into this system so New Zealand have information on every child death since 2002. These country-wide systems provide a rich source of data for identifying national trends, key learning and potential interventions. (More information: www.childdeathreview.org).

THEMED CHILD DEATH REVIEWS

Australia and Canada both conduct themed or aggregated reviews if they identify a particular theme arriving from CDRs so that new learning can be used to

influence policy and improve practice. Rather than focusing solely on deaths that have resulted from cases of serious abuse or neglect, themed reviews in these countries have been conducted around a wide variety of topics including methadone ingestion, suicide, infant sleep related deaths, Aboriginal children, domestic violence, fire deaths, deaths from drowning, as well as neglect and physical abuse. Four examples were presented highlighting how these themed reviews had been conducted and how the learning was used to influence positive change.

THE VALUE OF CHILD DEATH REVIEWS

A number of benefits were highlighted in relation to conducting CDRs, including:

- Provides a comprehensive, evidence based approach to understanding and preventing child mortality
- Broadens our understanding of how and why children die so we can prevent future deaths and improve child safety
- Are a key source of accurate information on shaken baby syndrome, youth suicide, infant deaths associated with bed sharing, substance use and other risk factors
- Provide a key source of information which can inform the development of evidenced-based campaigns to tackle these types of deaths e.g. safe sleeping campaigns.

Further information: The findings from the study will be written up in a book 'Preventing Child Deaths: Learning from Review' which will be published by Dunedin at the end of the year.

IN SUMMARY

In relation to case reviews these presentations emphasised the importance of progressing two critical streams in tandem:

1. A **public health approach** that looks more widely at risk factors for children within the individual, family and community context (i.e. wider than the child abuse and neglect or 'disease focus' of many SCRs)
2. Reviewing trends in **organisational practice** to identify factors that mitigate risk and are more likely to lead to effective professional practice.

Ultimately it is essential that data relating to child deaths and significant harm is collected and analysed in a manner that is *most* likely to lead to robust, widespread learning and improved policy and practice.

KEY MESSAGES AND IMPLICATIONS FOR SCOTLAND

In Scotland there has been a tendency to develop national policy and practice initiatives around looking at individual cases adopting a forensic approach. Significantly more could be achieved by broadening the analysis and looking across all of the data in Scotland to develop national policies and national practice change. The presentations and round table discussions highlighted a number of key messages and specific implications for Scotland.

NATURE AND METHOD OF REVIEW

In Scotland:

- Significant Case Reviews are commissioned and conducted locally by Child Protection Committees
- There is no national approach for reviewing *all* child deaths
- Policy and practice change tends to be the result of individual cases, rather than reflecting across cases and/or reflecting on good practice
- Current reviews tend to focus on the errors and mistakes, rather than adopting a wider analysis of the organisational context in which professional behaviour is taking place.

NATIONAL ANALYSIS AND LEARNING

In Scotland

- In 2010 the Scottish Government accepted the recommendation from the Short Life Working Group to commission a national analysis of SCRs (conducted since 2007) in order to distil trends and national learning. At the time of the seminar (September 2011), this recommendation had not been taken forward – which explains the urgency in some comments below. The nation-wide analysis of SCRs has now been commissioned. It is being undertaken by Dr. Sharon Vincent in conjunction with IRISS and is due to report in August 2012.
- There is no national database for consistently gathering information on child deaths in Scotland.
- There is also no consistent framework for presenting the findings from case reviews to allow themes about organisational strengths and vulnerabilities to be identified in a timely way.

OPPORTUNITIES THAT WARRANT FURTHER EXPLORATION

Scotland is a small country and, given the gaps identified above, there is an opportunity for Scotland to draw on the insights and experience of other countries in order to develop a more co-ordinated, national approach to SCRs.

Delegates drew on Sheila Fish's presentation to highlight the opportunity for **more organisational learning** in relation to how case reviews are conducted in Scotland. There was significant **appetite for conducting themed reviews** (across a number of cases as outlined by Sharon Vincent) as well as using a Systems Approach to explore a specific theme using a particular case (as outlined by Sheila Fish).

Delegates affirmed the **value of cultivating a culture of learning** where reviews are structured to enable organisational improvement, rather than focused on the more forensic, and often disempowering, analysis of the mistakes.

The **lack of legislative framework** in Scotland (in relation to guidance for conducting SCRs), **presents** a significant **opportunity** for Scotland to trial the Systems Approach across a broad spectrum of serious cases.

Sharon Vincent highlighted that **Scotland needs good local data as well as a centralised database**. Scotland currently does not have a centralised database or ways of feeding into this – so there is no way of looking across Scotland in order to analyse and address trends at a national level. With good national data, it would be possible to undertake aggregate or themed reviews to provide national evidence to influence policy and practice, and enable effective prevention initiatives to be developed. Both the USA and New Zealand have expressed willingness for Scotland to use and adapt the data systems they have developed for recording child deaths at a national level. One delegate at the seminar spoke of the work being done by NHS Quality Improvement Scotland in relation to sudden unexpected deaths, highlighting this as the possible beginnings of a central database. The development of any centralised data base will need to clearly distinguish the public health focus on epidemiological data, as distinct from the organisational learning approach that surfaces underlying patterns and trends of professional practice (see 'In Summary' section above).

There is still the opportunity for Scotland **to identify and learn from SCRs that have already been conducted** – by the Scottish Government fulfilling its commitment to commissioning a Scotland-wide analysis of SCRs conducted since 2007.

Additional themes in conversation included:

- being clear that a more nationally integrated approach *is* possible if there is political will
- while there is significant opportunity for a national approach and cross-sector learning – this must be balanced with the need for confidentiality
- more careful consideration needs to be given to how data is collected, analysed and used
- Scotland seems to have a culture of blame and competitiveness in relation to case reviews – the Systems Approach could hold useful levers for developing a more positive, and outcomes orientated culture of learning; joint cross-sector training could be another useful lever.
- maintain primary focus on learning and practice improvement that can mitigate risk, and not become unduly embroiled in historic debates (e.g. around legislative frameworks, family involvement etc).
- reactive methodologies are unlikely to be helpful in assessing risk, particularly in relation to cumulative harm
- there is opportunity for Scotland to trial a Systems Approach in a few areas, with MARS doing an evaluation
- there is opportunity for these initiatives to be positioned more firmly within the Government's children's rights and early intervention agendas.
- boldness is required to consolidate and strengthen our approach to case reviews in Scotland.

Overall delegates expressed that while Scotland has historically been somewhat 'behind the game' in regard to systems for reviewing child deaths, given the size of the country and relatively under-developed national analysis, there is a **significant opportunity for Scotland to be proactive and establish robust national approaches that draw on the learning and experience of other countries**.

KEY ACTIONS AND NEXT STEPS

As a result of this seminar, the MARS/SCCPN in partnership with the Child Protection Research Centre and other identified stakeholders have identified and are taking forward the following actions:

- Continue to encourage the Scottish Government to build on the 2010 commitment to commission the national review of SCRs conducted since 2007. The baseline audit and review is now underway and due to report August 2012.
- Continue to support the exploration of adopting a public health approach and reviewing *all* child deaths in a nationally coordinated way.
- Continue to disseminate learning and lessons from across UK and internationally
- Support practice in taking forward the 'Learning Together' model as one way of conducting Significant Case Reviews in Scotland
- Continue to explore opportunities to develop a national database for all child deaths in Scotland
- Continue to help embed a 'culture of learning' in the way Scotland conducts significant case reviews.

For further information, visit www.mars.stir.ac.uk.

REFERENCES

Fish, S., Munro, E., and Bairstow, S. (2008) *Learning together to safeguard children. Developing a multi-agency approach for case reviews*. SCIE Report 19. London: Social Care Institute for Excellence.

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The Scottish Child Care and Protection Network (SCCPN)
The University of Edinburgh/NSPCC Child Protection Research Centre

THE MULTI-AGENCY RESOURCE SERVICE (MARS) AND THE SCOTTISH CHILD CARE AND PROTECTION NETWORK (SCCPN)

Based within the University of Stirling, MARS aims to support professionals and agencies working in child protection by developing communities of expertise and sharing practice knowledge across Scotland. MARS works closely with the Scottish Child Care and Protection Network (SCCPN). SCCPN is a multi-disciplinary network of academics and stakeholders who work collaboratively to coordinate child care and protection dissemination and research. Together, MARS/SCCPN form the first child protection hub of its kind in the UK and was set up in response to Recommendation 27 of the SWIA report *An Inspection into the Care and Protection of Children in Eilean Siar* (2005). Initially funded by Scottish Government, it aims to facilitate access to child care and protection expertise to help agencies deal with issues of neglect and abuse. For more information or to join our mailing list, visit: www.mars.stir.ac.uk or www.sccpn.stir.ac.uk.

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The Centre was set up in 2007 as a unique collaboration between the University of Edinburgh and the NSPCC. Our research is designed to generate a more integrated and deeper understanding of child protection in the UK and internationally, in order to strengthen policy and practice. The Centre conducts two kinds of child protection research:

- critical comparison and analysis of developments in legislation, policy and systems
- primary research in areas of identified priority or gaps.

We want children in the UK to be equally and increasingly safe. To help improve child protection systems we are committed to pursuing a programme of knowledge exchange that makes a positive impact, including fostering dialogue between policy makers, practitioners and academia. For more information or to join our mailing list visit: www.childprotection.ed.ac.uk.

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The Centre was previously known as The University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection (CLiCP). This name features of publications produced between 2007-2011. The University of Edinburgh is a charitable body, registered in Scotland. Registration number SC005336.