Department for Education

A Study to Investigate the Barriers to Learning from Serious Case Reviews and Identify ways of Overcoming these Barriers

Research report

July 2014

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Acknowledgements

Kingston University's Institute for Child Centred Interprofessional Practice Serious Case Review (SCR) research team would like to extend our thanks to the Department for Education (DfE) for their support in overseeing this study to the interim stage, particularly Deborah Jenkins and Anne Gair. Thanks go to Andy Hudson, Head of School of Education for supporting this research. Thanks are also due Kate Dracup-Jones and Professor Toni Bifulco for their expert advice. A special thank you to Sue Woolmore for her support in ensuring all information went successfully to all Chairs of the Local Safeguarding Children Boards. Tina Corr and Alex Beishon are two people who deserve a special mention for their unstinting support, sometimes at short notice, who stepped in to make events and technology run smoothly. We would also like to thank the employers, managers and students who attended the pilot focus group. Finally, we would like to acknowledge our thanks to all the participants whose voices have been represented in this report.

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Disclaimer

Contents

List of figures

List of tables

EXECUTIVE SUMMARY

Kingston University's Institute for Child-Centred Interprofessional Practice (ICCIP) was awarded a contract from the Department for Education (DfE) to undertake a small study investigating barriers to learning from Serious Case Reviews (SCRs) in order to identify ways of overcoming these barriers and ensure that any learning is embedded in policy and practice.

The ICCIP Serious Case Review (SCR) multi-disciplinary team are working at national, regional and local levels towards developing an action plan for England on how to enhance and embed learning from serious case reviews more effectively. This report outlines how we engaged with frontline practitioners, partner agencies and other sectors in the process of collection and dissemination of views, opinions and strategies in a changing workforce landscape. It offers identification of emerging themes that indicate why lessons learnt from Serious Case Reviews (SCRs) have not been embedded in policy and practice and provides insights that may inform future policy, procedures and practice across different disciplines, agencies and sectors.

Key Findings of Emerging Themes

Major themes that emerged throughout this research relating to barriers to learning from SCRs demonstrated that there is considerable consistency of views across all four geographical areas of England, across frontline practitioners, frontline managers and senior and strategic managers, and across all agencies working in safeguarding. There was also a consistency of themes within the responses generated from a Survey Monkey questionnaire completed on behalf of Local Safeguarding Children Boards (LSCBs), pre and post focus group questionnaires and the focus group discussions that involved strategic and operational practitioners. Data analysis illuminated key emerging themes which have been organised under three main categories:

- SCR Processes and Publications;
- Learning Culture and Training;
- Systems Approach to Policy and Procedures.

Under each of these three categories, 'Barriers to learning from SCRs' and 'Enablers to learning from SCRs' are identified and presented below.

Barriers to Learning from SCRs

SCR Processes and Publications

- The length, time and content of SCR publications create an ethos of 'blame,' avoidance, apathy, defensiveness and increased workload. This is exacerbated by media coverage. The number and dispersal of SCRs nationally means it is difficult

to give them all local attention, and what gets attention is then skewed and determined by national media selectivity and coverage.

- The numbers of recommendations that generate new policies and procedures is overwhelming.
- The SCR reports are not accessible in terms of length and common language to make them meaningful and manageable to all users across different sectors, professions and agencies. Key themes and learning are not adequately identified nationally.
- The SCR process is itself costly in terms of finance and capacity and may not generate the most useable or interpretable learning for local practice.
- There is concern about publication in full and how this relates to transparency and confidentiality.

Learning Culture and Training

- There is insufficient regular, appropriate and purposeful training across and within disciplines.
- Not all training is appropriate for different roles and responsibilities of staff within and across different disciplines and agencies including the Private, Voluntary, Independent sector of private, community and voluntary organisations.
- The learning from SCRs is repetitive and can lead to lack of attention and engagement.
- Front-line staff have limited involvement in the generation of learning and ensuring its relevance and applicability.

Policy and Procedures

- Policy and procedures development and implementation are not proportionate or sensitive to the scale, locality and context of the case.
- Rapid policy and procedural change and implementation impacts significantly on frontline staff creating confusion and tensions relating to workload, roles and responsibilities and accountability.
- Change takes time to embed and too much change nationally and locally is destabilising and undermining.
- Policies and procedures do not always recognise the human and emotional aspects in terms of interpretation, judgement and decision making.
- Policies and procedures may not be sensitive to what is able to be actioned by practitioners with large workloads and who are already very busy.
- Communication systems are currently ineffectual in ensuring that learning from SCRs informs practitioners within and across disciplines, agencies and sectors.

Enablers to Learning from SCRs

SCR Processes and Publications

- The SCR processes should be less resource demanding, more timely, and more engaging of frontline practitioners.
- SCR reports should be more succinct and shorter.
- Reset the process to promote learning rather than blame.
- Reset the process to promote reflection and analysis rather than primarily description and hind-sight judgments.
- Key themes and learning should be identified within the reports and highlighted locally and nationally.
- There should be national, themed repository of reports, with some targeting at different professions, practitioners and management roles, agencies and sectors. (Since the initial first draft of this report the DfE have initiated a national and themed repository of all SCRs.)

Learning Culture and Training

- There needs to be a continuing programme of training at strategic and operational levels to reinforce and embed learning and practice change.
- Training should develop knowledge and skills for practitioners to understand thresholds, supervision requirements, effective record keeping, risk, referral systems and to develop effective communication skills with all stakeholders and partners.
- Interagency relationships need to be built in order to support the emotional impact of learning and decision making from SCRs (threshold decision making under pressure).
- The value of the 'child's voice' needs to be understood within the context of the family (background, culture and history).
- A new reporting system needs to be developed that captures learning from smaller incidents as well as major emergencies to better reflect the typical context of working practice (incremental and regular learning).
- There needs to be more regular and focussed training appropriate to different levels and engagement in SCRs (including scenario and case study approaches).
- The importance of learning should be recognised by senior leadership and champions to ensure engagement with and relevance for practice and practitioners.
- A stock of lessons learned for on-going incremental learning needs to be developed.

- A new evidence-based process of learning is needed that will directly begin to positively shape and transform services in order to promote an effective safety culture.
- There is a need to create an organisational and cyclical 'learning culture' within and across the services.
- The integration of an interprofessional learning 'tool' into the culture needs to be developed to ensure sustainability of a positive organisational transformation.

Policy and Procedures

- Changes in policy and procedures should be discussed and tested with frontline practitioners before roll-out and implementation.
- There should be awareness that over-proceduralisation squeezes out professional practice, judgement and accountability and ownership of actions.
- Frontline managers - and supervision- are crucial in changing, supporting and quality assuring practice and should be a particular focus of changing, enhancing and sustaining good practice.
- Strategic and senior leadership within and across organisations and disciplines is crucial in ensuring attention is given to the learning and changes generated by SCRs.
- Auditing the impact of, and embedding changes, needs to be given more attention.
- Clear lines of communication structures within and across all the services are required.
- An analysis from previous experiences and drawing conclusions for future directions can develop a stock of lessons learned for on-going incremental learning.
- There is a need for follow up learning and procedures to ensure corrective actions are implemented so that underlying root causes can be monitored system wide.

Recommendations

Recommendation 1: To review the appropriateness of Serious Case Reviews as a process for embedding learning across disciplines

Recommendation 2: To develop an on-going accessible database of national and regional incremental learning over time to identify emerging key themes and recognising there is a continually changing workforce landscape.

Recommendation 3: Design and develop evidence based learning 'tools' applicable nationally to facilitate collective but also targeted and tiered learning.

- Learning together - with a strong focus on multi professionalism;
- Learning for action and in action;
- Learning to challenge - learning to 'think the unthinkable' including working with non-compliant parents/carers; confidence to challenge apparent compliance and to ensure all the 'unseen and unheard' have been investigated for example the 'hidden man of the household'; child and young person; other voices not in the system such as grandparents and neighbours; and other underestimated sources.
- Learning together with and from front line practitioners, strategic managers and the Private, Voluntary, Independent and third sectors;
- Learning through supervision.

Recommendation 4: Develop a national accessible database for all practitioners to access SCR 'Executive Summaries' with on-going key themes identified for learning. Dissemination of regular themed reports in a variety of formats to facilitate different professional and agency audiences.

Recommendation 5: Ensure clear accessible guidelines to enable confidence across all disciplines in information sharing, thresholds and systematic recording systems and measuring impact.

Recommendation 6: Develop a Continuous Professional Development (CPD) programme for all practitioners to enable deeper learning to overcome obstacles to good practice by developing and consolidating 'hidden' interpersonal skills as well as legal and work based requirements in all forms of learning environments, supervision and professional development.

Recommendation 7: Cross disciplinary course development from initial training for all practitioners in the future to include reflection on the drivers that impact on different professional groups for example, health, education, social care and the private, voluntary, independent and third sectors.

Recommendation 8: Develop nationally learning and auditing tools which can be used locally to increase awareness of the key themes emerging for SCRs and to promote practice enhancement and impact.

Recommendation 9: Capture within local and national reporting structures the recording of how the learning and practice changes following SCRs are being taken forward,

Recommendation 10: Integrate within existing and planned inspection processes the assessment of the impact of the key themes identified through SCRs.

Building on the emerging themes and recommendations from the study, further exploration is proposed in the following areas:

1. How the SCR process might be made less onerous, less blaming and more practical;

2. How the findings and learning from SCRs nationally might be made more easily available and useable locally;

3. How the findings and learning might be better shaped and used to have a positive impact on learning for practice;

4. How the embedding of practice changes might be checked and consolidated.

Consideration should be given to developing a set of mandatory '*National Safeguarding and Child Protection Standards'*, applicable to all professions, agencies and disciplines working with children and young people.

CHAPTER 1: INTRODUCTION

Kingston University's Institute for Child-Centred Interprofessional Practice (ICCIP) was awarded a contract from the Department for Education (DfE) to undertake a small study investigating barriers to learning from Serious Case Reviews (SCRs) in order to identify ways of overcoming these barriers and ensure that any learning is embedded in policy and practice. Kingston University has a history of active engagement with safeguarding, child protection and SCRs, researching practice based issues and theoretical perspectives. ICCIP within the Faculty of Health, Social Care and Education boasts substantial expertise and knowledge in this area with active researchers and recent publications.

Highly publicised cases involving SCRs such as Victoria Climbié in 2003 and Peter Connelly in 2009 have resulted in initiatives and policy implementation to promote the engagement of professionals across different sectors and agencies in the children's workforce. The 'professionals' involved with each of the above cases were publically criticised for ineffectual individual and collaborative working (Laming, 2003 and 2009) and the resulting legislation introduced a policy shift and directives for all professionals to work together purposefully and productively (DCSF, 2004: DCSF, 2005). In the five published evaluative reviews of lessons learnt from the SCRs undertaken by Ofsted between 2007 and 2010, a continuing pattern of identified ineffectual practice was highlighted which indicated that 'lessons learnt' were not being embedded in practice.

Context and Background of the Study

Policy context

The Munro Review of Child Protection: *a child centred system* (2011) put forward the proposal to use a 'systems approach' for all Serious Case Reviews (SCRs). Munro suggests that a systems approach will counteract a 'blame culture' and develop a way of working that encourages people and processes to collaborate more closely. Each discipline has their own multiplicity of complex rules, relationships with each other within their own organisations and outward facing activities. The complexity of revealing new learning is acknowledged and depends on building a picture of how combinations of the varying contexts, sustainable relationships and infrastructures amalgamate to create new and smarter ways of working.

Munro (2011) states that there should be a stronger focus on understanding the underlying issues that made professionals behave in the way they did and what prevented them from being able to properly help and protect children. The current system she suggests is too focused on what happened and not why it happened. A central tenet of the systems approach is that any professional working in any area is a result of both their own skills, knowledge and the organisational setting in which they are working (Fish *et al*., 2012)

The aims and objectives of this study was to provide identification of emerging themes that indicate why lessons learnt from Serious Case Reviews (SCRs) have not been embedded in policy and practice and identify insights that may produce a potential action plan for future policy, procedures and practice across different disciplines, agencies and sectors.

This research identifies possible ways forward and adds to the body of knowledge and understanding of how SCR lessons learned are embedded in good practice and provide specific examples of where this has been effective. It was anticipated that the evidence collated would determine whether any organisation has the current means to embed policy into practice in light of recent and significant structural changes in different disciplines, agencies and sectors.

Pressures and challenges for interprofessional working

Evidence (Gardner, 2003) that has examined factors affecting multi-professional working, has indicated that barriers such as a lack of role clarity within and between professions and accountability ambiguity within policy implementation have existed for some time. Both strategic and operational practitioners have experienced the requirement to change existing working practices that have, in some cases, resulted in productive opportunities but in others have caused confusion, suspicion and anxieties that may have subsequently resulted in reduced public confidence in the current systems (Atkinson *et al.,* 2002: Nurse, 2007; Miller, 2008).

An overwhelming finding from previous SCRs indicates that 'two thirds of SCRs concern children under the age of five (and half are for infants under twelve months) (Brandon *et al.,* 2012; NSPCC, 2012; Ofsted, 2011). This means that a large number of these children fall within the Early Years services (Private, Voluntary, Independent (PVI) and Third sectors), or are looked after by families/carers, which adds to the complexity and transparency of information sharing.

Most of the biennial research into SCRs concentrates on children 5 years of age and upwards (Brandon 2012), therefore it is important to capture and identify any possible gaps in the current body of knowledge relating to the full age-range of children (Birth to 19 years). As well as those children in early years this may also include recognition of vulnerable older disabled children, whose disability may be hidden, and for whom reasonable adjustments in light of SCRs, may not necessarily be made (Paliokosta and Kindness 2012). This is further complicated by the fact that another major area of SCRs relates to the sexual abuse and exploitation of young people. According to the Child Exploitation & Online Protection Centre (CEOP 2013) the abuse of power and authority that comes with status, celebrity or otherwise, remains a potential threat to children. The 'vulnerability of certain institutions to predatory child sexual offenders should also not be underestimated' (CEOP 2013). There is also a need to capture the input of agencies who work with vulnerable young adults who may well have parenting responsibilities but who

may have competency and capability needs. The Children and Families Bill (2013) will require 'improving cooperation between all the services that support children and their families and particularly requiring local authorities and health authorities to work together.' The common thread is that learning still needs to be disseminated effectively amongst professionals, both at strategic and operational levels. All practitioners need to recognise each developmental stage as an integral part of a continual process. As a research team we gave careful consideration to listen, hear and represent the 'voices of the practitioners and their lived experiences' in all sectors working in this complex field.

Autonomy and respect for children and young people's views

Articles 1 to 41 of the United Nations Convention on the Rights of the Child (1989) ratified and signed in 1992, sets out the rights of children and the corresponding obligations of state parties (governments) to safeguard them. Article 42 requires states to publicise the principles and provisions of the Convention to children, young people, parents and carers, and *everyone working with children and young people.* The Convention protects children and young people's rights by setting standards in health care, education, legal, civil and social services.

Local Safeguarding Children Boards (LSCBs) must act on the duties outlined in the Children Act (2006) in that they are to listen to children, young people and their families and to draw on '*their insights when engaged in their other functions.'* It is imperative that owing to the vulnerability issues relating to babies and young children, all disciplines should be rigorous, not only about ethical aspects, but also the appropriateness of how evidence of their health and wellbeing is collected, monitored and acted upon. There are now acknowledged multi modal ways forward for engaging children to elicit their views and opinions at an early age. Alison Clark (2005) uses what is termed as the *'Mosaic Approach'* that encompasses a range of methods in order to gain as wide a picture of children's views and daily lives as possible. The Mosaic approach was developed during a research study to include the 'voice of the child' in an evaluation of a multiagency network of services for children, young people and families. Although not included in the research data analysis but in the preceding focus group discussion pilot for this research, a practitioner in a case referral meeting for four children aged between 2 and 15 years, found that the two year old child's voice was not considered within the team around the child meeting and yet it was the 2 year old who was witnessing most of the domestic abuse taking place whilst the older children were attending school. In terms of integrated working 'The authority must make arrangements to secure that early childhood services in their area are provided in an integrated manner which is calculated to—(a) facilitate access to those services, and (b) maximise the benefit of those services to parents, prospective parents and young children' (The Children Act 2006: 3.2, p 9).

Sidebotham *et al*., (2010) suggest that schools have the optimum opportunity for interagency collaboration to intervene early and address some of the complex issues that children and families experience. They also put forward the view that the Common Assessment Framework (CAF) (CWDC, 2009) could be used to find pathways to support children and young people. However, the term ‘Common’ is not now applicable as it is our experience of working with hundreds of work based practitioners from many different agencies and disciplines that the Common Assessment Framework is now adapted by each Local Authority which can make transference of information difficult when families move around.

CHAPTER 2: AIMS, OBJECTIVES AND METHODOLOGY

Aim and Objectives

The aim of this research was to identify emerging themes that indicated why lessons learnt from Serious Case Reviews (SCRs) have not been embedded in practice (barriers) and identify insights (enablers) that may inform future policy, procedures and practice across different disciplines, agencies and sectors. The intention was not to dwell on what has not worked but to identify and build upon that which has worked. The objectives were to maximise collective knowledge and expertise in order to create possibilities for enhancement to current practices. This was achieved through Appreciative Inquiry (AI) where participants were enabled to construct meanings individually and collectively through a variety of data collection methods.

Methodology

The research followed the principles of Prince2 Project planning; learning from previous experience and ensuring that the research was well-planned, monitored and tailored to suit the size, capacity and complexity of the working landscape (TSO, 2009). The research team has vast experience of managerial roles both across and within different disciplines which ensured that the research was conducted robustly and in accordance with set timescales.

A staged approach was adopted to consolidate available knowledge, identify current trends at strategic and operational levels, indicate current knowledge and practice across disciplines highlight in-depth collective perspectives and enable additional reflections and affirming collective ways forward.

The research methodology below outlines how we engaged with frontline practitioners, partner agencies and other sectors in the process of collection and dissemination of views, opinions and strategies in a changing workforce landscape. The core research team during this process followed the BERA Ethical Research guidelines and used the ethical framework designed for multi-professional working (Rowson, 2006). The research proposal was approved by the Kingston University Ethics Committee.

Methods

- **Literature Review (consolidating available knowledge)**

An analysis of literature and research was undertaken to examine current knowledge and embedded good practice across agencies and sectors. Previous research across four areas was used to illuminate and distil any learning that may have emerged from serious and traumatic events. The review covered recent research and highlighted the barriers

and enablers where learning had taken place and changes made in order to embed good practice through:

- Government policy documents reviews and related articles;
- Health perspectives;
- Emergency services;
- Aviation disasters.

- **National Survey (identifying current trends at strategic level)**

  A survey was undertaken with the National Association of Independent Chairs of Local Safeguarding Children's Boards (132 Chairs). The intention was to identify how current Chairs sought to ensure that lessons learnt from SCRs were heard, disseminated and applied in practice and how this might be enhanced and embedded. This was achieved by setting up a short 10 minute online survey that was linked by password to the ICCIP website which provided data to the research team.

- **Pre-Focus Group Questionnaires (indicating current knowledge and practice across disciplines)**

  Before each focus group discussion a short questionnaire was completed by each participant. The questionnaire was designed to elicit each individual's knowledge and understanding of SCRs from their professional discipline.

- **Focus Group Discussions (illuminating in-depth collective perspectives)**

  Two focus group discussions in four different geographical areas across England were populated according to the LSCB's guidance and included 10-12 participants. The selection for each group included strategic (Group 1) and operational (Group 2) roles. The reason for the division of groups addressed issues around the ability for each member of the group to be confident they had their voices and views heard in a positive smaller group environment, minimising possible coercion. The following shows an indicative list of participants.

Group 1 Strategic (Senior Management and Development) Roles

- Chairs of LSCBs, Police Borough Commander, Police Inspector, Head Teachers, Multi-agency Senior Managers, Directors of Children's Services and Heads of Children's Social Care, relevant University/ College Deans, Trainers for Child Protection, named doctor/nurse for child protection

Group 2 Operational (Practitioner and Front-line Management) Roles

- Social Workers, early years practitioners, teachers, health professionals, GPs, health visitors, family nurse practitioners, community nurses, paediatrician, CAMHS, Children Centre staff, Public Protection Unit, Police Sergeants and Constables, Civilian Investigators, independent sector, Adult Services

The AI focus group discussions were facilitated by the Principle Investigator (PI) in the presence of a second facilitator and a third researcher responsible for digitally recording the interview, as well as capturing manually, key themes arising from the discussions. The presence of an administrator at all focus group discussions also ensured that the interviews ran efficiently. The AI focus discussions lasted approx.1 hour.

- **Post Focus Group Reflective Analysis (enabling additional reflections and affirming ways forward)**

  Immediately following the focus group interviews each participant was asked to undertake a brief written reflection of their experience, critically analysing their contribution, highlighting areas of interest or development and identifying any potential impact on practice. This provided the opportunity for participants to affirm their contribution to the research process ensuring that their voice had been heard. This took about 20 minutes.

Time management of fieldwork

The organisation of the Focus Group discussions required sensitive planning to enable key stakeholders maximum potential to participate with minimum disruption to normal working hours. The timings shown below were adhered to so that there was a maximum commitment of 3 hours (allowing for travel).

Figure 1: Timings in each of the four geographical areas

	Pre-Questionnaire	**Focus Group Interview**	**Post Reflective Analysis**
Morning Session **Group 1**	10:00-10:30	10:30-11:30	11:30-12:00
Afternoon Session **Group 2**	14:30-15:00	15:00-16:00	16:00-16:30

Data Analysis of the different phases

An analysis of literature took place in order to read, interpret and thematise the plethora of past knowledge in the field of lessons learnt from SCRs as well as lessons learnt from other systems. Following identification of recurrent themes, findings were summarised under thematic headings and information was tabulated allowing identification of prominent themes.

Some of the data from the national survey and pre-focus group discussions were analysed quantitatively where appropriate to create current trends in tabular representation.

A combination of both manual and computer assisted methods were used for the systematic analysis of qualitative and quantitative data stemming from the national survey, focus group discussions and the pre and post questionnaires.

Figure 2: Analysis and Reporting Timescale

STAGE 1	
Weeks	**Activity**
1-4 (4 weeks)	Setting up the project Literature Review National Survey
5-9 (5 weeks)	Fieldwork (pre-AI questionnaires, AI Focus groups, Post AI reflective analysis) On-going data analysis
10-15 (6 weeks)	Analysis Interim Report for DfE approval
(2 weeks)	Final report for publication

CHAPTER 3: EMERGING THEMES FROM CURRENT LITERATURE

Table 1: Prominent Themes emerging from current literature

Barriers	Enablers
• Inflexibility of SCR framework impacting on interagency working (role ambiguity, professional trust, implicit and explicit hierarchy between individuals and disciplines). • Length, time and content of SCR publication creating ethos of 'blame', avoidance, apathy, defensiveness and increased workload. • Reactive to media attention • Policy implementation responsive but not proportionate to scale, locality and context of case • Insufficient regular, appropriate and purposeful training across and within disciplines	• Instigate a learning culture that recognises clear lines of responsibility and accountability with acknowledgement of professional expertise when making judgements enabling flexibility within complex systems. • SCR national reports to be refined to 'learning themes' with opportunities for practitioners to discuss and reflect upon cases in a 'safe' environment • Regular and multi-levelled training, (specific to disciplines, across disciplines and focussed on key practitioners where appropriate that acknowledges the emotional impact on practitioners).

GOVERNMENT POLICY DOCUMENTS, REVIEWS AND RELATED ARTICLES

Recent literature reviews in safeguarding children (Martin, Jeffes and MacLeod, 2010) have explored issues and challenges in safeguarding systems and practice and have included comment on legislation, statutory and inspectorate documentation. This section of the SCR literature review presents related works, government policy and research that examines perspectives from operational and strategic practitioners.

Most of the works reviewed cited the historical context within which they have been situated and recognised the increased collaboration required between professions that has become statutory following the reform of welfare services involving heath, social services, criminal justice and education after highly publicised SCRs. There was some indication that the shift in reconfiguration of services and subsequent strategic planning has in some instances resulted in operational implementation with inappropriate training. The indication is that judgements in practice have been profoundly influenced as operational practitioners have experienced role ambiguity due to strategic changes to

practice across disciplines. Barr and Low (2011) suggest this is a result of the rapidly changing policy context within each discipline where practices do not have time to embed before new directives are received. A recurring theme would appear to be the need for on-going generalised and specific training, dependent upon clarification of roles within and between different professions, disseminating lessons learnt from SCRs (Barlow and Scott, 2010).

The articles by Lees and Meyer (2011) and Patsios and Carpenter (2010) discussed the expansion of interprofessional working requirements and the rise of training programmes to facilitate engagement for individuals from different professions. However, they identified a tension reported by practitioners that the imposed statutory requirements to work effectively across disciplines was vulnerable should government directives change. In short, from the practitioner perspective, the directives that have influenced the emergence of interprofessional working practices within the safeguarding field could just as easily be withdrawn. Both articles identified demotivation and lack of engagement in training programmes for those professionals for whom attendance was compulsory rather than self-chosen (Lees and Meyer, 2011: 88; Patsios and Carpenter, 2010: 5). This concurred with Ecklers *et al.* (2006) who recognised tensions involved in the rapid pace and uncertainty of reform that left little time for individual professionals to adjust to new roles resulting in avoidance of engagement.

A number of works referred to the defining influence of a skilled 'group facilitator', highly effective 'training coordinator' or 'paraprofessional' as being essential to effective on-going dialogue between professions to ensure information was shared and learning was embedded in practice (Lees and Meyer, 2011; Patsios and Carpenter, 2010; Bannon, Carter and Ross, 1999). This emerging 'role' concurred with Lumsden's (2012) research (from an early years education perspective), that identified a 'new professional space' at the intersection of health, education and social care that requires particular knowledge, skills and attributes to facilitate effective coordination and learning between and across professions. The potential implication is the suggestion of a new, consummate role working across professions monitoring the application of lessons learned from SCRs.

One of the challenges highlighted in several works was a 'power imbalance' that was recognised to exist within and between professions. Issues such as equal status, demarked hierarchy in job titles or perspectives of individuals' levels of management responsibility appeared to determine the extent of individuals' propensity to engage with embedding learning in practice (Hewstone and Brown, 1986; Leadbetter, 2006; Lees and Meyer, 2011; Macleod *et al.,* 2010). Patsios and Carpenter (2010) indicated that where one profession had a 'louder voice' then the problematic solutions presented were not necessarily conducive to other professions, as operational implications may differ significantly from one context to another. The potential implications of one profession determining policy could be inconsistencies and/or misunderstandings within and across other professions that could result in risk averse practices or raised awareness of risk identified by Anning *et al.* (2006). The papers reviewed have indicated that there may be

some specific knowledge education that might be better undertaken jointly across professions but on entry to the workforce prior to the establishment of preconceptions and prejudgements (Clark, 2010) although Ecklers *et al.* (2006: 250) cautions that '*learning together has not always resulted in working together*.'

The notion of effective communication is repeatedly referred to in the literature examined. Lees and Meyer (2011: 86) identified that practitioners working together to solve problems that needed collaborative solutions created 'bonds of loyalty' and a change in attitudes and behaviour due to increased saturation of relational contact that enhanced communication. In other research there is reference to 'professional trust' or 'true cooperation' (Patsios and Carpenter, 2010) as a result of working together over time that has enhanced communication across professions and agencies. Despite this positive affirmation of improved communication, in separate disciplines it has been reported that training has embedded the need for confidentialty so strongly that it has made some individuals suspicious and/or vulnerable when being asked to share information (Holmes, Munro and Soper, 2010). The literature indicated the need for operational staff to be given 'permission' to disseminate and discuss learning from SCRs without fear of breaking professional protocols in terms of confidentiality for example; the need for clarification of what can and cannot be discussed in open forums.

A number of works referred to the need for a 'safe' working environment in which discussions about safeguarding and potential concerns could be aired without fear of reprisal (Lees and Meyer, 2011; Patsios and Carpenter, 2010; Bannon, Carter and Ross, 1999). Previous research by Atkinson *et al.* (2002) identified the challenges faced when individuals were not confident to share knowledge and practice in an open forum. According to MacLeod *et al.* (2010) this fear has been exacerbated by media portrayal following SCRs and subsequent social perceptions of who is to 'blame' causing fluctuations in referrals from operational staff (Holmes, Munro and Soper, 2010). Bannon, Carter and Ross (1999) identified that GPs in their study referred explicitly to having a fear of 'personal consequences' which directly influenced their decisions to engage.

The indication from the literature reviewed is that barriers to learning from SCRs may relate to wider issues in regard to safeguarding and child protection policy and practice. Significant anxieties expressed by operational and strategic practitioners have been related to uncertainties with workload, ambiguity in roles and fear of personal consequences. Suggestions to address these issues include; improved, on-going general and specific training (within and across professions); clarity of responsibility and coordination (improved systems); and the need for a safe working environment where it is recognised that there is risk in professional judgement that may not always have positive outcomes.

For several years, the government has commissioned national research studies to identify and disseminate common themes and trends stemming from SCRs. The themes identified in these biennial reviews have been very supportive in the national and local

understanding and development of policy, practice and relevant training. Often the themes, however, have been described as repetitive and untimely (Sidebothan *et al.,* 2010b) and efforts have been made to identify how the lessons learnt from SCRs can be better embedded at a local and national level.

Government documents and policy reviews have led to an identified need for a far more child-centred system. Lord Laming's Review (2009) 'The Protection of Children in England: A Progress Report' concluded the Serious Case Review process is revised so that it supports swift, effective learning of lessons when a child suffers serious harm, and that Ofsted inspects Serious Case Reviews on how well they learn these lessons. The Government has agreed with Professor Munro's conclusion that 'the system has become too focused on compliance and procedures and has lost its focus on the needs and experience of individual children.' (Department for Education, Equality Analysis Safeguarding Statutory Guidance, 2013, p.1). This thematic literature search sheds light on a number of barriers and enablers for learning from SCRs, as found in the policy documents explored.

Barriers to Learning from SCRs

A conclusion of a study, funded by the DfE (Brandon, 2010), of a full cohort of 161 'serious case reviews' of child death and serious injury through abuse, was that most of these worst outcome cases were mostly too complex to be predictable or preventable. Limitations to learning from these high profile cases are illustrated by this study in the context of three categories: 'serious physical assault of young babies', 'neglect', and 'older, hard to help young people'. However, a number of barriers to learning from SCRs have been identified in the context of various studies carried out in an effort to minimise harm in the above groups. Insufficient training or engagement of some professionals has also been an identified issue in accessing learning from SCRs (Ofsted, 2010).

Inflexibility of the SCR framework has been a key issue. Whilst reviewing lessons for interagency working has been identified as important by the Laming Report (2009) that 'weaknesses also exist within individual organisations from which lessons could be learned to protect children better from harm.' Many social workers described themselves as working in 'an over standardised framework which makes it difficult for them to tailor their responses to the specific circumstances of the individual child'. This is not helped by the arbitrary national timescales and the way they then relate to practice. According to the Working Together (DfE, 2013) document this particularly relates to the assessment of children. Munro states that arbitrary national timescales drive practice and behaviours and remove the scope for social workers to exercise their judgement. This was also identified by Brandon *et al.* (2010). The 'translation' of the national timescales associated with assessment into Ofsted performance indicators has obstructed the potential for innovation. The need to meet statutory timescales has been one of the main barriers. This is reinforced by an identified tension between acting quickly on audit learning and the development of deeper learning that requires time (Brandon *et al.,* 2010; Sidebotham *et al.,* 2010; Munro, 2011b). The typology being piloted by the Social Care Institute for

Excellence (SCIE) points out that although in three quarters of cases the outcome is attributed to human error, this emphasis on individual blame is unhelpful (Brandon *et al.,* 2012).

The DfE (2013) suggests that 'too many reports of SCRs are being written in a way which makes them difficult to publish. This leads to the reports not being published and, consequently, important lessons about how better to protect children are not shared fully' (DfE, 2013: 23.) This is also in line with Ofsted's findings about the use of systems for flagging up concerns being problematic and an ongoing issue of 'professional drift' resulting in lack of action (Ofsted, 2010). Inaction can be expressed as insufficient clarity about what had been agreed or as a lack of follow-up of the agreed actions. This also implies amongst other things poor communication, including failure to include key professionals or agencies, difficulty and lateness in responding dynamically to new and changing information. According to Brandon *et al.* (2010) not enough practitioner involvement is taking place in the context of the SCR process and the learning stemming from it. According to Ofsted the assessments carried out resulted in 'inappropriate plans or did not lead to action to tackle the concerns' (Ofsted, 2010: 22). Something that has been seen as a reason for learning not taking place, is the fact that research findings about abuse, neglect, domestic violence and substance misuse, where they were relevant to the particular case, were not shared (Ofsted, 2010:19) despite guidelines provided by the Ministry of Justice 'Achieving Best Evidence' (ABE) in Criminal proceedings: Guidance on Interviewing victims and witnesses, and guidance on using special measures DfE, 2011). Findings from in-depth studies of small populations of worst cases can be misrepresented and learning from these idiosyncratic studies needs to be linked more clearly to large population studies (Brandon, 2010).

Enablers to Learning from SCRs

The following have transpired as positive practice outcomes and recommendations for learning from SCRs. According to 'Working Together to Safeguard Children' recommendations (DfE, 2013), more flexibility for professionals and within the system would facilitate a less prescriptive process for conducting SCRs; that would allow LSCBs the flexibility to select a learning approach which suits the circumstances of the case being reviewed. This would enable LSCBs to use the 'systems methodology' recommended by Professor Munro.

'It is no longer required that Individual Management Reviews (IMRs) should be commissioned from all agencies involved with the child; or that there should be a full chronology of the case and a genogram; and there is no longer a standard format for SCR documents' (Department for Education, Equality Analysis Safeguarding Statutory Guidance, 2013); The child protection system should be flexible enough to allow all professionals to exercise their professional judgment in responding to the needs of individual children and families and to put children at the centre of assessment. Professional judgment, based on a sound theoretical understanding, is also argued by Brandon (2010) to be a better route to safe practice than over adherence to performance

indicators. The complexity of the case and the needs of the child should drive the length and depth of the assessment, not a national timescale or centrally prescribed process. Practitioners should routinely involve fathers and other male figures in the family in assessing risk and in gathering all the information needed to make an assessment. Local Safeguarding Children Boards should also consider how they can better engage the general public in safeguarding children, according to Ofsted's document 'The Voice of the Child (Ofsted, 2011).

In her final report, 'A Child Centred System', Professor Munro (DfE, 2011: 10) recommends that the child protection system should:

'remove constraints to local innovation and professional judgement which are created by prescribing or endorsing particular approaches e.g. national performance indicators associated with assessment' and specifically required the Government to 'remove the distinction between initial and core assessments and associated timescales'.

Recommendations by the Department for Education, Equality Analysis Safeguarding Statutory Guidance, 2013:12 & 21) have been that proportionate and contextualised response to individual cases should be conducted by LSCBs with transparency, independence and family involvement. The systems framework being developed also assumed a significant amount of professional interaction with the families which was always the case in SCRs (Brandon *et al.,* 2012). Importance was placed on focusing on a thorough analysis of what happened in the case and why, and what improvements needed to be made to reduce the risk of recurrence. Scoping of reviews in a manageable timescale had been a recommendation by Brandon *et al.* (2009, chapter 4 in Brandon *et al.,* 2010) with family involvement as a common practice, which also recurs in Ofsted's (2011) recommendations.

The DfE have commented on the need to improve the way SCRs are written with stronger emphasis on ensuring that SCR reports are written in a way which is suitable for publication, and reminds LSCBs of their duty in law and the very strong public interest in publishing reports so that important lessons can be learnt both locally and nationally to help vulnerable children (over-represented in SCRs, namely boys, children with disabilities and children of Black or Black British origin). It is the belief of the DfE that ensuring SCRs are published and lessons learnt should have a positive impact on future services for children in those groups as well as other children who are subject of an SCR (Department for Education, Equality Analysis Safeguarding Statutory Guidance, 2013: 12 and 21). There is an argument that practices like this have supported the health service and the airline industry on understanding mistakes and making appropriate changes, improving safety and confidence; arguments relating to confidentiality and blame culture that were identified in several biennial reviews would be on the opposing side of the argument.

OVERVIEW OF EMBEDDING LEARNING FROM A HEALTH PERSPECTIVE

A Health focus starts from Hyland and Holmes's analysis of specific health recommendations arising from Serious Case Reviews, with a brief of 'How to Achieve Better Learning?' (2009).They note the 'opportunity for the National Health Service (NHS) to become an 'organisation with a memory' and to benefit from learning' (2009: 201). This section will explore their four health recommendations relating to processes of SCRs and Local Safeguarding Children Boards, staff training and regular audit cycles. The training element will be enhanced using Horwath and Tidbury's 'Training the Workforce following a Serious Case Review: Lessons Learnt from a Death by Fabricated and Induced Illness' (2009). Here the 'emotional impact on the workforce' is recognised, allowing for identification of operational as well as strategic opportunities for, and barriers to, learning from SCRs.

This literature review, to engage in learning from SCRs, has to acknowledge the complexity of the National Health Service (NHS) strategic and operational safeguarding statutory responsibility, in relation to Section 11 of the Children Act 2004.

'A *wide range of health professionals have a critical role to play in safeguarding and promoting the welfare of children including: GPs, primary care professionals, paediatricians, nurses, health visitors, midwives, school nurses, those working in maternity, child and adolescent mental health, adult mental health, alcohol and drug services, unscheduled and emergency care settings and secondary and tertiary care'* (HM Gov., 2013: 50)

Barriers to Learning from SCRs

With such a variety of specific, demanding professional roles it may not be surprising that Laming noted a 'wariness of staff throughout the health services to engage with child protection work' (Laming, 2009: 6). His report follows on from the SCR relating to Baby 'P', with implications for universal services, noting specific health professionals (Haringey LSCB, 2009: 4-5). He placed the onus on the Secretary of State for Health to ensure 'General Practitioners (GPs), community nurses and paediatricians [...] be helped to develop a wider range of skills and become very much more confident in this important area of their work' (Laming, 2009: 6). Subsequently, these proactive safeguarding roles and responsibilities are promoted through role-related documentation and guidelines (RCPCH, 2010, RCN and RCPCH, 2012, GMC, 2012). Inclusion of all staff groups now occurs through levelling core competencies for online and face-to-face training purposes between 1 and 6 for example Level 1: all non-clinical staff working in health care settings; receptionists, administrative, catering, transport and maintenance staff to Level 6: Experts (RCPCH, 2010:10, 2013). A review of this training framework is due in 2013 '*drawing upon lessons from research, case studies and serious case reviews'* (RCPCH, 2010*:* 5) demonstrating a willingness to learn from practice. Government directives

continue to organise strategic and operational learning directly from SCRs such as Haringey's (LSCB, 2009).

With its own Department of Health, political agendas impact directly on all strategic planning for health (Peckover: 2011) with frequent changes at national, regional and local level (Davies and Ward, 2012: 13-15). Strategic leadership roles always need to adjust to government directives, as with the current specific mandate for the NHS Commissioning Board to define improvement in safeguarding practice and outcomes, enabling Local Safeguarding Children's Boards (LSCBs) and Health and Wellbeing Boards (HWBs), as they develop, to work collaboratively. A key objective is 'to make partnership a success', while 'continuing to improve safeguarding practice in the NHS' (Hyland and Holmes. 2009, Department of Health, 2013: 24). However, managing locality boundaries and identifying designated and named lead professionals for safeguarding is also occurring. 2013 has seen the establishment of Clinical Commissioning Groups (CCGs) with responsibility for Safeguarding Quality Assurance and overseeing contractual arrangements with all providers, as well as Health and Wellbeing Boards. This includes securing 'the expertise of designated professionals' within the NHS:

- designated doctors and nurses for safeguarding children and looked after children
- designated paediatricians for unexpected deaths in childhood (HM Gov. 2013: 51)

All providers of NHS funded health services, including public, voluntary and independent sector and social enterprises then need to identify a named doctor/ nurse / midwife as appropriate for safeguarding who can liaise with designated professionals. A 'lead' / host' arrangement for the designated professional team, or a clinical networking arrangement is required (HM Gov, 2013: 51).

Rowse's research (2009) highlighted the 'pivotal role' and important attributes of the 'named nurse' for children's nurses directly involved in child protection procedures, although not necessarily SCRs. In relation to this study many health practitioners may not find themselves directly involved in the SCR process but are in positions within their daily roles of working closely with babies, children, teenagers and adults across the lifespan and so, as universal providers, have potential to identify concerns early on. Rowse's emerging core themes cover:

- 'involvement in child protection has a lasting impact on individuals.
- during a case someone with procedural knowledge at each stage is vital in helping participants manage their involvement'

The claim 'Nurses need emotional support from the right person in the right place at the right time for them.' (Rowse, 2009:179) is likely to be true for all professionals involved in SCRs and child protection processes. Armitage, Taylor and Ashley (2012) discuss

possibilities for children's nurses within multi-disciplinary teams to carry out 'systematic assessment in child protection' by adding a Human Factors Approach to Failure Mode and Effects Analysis (FMEA)). Such a systems approach to learning they suggest, could work 'in tandem' with the Social Care Institute for Excellence (SCIE) model of a systems-based SCR, as encouraged by Munro (2011).

While National systems of the Health Service address learning from Serious Case Reviews in establishing policies and procedures, the impact of change can create identity confusion and tensions for front-line staff. Using Health Visitors as one example, Laming acknowledged a

'greater challenge [...] the need to address the status, training and responsibilities carried by health visitors [....] to increase the numbers, confidence and competence of staff […]. A robust health visiting service delivered by highly trained professionals who are alert to potentially vulnerable children can save lives (Laming, 2009: 6 and 57). Yet this can cause conflict with a relationship-based role, moving between universal provision to progressive universalism, with insufficient staffing requiring a 'complex filtering of cases' (Peckover, 2011:120). There remains scope for investigating the 'spatial, organisational and temporal aspects of home visiting' (Peckover, 2011: 122) as well as ethical tensions that may arise as trusting relationships are developed between the health visitor and the family (Greenway, Entwistle and ter Meulen, 2013: 209). 'The lack of certainty or meta-narrative about health visiting may itself be a strength, enabling the profession to adapt itself in response to policy and practice developments (Peckover, 2011:123).

Key frontline operational staff within health care are often in very close personal proximity to babies, children and teenagers, so training that encompasses management of personal space is essential (DCSF, 2009). Specific strategic steps to embed good practice require an increasing number of practitioners in universal services to identify and assess need for example, the *Healthy Child Programme* – routine assessments by midwives, health visitors and GPs. With the current government commitment to 'an additional 4,200 health visitors by 2015 to help 'ensure the vital support for new families' (HM Gov., 2013) training content is a key factor.

A cross-party Manifesto – The 1001 Critical Days, using online material, is highlighting 'the importance of acting early to enhance the outcomes for children' and seeks to 'use best practice to guide suggested intervention' seeing this time as a *'critical window of opportunity'* when parents are especially receptive to offers of advice and support' (Wave Trust, NSPCC, 2013) However, this critical window of opportunity needs to be seen through a lens of professional curiosity, ensuring it is not a sign of *'start again syndrome'*, with potential to miss previous family history (Brandon, *et al.,* 2008: 325). Front line staff, such as Health Visitors, may see themselves as 'referral agents', for example with early recognition of 'neglect' yet their thresholds are often not seen as high enough to generate immediate source provision from social care services, leaving them 'angry and frustrated

over the lack of social services input with families in those areas of 'high concern' often described as 'grey areas' (Appleton, 1996, cited in Davies and Ward, 2012: 47).

Enablers to learning

Good practice can be claimed when a Health Visitor's ability to refer families directly to local targeted services may alleviate a number of referrals, but this will still need to be followed through (Brandon *et al.,* 2008: 324; Davies and Ward, 2012: 138). Reflective or evidence-based practice informs development and change within health services but there remains scope to further develop these skills in relation to learning from SCRs. A focus needs to be on *why* aren't adults / parents co-operating in this way, at this time, with this individual? Key 'what to look for guidelines for all health and social care staff 'has been created by Davies and Ward (2012: 53) valuing good practice skills such as following up missed appointments. Morrison (cited in Davies and Ward, 2012: 45) promoted seven sequential elements of process for working with parents (Social Care) as also useful for Health staff.

Use of the 'Framework for the Assessment of Children in Need and their Families', acknowledges an 'ecological transactional' perspective (Davies and Ward, 2012: 42-43) and involves:

- Good quality social and family history-taking
- Analysing interactive effect of vulnerabilities and risk
- Better understanding of ecology of child abuse and neglect
- Children's voices.

A recommendation to 'seek views of children' (Horwath and Tidbury, 2009: 184) benefits from research not directly related to learning from SCRs, to identify why and how this is valuable (Gardner and Randall, 2012). Synthesising knowledge and expertise from other aspects of health care professional practice can be beneficial. Here the value of interviewing a child alone and then with a parent were found to provide additional insights into a relationship, with potential impact on clarifying factual information (Gardner and Randall, 2012:142). Health visitors, midwives and GPs have opportunities to see this within their routine practice, while being aware 'Adults define the world for children in a way which makes it difficult for them to envisage another' *(*Haringey LSCB: 4.8.3).

Training frameworks have been discussed above in relation to specific levels of job roles. When planning and delivering training following SCRs, though, there is a need to recognise the 'emotional impact on the workforce' (Horwath and Tidbury, 2009). In a case involving death due to a Fabricated Induced Illness (FII) they identify specific barriers to learning, including:

- *'time delays between the death and the SCR and logistical impacts;*
- *the need for selected trainers not only to have relevant knowledge and skills of the subject matter but also be able to manage complex group processes;*
- *lack of ongoing supervision for course participants and trainers;*
- *the need to rebuild inter-agency relationships, especially if the SCR was seen to apportion blame and name culpable parties, maybe then picked up by media' (Horwath and Tidbury, 2009).*

Examples of good training practice included the development of guidance to inform practitioners about specific health issues – in this instance a template and DVD with specific guidance on managing F11 was created and made available nationally (DCSF, 2009).

Horwath and Tidbury's (2009) learning themes for training within the SCR / LSCB process also link with Hyland and Holmes's recommendations (2009). They identify difficulty in achieving senior management and middle manager training, best overcome with 'sessions designed and publicised as addressing their specific needs […] short sessions, for example, as part of a LSCB regular meeting' (2009: 186). Policy and protocol may be developed with assumptions that staff attending training come familiar these changes.

The expertise of trainers involved in post SCR delivery has also been a learning factor - creating barriers or enhancing learning. They need supervision and de-briefing times. Skills in managing group processes need to keep a 'child focus' while balancing emotional containment with opportunities to express feelings about a child dying' (Horwath and Tidbury, 2009: 187).

Supervisory support needs to be sufficient before staff are involved in training, as well as afterwards. Ethical issues need to be faced if expecting staff who have been directly involved in a child death to participate in group training that focuses on the details of the case as training, not counselling; boundaries are required.

For interagency training, co-trainers can combine expertise but require time to plan and to de-brief after sessions. There is a need to be alert to their tendency to 'mirror defence mechanisms used by practitioners faced with difficult cases and to lose focus on the child,' (Horwath and Tidbury, 2009:186 -191). A checklist for training following SCRs, useful for LSCBs and training sub-committees is evidence of good practice (Horwath and Tidbury, 2009: 92-193). With an ongoing commitment to safeguarding, whether influenced by SCRs directly or not, this mammoth universal NHS is adapting, becoming an 'organisation with a memory [...] able to [...] benefit from learning' (Hyland and Holme, 2009: 202).

OVERVIEW OF EMBEDDING LESSONS LEARNED FROM EMERGENCY SERVICES PERSPECTIVES

There are extensive publications on learning from the management of emergency incidents and disasters available worldwide with a considerable majority of the literature originating from the United States of America. In contrast, a recent collaborative study by the University of Sheffield and partners for the National Institute for Health Research (Lee *et al.,* 2012) found that in the UK there is a limited knowledge base around emergency planning and that there are gaps in how lessons learnt from previous disasters are embedded and retained by organisations and individuals involved in emergency management and response.

This failure to embed or retain the learning from such critical events is a common theme that emerges from the literature. Lessons learned or recommendations from reviews of emergency management appear to be repeated in each investigation or post incident review. Alexander (2011) suggests that the test of a lesson learned is its contribution to the solution of a problem.

Within the emergency management context there are many examples of different mechanisms for evaluating an incident. These processes to identify lessons learned include post incident reviews, reports and various kinds of debriefings. It is possible that the most important lesson we are failing to learn is that the process for identifying lessons is not suitable or fit for purpose.

Post Incident Reviewing (PIR) is an evaluation of incident response using systematic analysis of what happened and why and documents actions and outcomes. Donahue and Tuohy (2006) describe a lessons learned system that is widely used by United States of America emergency services. The US Army's After Action Review (AAR) is a comprehensive, reflective, learning process developed in the 1970's. Similar models are used in varying formats internationally. The processes may vary but all share a common goal of gathering information on how services responded or performed in order to prevent the recurrence of mistakes and to improve responses to critical situations in the future.

> *"The appeal of learning from experience-both to avoid duplicating mistakes and to be able to repeat successes-is widely perceived, and many organisationsacross the emergency response disciplines have formal procedures for identifying, documenting and disseminating lessons from incidents in the hopesthat they and others will be able to learn from past experiences and improvefuture responses"*
>
> Homeland Security Affairs (July 2006)

A number of common themes have emerged from the analysis of AAR's and can be categorised as barriers to, and enablers for, successful learning.

Barriers and Enablers to Learning

Commitment to change

If the lessons identified from the extensive reports of accidents and events is to be translated into learning and embedded in improved practice this assumes that organisations can change. Organisational change is challenging and this is particularly evident in the area of emergency management. Hardy (2013) suggests that adaptive organisations are constantly adjusting and learning from both success and failure and use a range of approaches including lessons learned training to improve their practice in order to enhance emergency response. Donahue and Tuohy (2006) however, argue that the complexity of the emergency services community contributes to different interpretations of the identified lessons depending on which agency or discipline they represent.

The various emergency services do not share common operating procedures which makes it difficult when attempting to identify behaviours that require changing. The impact of media and political attention when emergency incidents or disasters occur cannot be underestimated. This scrutiny can influence behavioural change. Sustaining a commitment to change when faced with day to day pressures can influence whether learning and change is prioritised.

Systems for Reviewing and Reporting Emergency Incidents

Learning can be hindered by the time it takes to produce reports. The staff involved may have moved on and shifting political priorities can impact on embedding learning. The absence of a common report format is a barrier as most services or agencies prepare reports from their perspective and there may be conflicting views expressed by different agencies. There is often a lack of moderation of reports enabling a validation of the identified lessons.

Reviews frequently focus on what went wrong with scant attention paid to what went well and this leads to concerns about a blame culture. Reports may lack sufficient detail and do not always employ the use of a common language which would ensure that dissemination of the required learning is available to all services

Writers both in the United States and the United Kingdom have commented on the lack of a national database or centre for the collection of lessons learned that is easily accessible and would contribute to the body of knowledge on embedding learning in practice and improving the response to emergencies in the future.

Organisational Learning

For successful learning to take place a learning culture must exist within the organisation. The literature reveals that the learning process is not taught in some agencies (Donahue and Tuohy 2006) and many lack an understanding of the learning cycle. It can also be

difficult for agencies to apply learning from other services to their specific situation and lessons learned may not be evaluated until the next emergency situation.

> *"Because lessons from major incidents are not easily accessible, are not detailed enough to be useful and their relevance is not immediately obvious, agencies are reticent about committing the time and effort needed to reall understand, develop and implement corrective actions that would improve their performance….those changes most likely to become embedded are smaller internal adjustments, rather than broad culture changes.*
>
> Donahue and Tuohy (2006)

There are further challenges in that emergency services often focus on lessons from specific incidents and do not consider them within the context of systemic issues or behavioural responses (Lee *et al.,* 2012). Organisations also fail to capture the learning from everyday incidents that can indicate the need for preventive action. There is often no method for recording these potential learning opportunities. Emergency services have to balance the tension between prioritising the learning of lessons identified and dealing with the daily demands of their role.

Inter-agency Collaboration

The importance of effective inter-agency collaboration and communication is a recurring theme in the literature around emergency response to critical incidents or disasters and most major lessons relate to inter-agency working. Critical incidents require effective command and control structures that are co-ordinated particularly when a large number of agencies are involved; each of which will have their own command structures.

> *"The task looking forward is to enable first responders to respond in a co-ordinated manner with the greatest possible awareness of the situation. Emergency response agencies nationwide should adopt the Incident Command System (ICS). When multiple agencies or jurisdictions are involved, they should adopt a unified command. Both are proven frameworks for emergency response."*
>
> The 9/11 Commission Report 2004: 315,397

To achieve order from the chaos requires collaboration and the ability to be flexible and adaptable. Lee *et al.* (2012) identified individual behavioural and organisational issues as a key theme for further research.

Different services and disciplines operate in professional silos and frequently have to compete for resources particularly in times of economic restraint. It is also suggested that individual agencies attempting to learn lessons in isolation is not sufficient to embed learning which should take place within and across agencies.

Training and Development

Learning will not be embedded in practice and sustained without effective training and development activities across all levels of the organisation. Identified lessons are often not translated into training programmes or exercises and may not be easily accessible particularly when there are difficulties in releasing frontline staff to attend training. Service responders need to develop confidence in new processes and procedures that emerge from training as there is a risk that when new systems are tested they may revert to former behaviours and practices.

The funding to support training is not prioritised especially when there are competing demands for financial resources and strategic managers will want reassurance that the lesson learning process and desired outcomes are effective before investing limited resources.

Enablers to Learning

- Develop an effective learning culture within and across all levels of the organisation including consideration of the systemic and cultural issues that influence sustainability.
- Increase accessibility to all disciplines by ensuring that information from different agencies is translated into a common language
- Develop a reporting system that captures learning from smaller incidents not just major emergencies. This enables incremental learning and increases the likelihood of sustained learning.
- Develop a common format for reports that adopts a systems approach to identifying lessons and proposing solutions across all levels of the organisation
- Adopt an integrated approach for reporting lessons and corrective actions to inform the development of training programmes
- Implement common emergency operational procedures across all services
- Develop a national database or centre as a repository of lessons learned with the capability to identify, analyse and disseminate to all agencies.
- Provide training in both single and multi-agency contexts
- Design teaching and learning programmes that are relevant and accessible to all disciplines, drawing on previous experience, analysis and proposed corrective actions.
- Utilise simulation exercises to practice new learning and test sustainability
- Develop mechanisms for feedback and monitoring of lessons learned
- Ensure sufficient resources are available to support learning
- Commission further academic research on how lessons can be learned effectively

It is clear that for identified lessons to be embedded in policy and practice a co-ordinated systems approach to the review and reporting of incidents can be effective. Training and the use of simulation exercises designed around these lessons emerge as crucial for embedding learning and building workforce capacity to sustain the learning and develop a learning culture within the emergency response services.

OVERVIEW OF EMBEDDING LEARNING FROM AN AVIATION SYSTEMS PERSPECTIVE

The Munro Review of Child Protection: *a child centred system* (2011) put forward the proposal to use a 'systems approach' for all Serious Case Reviews (SCRs). Munro suggests that a systems approach, used in aviation engineering, will counteract a 'blame culture' and develop a way of working that encourages people and processes to collaborate more closely. She suggests that there should be a stronger focus on understanding the underlying issues that made professionals behave in the way they did and what prevented them from being able to properly help and protect children. The current system she suggests is too focused on what happened and not why it happened. A central tenet of the systems approach is that any person working in any area is a result of both their own skill and knowledge and the organisational setting in which they are working.

Vincent (2004) suggests that SCRs *'should act as a window on the system'* which will enable looking at the system holistically and not a search for the root causes. One of the criticisms of the systems approach is that it is viewed as being predominately to do with machines (technical) whereas working in the children's workforce is to do with people and their relationships (social). However, Dr Sheila Fish *et al.,* suggests that both are *'socio-technical'* systems.

'This means that the interactions between people and equipment are fundamental in shaping the way work gets done. The systems approach sees people as being part of the system because their behaviour is shaped by systemic influences. It looks, therefore, at the interactions between people and factors in the workplace. In the systems approach, people and processes jointly create the system.'

> Dr. Sheila Fish, Eileen Munro & Sue Bairstow (2012) *'Learning together to safeguard children: developing a multi agency systems approach for case reviews' (*accessed 28 August 2013 www.scie.org.uk)

The Social Care Institute for Excellence (SCIE) are promoting the 'Learning Together' (2013) model that has been designed specifically to be relevant to cases involving multi-agency working and can also be applied to any example of professional practice. The SCIE model is taken from an aviation engineering background which looked at how to improve safety and *'make it harder for people to do something wrong and easier to do it*

right.' It uses an action research cycle methodology that identifies issues within the systems and structures in place in order to clarify ideas for re-designing systems at all levels (strategic and operational) which will support all workers to operate at optimal levels. However, the transitional process of conveying approaches across disciplinary fields can be extremely difficult. A systems approach can create challenges that are hard to overcome if policy makers fail to take account and address the surrounding issues that encapsulate the systems that already exist to deliver better outcomes for children and their families.

In order to be inclusive when using a systems approach all domains, disciplines and communities would need to be informed and have heightened awareness and commitment to the processes involved in learning from a SCR. As suggested by Lave and Wenger (1998:15) in a community of practice across disciplines a person in one domain for example, early years, and another member in the same community of practice but from a different discipline, may not always share the same values and commitment to the early years domain even though they all have a passion for their own area and interact with others regularly. For the Local Authority of Haringey the imperative was to initiate a whole systems approach in order to embrace change. One of the keys to this change was to enable the staff to share the same values when working with children and families and that judgements made must always be within the context of emotional intelligence and empathy. This context also needs to include an ethical dimension such as the FAIR Framework designed by Richard Rowson (2006: 14) for practitioners working in and across multi disciplinary and culturally complex organisations. He suggests that there are four basic values*; fairness, respect for autonomy, integrity, and seeking the most beneficial and least harmful consequences, or results.*

In a systems approach it could be problematic to predict all the consequences of the change of direction for those working in children's services in advance of its introduction and would need to be adjusted and developed over time. Using a systems approach for SCRs would also need to be seen in the national, regional and local context. Pilot projects using the SCIE systems approach are taking place in Coventry, Devon and Lancashire and have yet to be evaluated. Given the complexity of multi agency and professional practice in all the sectors involved in SCRs and in order to fulfil their roles effectively each practitioner will need to reflect on, and have confidence in, their own values that are appropriate for their work within a systems approach. Every day practitioners make decisions in their work, based on past experience, training, knowledge and understanding of the policies and procedures that are to be followed within the codes of their particular discipline. They will make judgments on behaviour deciding whether it is right or wrong, acceptable or unacceptable. Sometimes practitioners will have an 'intuition' about a particular situation and feel strongly about an action that needs to be taken. The action may be contrary to the guidelines within the system. This can be particularly difficult when making decisions under pressure.

Platt and Turney (2013: 6) suggest that the techno-rational model promoted by Munro when decision making on thresholds is too limiting and that a more useful process would be to adopt a naturalistic decision-making process. They argue that poor judgements can be made on threshold decisions using a systems approach because of the need to make decisions quickly arising from a pressurised working environment.

'The approach is too narrow and fails to address the complexity of the decision making process, assuming a rationality that, we suggest does not exist in practice.'

'Making Threshold Decisions in Child Protection: A conceptual Analysis.' *British Journal of Social Work (Advance Access February 2013)*

What is clear from the embedded learning from aviation disasters is that the risk involved in flying today is almost 'zero.' However, according to Mr. Nicholas Sabatini, the Federal Aviation Administration's Chief Safety Official in a speech made in June 2013 states that:

'No one can provide a 100% guarantee that you will be completely safe in an airplane, a notion that holds true for literally every mode of transport. There's no guarantee that a drunk driver will not hit you while crossing the road, or an iceberg will not sink the 'unsinkable' Titanic.' http://www.buzzle.com/articles/howsafeisflying.html *(accessed 30 August 2013)*

Organisational Change - Safety Management Systems (SMS)

In order to ensure greater safety and prevent aviation disasters where possible, a set of measures were introduced in the early 1990s to change the organisational culture that existed. The term '*organisational accident'* emerged in formal recognition that most of the factors that lead to accidents are under the control of the 'organisation' rather than 'individuals'. This formal recognition appears to be a turning point in the way that the orgnisational culture of learning from disasters within the aviation sector was integrated into a new way of examining how to provide a safer environment for both the sector and the people who work within it. As the threats to safety appeared to be embedded within the organisation it required organisational action. Out of the resulting organisational actions the term Safety Management Systems (SMS) is now embedded in training and practice at both strategic and operational levels. Three of the most important aspects to emerge from the aviation SMS approach are firstly, inaction is as crucial to the system as any action taken; secondly that Line Managers are accountable for any safety related actions or inactions and; thirdly working pressures can cause risky short cuts that are tolerated thus making for unsafe conditions Boyd (2001).

According to Cooke and Rohleder (2006:11) incidents arise from the interaction between '*unsafe conditions'* and *'risky behaviour'*. In order to identify where transformational organisational learning has occurred which is now incorporated into the SMS and incident learning approach, several categories are identified. The following represent an

overview of themes arising from barriers and enabling strategies that have been used to embed learning in order to prevent aircraft disasters.

Barriers to Learning

Poor Communications

Poor communications at all levels, strategic and operational, is a key area for looking at organisational change. Cooke and Rohleder (2006) suggest that SMS is not enough as this system is less likely to learn from the pre-cursers to a disaster and that lessons can only be learned in the SMS with hindsight. An organisation may experience thousands of 'low severity' incidents a year - there must be an easy database for capturing lessons learned. They suggest that an organisational '*incident learning system'* should be in place which complements and tracks inevitable incidents that arise. The incident learning system enables an organisation to extract useful information to build a picture of common themes over time thus enabling a more effective approach to embedding learning at all levels. It would appear that a learning organisation needs both the SMS system and the incident learning system in place in order for any system to operate effectively.

Threat Categories (Operational and Strategic)

In the past the cause of many aviation accidents was inadequate communication between crew members. The Captain's word was correct with little or no communication from the crew members. The inexperienced pilot, insufficient or improper training and checking can also play a role if the pilot is due to upgrade, transition, or attending initial training on new or different equipment flown.

Organisational Lapses

Where an institutionalised process, procedure or requirement that allows vital tasks or information to be handled in such a way as to prevent an accident precursor from being recognised. There may be times when a safety intervention is prevented from being recognised or from being initiated.

Flawed assumptions

Are essential elements of safety determinants – design, operation and maintenance. If the part – human or feature does not perform as it was assumed then a different outcome may be catastrophic

Human Error

If human action is done incorrectly it can result in a catastrophic accident.

Pre Existing Failures

Is where a failure condition on a single or fleet of aeroplanes that exist either as a latent condition or as an active fault. The failure condition itself may not represent a hazard but in combination with one or more additional failures or malfunction/s an accident can result.

Unintended Effects

Is where an initiative, change or new process or other activity intended to improve something actually produces, in addition to the improvement, an undesirable outcome.

Training

Learning lessons will be ineffectual unless there is multi agency training at strategic and operational levels across all areas to develop a safe and sustainable learning environment.

Enablers to Learning from Aviation Disasters

- Truly integrate a learning 'tool' into the culture and thus ensure sustainability of a positive organisational transformation
- Develop ability to learn, improve and analyse from previous experience and draw conclusions for future directions by developing a stock of lessons learned. This must be done throughout the whole organisation and at all strategic, operational and departmental levels through a reporting-investigation-corrective actions-impact cycle
- Develop an identification and reporting system that includes input on '*incidents*' including those that *may or may not* create an *unsafe condition* in order to develop a safe climate which is rewarded rather than punished
- Develop self-actionable strategies to better understand safety culture
- Implement a new evidence-based process, or modify an existing one that directly begins to positively shape and transform safety culture
- Utilise elements of a behavioural-coaching approach to help shape a safety culture, without the requirement of a full safety process
- Provide group reflection time on past incidents for visualising possible failure modes that have not yet occurred but that might be possible
- Decide on incident thresholds
- Training at strategic and operational levels across all areas in order to build knowledge and skills in order to integrate key enablers across all levels of an organisation
- Documented guidance and good practice passed on to less experienced staff

- Reduction and prevention of safety problems caused by communication between design, maintenance and operation organisations
- Capture lessons learned through development of regulations, policies, practice and procedures. Ensure follow up procedures to ensure corrective actions implemented so that underlying root causes can be corrected system wide
- Periodic reviews and feedback to give a unique feedback

It appears that a systems approach can be positive and successful if a learning organisation enables a management process for operational improvement over time. However, it is important to recognise that that if organisations do not allocate enough resources to process the change in all sections, sustainability becomes a burning issue. According to the Centre for Aviation Safety, as the body of knowledge grows and becomes more robust, it could be applied in other high-consequence domains for example, health care, nuclear safety, and chemical safety.

CHAPTER 4: FINDINGS AND DATA ANALYSIS
NATIONAL SURVEY DATA ANALYSIS

A National Survey was sent to all Local Safeguarding Board (LSCB) Chairs, (with a code for confidentiality) between May and July 2013. The aim of the National Survey was to build on prior **learning** from thematic analysis of the literature and capture current perceptions and beliefs of LSCB Chairs in relation to lessons learnt from SCRs.

Sample

All 132 LSCB representatives in the country were approached and a total of 68 responses were collected (51.5%). Some of the respondents indicated responsibility for more than one LSCB geographical area. On analysis, this determined an 82.6 % representative coverage of the national LSCBs in England.

The breakdown of the 68 responses in terms of roles of representatives was as follows:

59 LSCB Chairs

3 Business Managers

2 SCR Panel Chairs

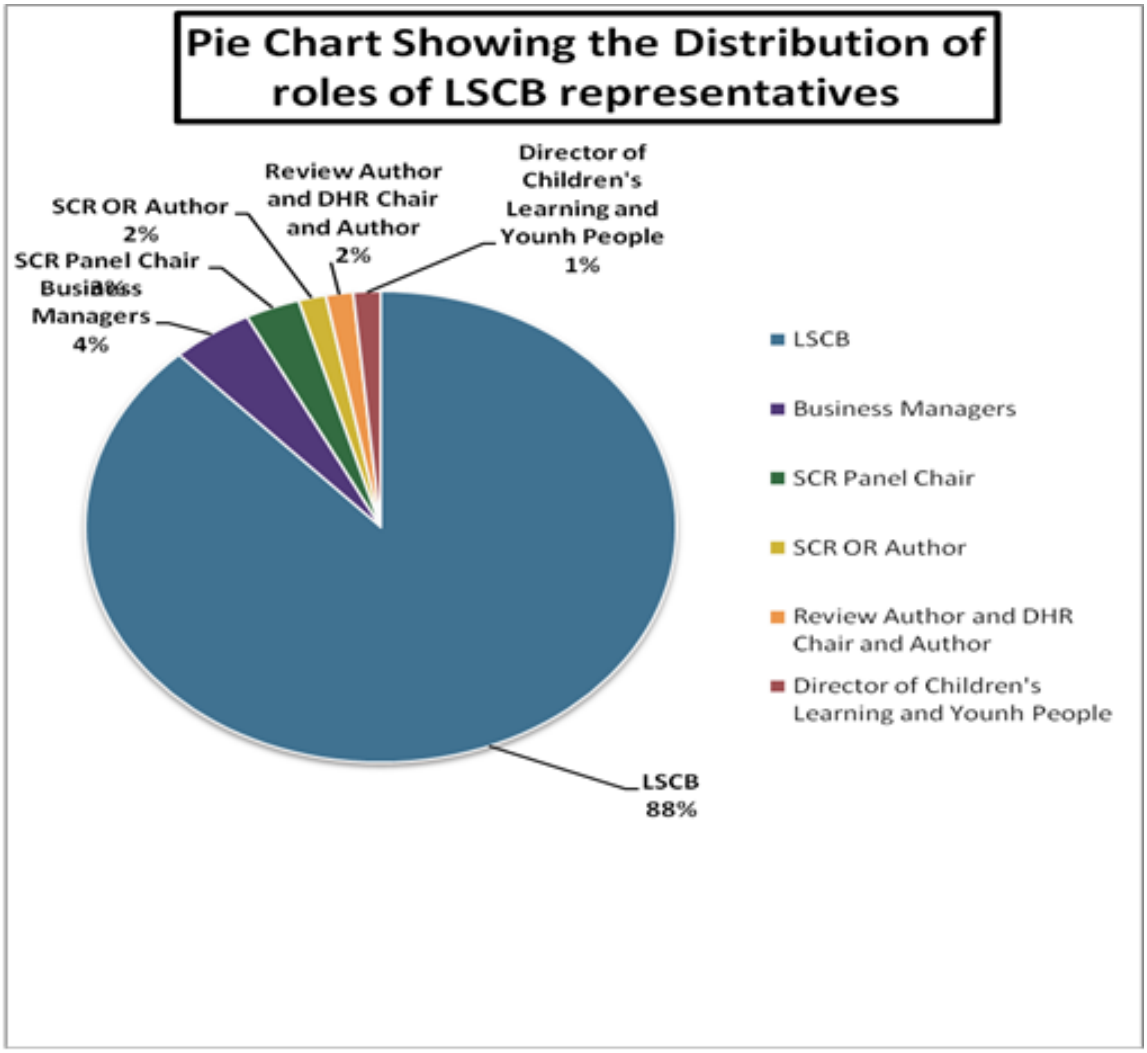
1 SCR Author

1 Review Author and DHR Chair and Author

1 Director of Children's Learning and Young People

1 Service Manager Safeguarding and Quality Assurance

Figure 3: Distribution of roles of LSCB representatives



The Survey consisted of five questions, two of which had a quantitative element.

a) How much learning do you think takes place as a result of SCRs at a NATIONAL level?

b) Why do you think this?

a) How much learning do you think takes place as a result of SCRs at a LOCAL level?

b) Why do you think this?

What currently works best in ensuring that learning comes out of SCRs?

What are the main barriers to learning from SCRs?

How do you think learning from SCRs can be improved and embedded in practice?

Questions one and two contained a measurable question each, seeking to identify the perceived impact on learning from SCRs at local and national level respectively, so these responses will be communicated quantitatively.

The rest of the questions were approached qualitatively, stemming from thematic analysis, following cross referenced coding and creation of categories by two members of the team for each section.

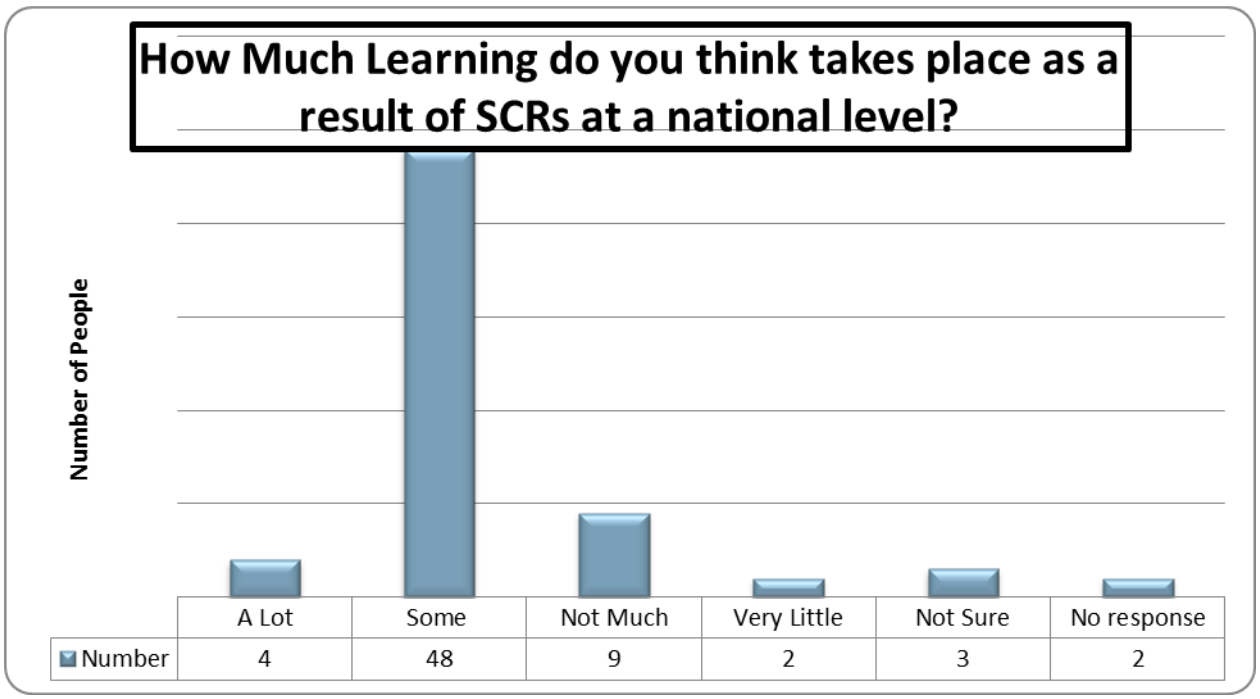
National Learning Key Themes

Q1 In the question 'How much learning do you think takes place as a result of SCRs at a NATIONAL level', the overwhelming response (70% of the respondents) was that 'some learning' is noted.

More specifically the responses were mapped out as following:

A lot (of learning):5.8%, Some (learning): 70.5 % Not Much (learning): 13.2%, Very little (learning): 2.9%, Not sure: 4.4% No response: 2.9%

Figure 4: LSCB's representatives' perceptions on learning from SCRs at a National level



Q2 The answers to the question 'why do you think this?' gave a plethora of discussion points that were thematised and categorised in terms of recurrence.

Largely the themes were presented under the emerging umbrella categories of Barriers and Enablers and are presented by order of occurrence starting with the most highly occurring themes.

Barriers to Learning

- A highly recurring theme is that lessons are not translated into action or the application to practice is not always visible. Learning that does take place is more likely to be by senior managers and lead to more procedures and guidance.
- There are limitations to dissemination and learning, lack of systematic review of lessons, whereas the accessibility and usefulness of national sources at local level is debated.
- National policy, government agendas and debate is not well informed by SCRs.
- SCRs are considered to have limitations as a process.
- SCR process is itself costly of capacity and may not generate the most useable or interpretable learning for local practice.
- Timing has been considered as a key barrier in relation to volume/ capacity/ costs/ completion and reporting.
- There is concern about publication in full and how this relates to transparency and confidentiality. The media impact exacerbates these concerns.
- The current importance/ role of the media in determining what gets given attention through selective media coverage of events and of SCRs.
- Blame culture has been seen as big barrier, which often translates as micromanagement in policy.
- Learning and impact is more likely to be local rather than national and based on local (and may be regional) SCRs rather than all SCRs nationally.
- Limitations have been found impacting on front-line practice and on local contextual focus. Attention is needed in partnership processes and interagency working.

Enablers to Learning

- An overwhelming response related to the need for collation/ analysis/ dissemination of lessons learnt from SCRs.

The above was related to multiple comments relating to impact. The following summarise some key themes:

- Need to capture in a timely manner but also to concisely synthesise the findings and learning from all SCRs, but also to focus on context so that learning can be considered against local circumstances. Lessons should also be made explicit, practicable and relevant to front-line practice and practitioners.
- Not just dissemination but drilling down and following-up on implementation and on impact. This may be through (multi-professional) training and through procedures and guidance but implementation and impact needs to be monitored, reviewed and reported and over-time so that learning attrition is reduced

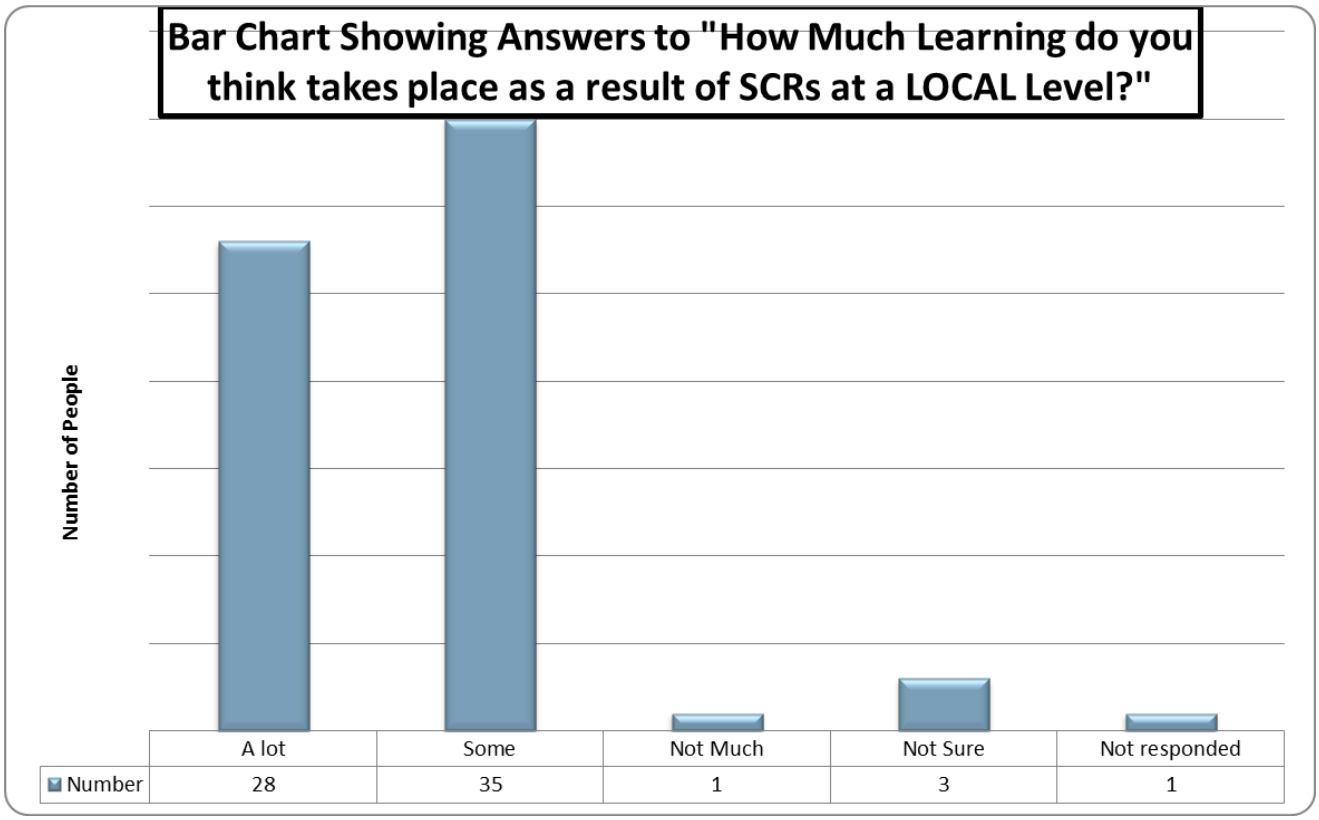
Local Learning Key Themes

In the question 'How much learning do you think takes place as a result of SCRs at a LOCAL level', the responses were divided between 'a lot' (51%) and 'some learning' (41%) .

More specifically the responses were mapped out as following:

A lot (of learning): 41% Some (learning): 52% Not Much (learning):1.4% Not sure: 3 (4.4%) No response: 1.4%

Figure 5: LSCB's representatives' perceptions on learning from SCRs at a Local level.



It stems from the data that the majority of respondents could see at least some or a lot of learning taking place from SCRs. The themes are again presented under the emerging umbrella categories of Barriers and Enablers and are presented by order of occurrence starting with the most highly occurring themes.

Barriers to Learning

A highly recurring theme relates to monitoring and sustainability of learning from SCRs, as the consistent impact remains limited. Measuring the impact of sharing still remains a problematic area, as there are complexities in its realisation.

- 'I don't know the extent of the learning/ difficult measuring dissemination/ learning'

Resources and capacity issues were expressed in the context of:

- people being overwhelmed by demands of day work
- workforce being fragmenting and reducing
- existence of intolerable strain on the front-line
- deterioration of the above due to current financial austerity

The resources and capacity issue is combined with the fact that SCRs, that are of variable quality, have their own limitations. They can be:

- of too much volume
- lost in detail
- costly
- include repetitious findings

Respondents reported that it is hard 'telling the wood from the trees and getting swamped in detail', especially because there are so many SCRs and findings tend to be repetitious so there is a tendency to prioritise those achieving national prominence. Repetitive recommendations lead to 'mind-numbing' action plans.

- Institutional issues that relate to resistance and agency defensiveness constitute a barrier to learning from SCRs, whereas how an SCR is undertaken can sometimes break relationships. Defensiveness, secrecy and lack of transparency affect communication amongst services.
- Local variation on impact was a strong theme, with local learning varying a lot between LSCBs and between agencies respectively.
- Timing of dissemination of lessons seems irrelevant to learning and capacity to utilise in practice.
- Learning is hard to take place when strategic managers are not engaged. This was translated in the context of:
    - local authorities failing to send correct people to learning lessons, resulting in senior managers often not being present
    - the learning not necessarily being at the right level, as it is given to practitioners and first line managers but is not directed at strategic managers to create double-loop learning

- Front-line staff have also been reported as having limited involvement in the generation of learning. The importance of senior leadership and champions is highlighted, whilst also ensuring engagement with and relevance for practice and practitioners.

Enablers to Learning

- The way the learning from SCRs is disseminated plays a fundamental role in the success of learning from these lessons.
- Accountability and clear action plans including systematic follow up and auditing were presented as facilitators of learning.
- Standard processes in use across (many/most) LSCBs to learn from SCRs and to embed this learning was:
    - Action plans
    - Dissemination
    - Training
    - Systematic follow-up and auditing to check on impact

- The importance of national lessons learnt locally was recurring in the context of different suggestions:
    - biannual, themed national reports to be used locally
    - monthly SCR meetings in the context of multi-professional involvement across agencies

- Local identification of issues and strong links with practice:
    - intensive attention is given to local SCRs but apart from high profile SCRs little systematic attention is given to other SCRs
    - local issues we know and understand have more immediate impact and so people pay more attention
    - local applicability adds value for local professionals
    - other reviews also used for local learning

- Ownership and participation in the SCR process on behalf of operational/ front-line professionals, in order to develop recommendations and actions.
- Leadership taking responsibility in the context of LSCB meetings with main reviewer and workshops for senior managers.

Question 3. What currently works best in ensuring that learning comes out of SCRs?

LSCB representatives were asked to focus on current good practice relating to learning from SCRs. Although enablers were already touched upon in the above question, this time the informants were responding to a direct question rather than expanding in a self-directed way, as above. It was found that some of the themes that were presented

already were elaborated in this section. The following themes were created starting again from highest occurrence:

Communication Strategies

- Summaries of key issues widely disseminated and constantly referred to by all agencies. Where this is happening, it is considered very helpful
- Presentation of learning thematically as these relate to current and future Board priorities.
- Using a learning model such as the SCIE model
- Looking for cases with any similarities to the one subject of the SCR - checking and re-checking
- Ensuring that the LSCB receives regular updates about progress from the SCR and any emerging lessons
- Developing our capacity (technical and emotional) to relate inputs, outputs and outcomes as these affect all and some children
- Making sure all involved are well de-briefed after the process as they can communicate a lot of learning, informally, at grass roots level
- A multi-layered approach to sharing the learning points, for example briefings, newsletters, embedding in training, team briefings, workshops, drive from strategic managers workshops, written short bulletins, training plans incorporating learning/findings from SCRs
- The past biannual reviews by Brandon *et al.* are rigorous, sound and reliable (but not sufficiently used)
- Cascading specific points arising out of local cases, for example that bruising in immobile babies must always be a cause for concern.

Securing Quality through QA Activity / Action Planning

- Great emphasis was also given to the way learning is supported by Quality Assurance activity. More specifically good practice included:
- Seminars, workshops and campaigns/newsletters with follow up audit and QA activity
- A robust QA framework of auditing cases involving practitioners should probably suffice if its robust and the quality is subject to inspection
- Ensuring that reviews are primarily about learning and quality improvement, rather than as an accountability mechanism.

- Recommendations from SCRs set by LSCBs create greater ownership and accountability for learning. Partners are more easily held to account for embedding learning by LSCBs.
- Monitoring progress with implementation of recommendations/Follow up by LSCB
- Thorough, systematic follow up led by the LSCB Exec; Consistency of personnel; Root cause analysis
- Clear action plan which is kept under review. Embedding issues in regular training (either board or single agency)
- Reviewing the "learning" against previous audit findings - to really understand system issues and avoid simplistic responses
- Having a clear idea of what 'good' looks like and how we know where we are in relation to such a definition.

Sharing Learning in the Context of Partnerships and Multi-agency Work

- Key sessions with first line managers using best practice guides. Practitioner multi-agency conferences
- Proactive learning events
- Integrate the focus on the child and its journey with the core functions of the Board to ensure joined up and coherent joint working
- An integrated approach to case review, quality of practice and training in the context of a robust policy, procedure and practice guidance/ Engagement of the multi-agency partners from the beginning
- Awareness raising and providing training
- Ensuring that the actions arising from the learning and the learning itself are embedded across the full range of work that is done in an area both single and multi-agency
- A committed Board Business unit which works well and is well staffed and supported by the agencies.
- SCR sub groups of the LSCB are an important vehicle for disseminating and discussing learning across agencies.

Developing a Culture of Learning with Front-Line Practitioners Locally

- Using every opportunity to share the learning, especially *with practitioners*

- A culture of continuous learning and development and people are given the time and space to reflect on practice and how the learning from SCRs can inform their own work
- There needs to be a collective ownership of the issues and an individual responsibility to implement the outcomes
- The responsibility for extracting and implementing learning should not be delegated to a task group or sub group
- Completion of individual agency reviews to promote a culture of local reflection and learning
- Local initiatives arising from local or very high profile cases.

Avoiding Blame

- Undertaking the SCR in as supportive a manner as possible
- Using a systems based approach in the first place to ensure that it is clearly understood that the objective is learning not blame
- Honest non-judgmental participation of frontline, middle and senior staff
- Strong ownership by all the agencies to implement recommendations and sign off all the actions
- The learning from one case with a tragic outcome isn't seen as a proxy for the health of the whole system.
- Being able to take a proportionate approach and using an approach which allows boards to consider issues rather than recommendations.

Publication Processes

- Making it clear that there is an expectation that SCRs will be disseminated.
- Strategic leads to be involved in writing
- Having an independent author with time!
- A thorough dissemination after the SCR and embedding learning in inductions and supervisory processes.
- Dissemination of information and training/info sessions.
- Very difficult to compare findings which are expressed so differently - which is why the bi-annual review is so useful.

Strengthening Relationships

Strengthening relationships which focus on honesty, transparency and a willingness to learn to improve

> *'We use learning throughout our learning and development activity, we send out links to relevant SCR in any communications. We refer to them in our policy/procedure work etc so embedding the learning throughout our LSCB is important.'*

Supervision

- Reflective and challenging supervision model in which the actions and reactions of professional staff are scrutinised
- Highlighting a few points from the findings and using the LSCB to highlight them through newsletters, attendance at meetings and the work of the sub-committees
- Distinguishing between workforce and workplace
- Front line managers get the key messages, they are able to incorporate into their supervision practice. They are critical in this process
- Lower caseloads as a result of consultation.

Miscellaneous

The following themes are not necessarily recurring, but they are still relevant and insightful:

- Not undertaking too many (SCRs) and being clear why you're not
- More relaxed guidance is welcomed as it gives autonomy
- Good national learning comes out of the academic studies
- The systems approach to SCRs does lead to better quality recommendations and more focus on practice
- Dissemination events form the national overviews supported by materials that LSCBs can use locally
- A clear SCR process and as much relevant information being made available to SCR panel at least a week prior to panel meeting
- SCR Panel made up of Executive members of involved agencies who are also Board members(ownership)
- Full family involvement in the reviews
- SCRs must be given priority.

Question 4. What are the main barriers to learning from SCRs?

'It is important to recognize that getting safeguarding right every time is a big challenge and cannot be guaranteed even if SCRs were a perfect process for' (LSCB Chair) . However, the following are themes that stemmed from the direct question to LSCBs of 'what constitutes barriers to learning'. The order of presentation depends on the occurrence of the statements, starting with highest occurrence first.

Attitudes

Professional, organisational and cultural resistance was recognized as a major barrier from learning from SCRs.

- Apathy of agencies to appreciate the seriousness of the SCR and the implications of the SCR process that can and does, sometimes, hold people and organisations to account for failures in combination with a lack of real commitment
- A perception by agencies and staff that 'this couldn't happen to us'
- Culture of organisations is not always a positive learning one
- Fear, as the Government climate still feels punitive rather than facilitative
- Lack of transparency and openness
- Managerialism as a response to accountability.

Political and Media Spotlight

At the same time, media attention adds to the difficult climate adding fear of negative media responses. No sustained action is identified across several parliaments and or local election cycles and action seems to be fuelled in short term by moral panic:

- This will not be helped by the political pressures around publication and the current hostile environment around transparency which must be balanced against the family's right to privacy.
- *'The media witch-hunts and salacious headlines act as an opposing force-field to the desire for openness and transparency'*

On the other hand:

- The DfE consultation about relaxation of safeguarding requirements in schools doesn't tie in with drive to improve.

Time and Action Fatigue

Time and work pressures for strategic and operational staff respectively were expressed under the following themes. Time was missing for:

- Capacity and recognition of the importance of learning and reflecting on practice

- Understanding that learning is more than dissemination of information. When learning involves bringing about changes in practice, processes and systems, then this is much more difficult
    - Opportunity for all members of staff to hear the relevant messages. Is missing.
    - Reflection and development of the required "professional curiosity" that are replaced by formulaic responses driven by thresholds

- The need to complete a review in 6 months and evidence timely learning versus the complexity of the learning required is an ongoing issue.

The time limitations combined with the need to constantly respond to actions that follow up the reviews create action fatigue to professionals.

- This is especially the case for LSCBs that carry out regular SCRs.
- The number of different initiatives make it too multi layered to change policy, procedures, culture and behaviour.

Development of Defensiveness

The time pressures described above contribute to the development of:

- defensiveness that can grow the nearer to publication you get (often justified because of all the political pressure there is around SCRs)
- Professional mistrust stemming from a blame culture making SCRs seen as "bad" thing'.

Accountability and Continuity

- There is lack of a proactive government response, whereas Ofsted's approach to inspection is not clearly geared to inspecting the issues which come out in the SCR review
- History and understanding of why something needs to be done is lost due to organisational churn
- There is lack of dedicated staff to monitor follow up.

Resource Challenges

- Capacity and resources have also been identified as a negative factor:

  More specifically:

    - Invariable implementation of messages results in more work and as a result heavier caseloads

- Financial austerity and reduction in budgets and reorganisations in virtually all public sector organisations lead to a tendency to become more 'siloed'
- The lack of supervision is even more evident in this climate and staff not being listened to.

Barriers to Information Sharing

Failing to disseminate lessons down and failing to facilitate messages up to senior managers and Board level from the front line lived experience is a recurring issue.

This is linked to:

- **Bureaucracy**
  - Potentially a bureaucratic process where most of the recommendations could be written at the first meeting of the SCR Panel
  - Munro is right in highlighting the need for less bureaucratic approaches to safeguarding- but the focus of DCS in many years is Ofsted rather than learning from SCRs
  - 'Government policy which is not evidence based.'

- **Lack of systematic summarising**
  - Lack of systematic summarising and key simple messages obstructs information **sharing** and creates difficulty in moving any connection between personal tragedy and an effective translation into both organisational responses and behaviour changes.

More specifically:

- Generally information sharing is an issue which appears in all cases and has appeared consistently for many years
- The number and size of the reports, the duplication of the findings (training, supervision, information sharing are always included), the capacity of the LSCB- only 4 Board meetings a year
- *'Telling the wood from the trees. Looking at the national reports on CASPAR one reads again and again about the same things: risks when new mothers have mental health difficulties, vulnerability of those in homeless accommodation or with immigration problems, failure to engage male partners etc'.*

Multi-Agency Work Issues

- Issues relating to multi-agency working included the following:
- Inter-agency conflict and misunderstandings
- There is inequality amongst agencies to actively expose what might have gone wrong and therefore it is less likely that real lessons will be learned in all agencies
- Lack of integrated workforce plans
    - Action plans often consist of single actions for one agency and with an assumption that once it's completed, the original concern has been dealt with
- Poor and too many recommendations that focus on process and not core agency and inter-agency practice
- Lack of understanding of effective ways to disseminate learning across front line workforce on a multi-agency basis
- Trying to use a technical solution to what is a complex multi-faceted problem of change and development in practice.

Training Limitations

More specifically there has been identified a lack in:

- Having enough trained, experienced and qualified staff
- Forums to share learning and genuinely measure practice improvements
- Staff engaging with and participating in any formal learning sessions.

Question 5. How can learning from SCRs be improved and embedded in practice?

This question was approached qualitatively as it is meant to provide insights of strategic managers towards improving learning from SCRs and embedding it to practice. Generally, a wish was noted to have information collated nationally from SCRs but for this information to be analysed and then the messages to be made succinctly and easily available and to be focussed on practical actions, not only analysis.

There are particular pleas for:

a. National assistance in creating auditing and quality assurance tools

b. National assistance in producing tools to assist and facilitate learning

There is a strong emphasis on training and supervision – with this targeted on front-line practitioners and their front-line managers – and for it to be multi-professional and multi-agency, but with commitment and leadership from senior managers to ensure it is happening and is having a positive impact.

More specifically the following themes were identified, starting again from the ones with highest occurrence.

Learning from Experience what Biannual Reports are bringing is Important, but it is also Important to Make Changes in the Process of Learning SCR Lessons:

- Overview reports to be widely disseminated with training events. It is important to focus on learning from others' experience - some staff at the front-line will not be familiar with SCRs in other areas/Authorities and would learn from others' experience.

  "Greater clarity in what is happening around the country would also help. We should not have the approach of wait until something happens to us before we do something!"

  'Learning should be incorporated at every level, from initial qualification through to personal development.'

- Strategically, learning should be incorporated into planning for the workforce
- Use non SCR cases as well as SCR cases to identify learning.

Learning Linking with Training

- Qualifying training for those working with families should include learning from SCRs
- Expand the training opportunities for chairs and authors
- Better involvement of practitioners and managers to increase ownership and excite the possibility of improving their practice. Make them part of the solution
- Practice Inter agency training
- A greater focus in University courses for students undertaking SW and Nursing degrees on Serious Case reviews and bridging the theory practice gap.

Engagement with Learning/Thematising/Collation and Analysis and Dissemination of SCR Learning

- Taking the main themes from SCRs and ensuring a focus on them in learning and development
- There is a need to focus on fewer but more meaningful recommendations and actions
- If there are recurring themes, it might be better to cross refer to the other cases and remind staff of those issues rather than use them as the focus of each and every review
- Developing a focus on key recommendations

- Easy read digest of findings with links to Boards which have implemented them so we can learn from each other
- They should be shorter and be less about blame and more about issues and learning for the whole system
- The ability to identify themes from both local and national SCRs which also resonate with themes arising from QA activity - i.e. neglect, Looked After Children.

Dealing with Resources Variation at Different LSCBs

- 'A national formula for funding SCBs so that all boards, large or small can give the attention locally to the learning from SCRs that they should.'
- 'the most senior managers need to accept that this is an iterative process which we can never stop, that part of running an organisation is making space for training and listening to staff.'
- 'Nearly all will say that they are part of a learning organisation but pay it lip service too often. Again it is getting better, or at least was until the latest cuts started to impact on case loads and referrals across the public and third sectors.'
- Some solutions were proposed in relation to the above:
    - Use of business planning and away days
    - Adequate resources for the workforce and workplace
    - Involving practitioners and first line managers more in the review

Supervision of Front-Line Staff as a Facilitator for Learning

- Good supervision of front-line staff, using experience from SCRs
- Supervision from staff who focus on Learning rather than blame culture
- Summaries that are widely disseminated and reinforced in training and in supervision
- Recognise role of supervision to explore how learning is being applied in current cases and create a process so this can happen on a multi-agency basis too for the team around the child/family or core GP.

Removing the Blame and Promoting a Safe Culture Locally and Nationally

- There is a real mismatch between the intention of SCRs to be for learning purposes, and the political/media pressure on identifying someone to blame'
- Learning would be improved if agencies felt they were operating in a safe environment

- A more open and facilitative response from senior managers and Government is needed.

Accountability/Quality Assurance and Measuring Impact of SCRS

- Making senior managers more accountable for the outcomes
- Identifying where that position in an organisation has been responsible for action or inaction leading to the failure identified
- Organizations/ agencies accepting responsibility for any failures and identifying the need for change in process, practice and culture
- A summary of the key learning from SCRs nationally and a performance management tool which can be applied by the LSCB at the end of the SCR and 3 to 6 months later to reassess how well embedded any such changes are
- A follow up to ensure that any learning is actually embedded, before the next series of large amount of recommendations comes along
- Ofsted should more clearly link its inspection work to lessons from SCRs
- LSCBs need to be more questioning - and doing a Learning Together review.

More Multi-Agency Approach is Required

- More multi agency approach, and sufficient resources for new practices to be thoroughly embedded
- Recognition that safeguarding on the continuum from universal services through to the sharp end of Child protection services
- National policy that supports local joined up work could be helpful.

Systems Methodology (SCIE and the Systems Thinking of Learning Together) to be Further Embedded

- The process can actually trigger as much change to local practice and culture as the actual findings
- The systems methodology should go a long way to aiding this. Operational staff need to understand why the learning has come about.

Increase Families Involvement in the Process

- Their perspective can be very informative and might result in more meaningful recommendations.

Early Intervention to be the Focus of Different Services

- Greater emphasis on primary and early prevention
- Continuing the national focus on improving social work and the development of health visitors.

Attitudes to Risk to be Reconsidered

- The messages always seem to be that certain risks were underestimated. If we could differentiate more effectively between risks and sources of resilience that would help.

SUMMARY

It is of interest that the responses addressing the different questions all included similar themes, which have been grouped under the following emerging headings that could entail good practice, barriers and enablers:

Communication and learning

Accountability

Multi-agency working

Culture of learning

Blame

Publication

Relationships

Supervision

Table 2: Summary of questions 3, 4 and 5 (themed and cross checked with questions 1 and 2).

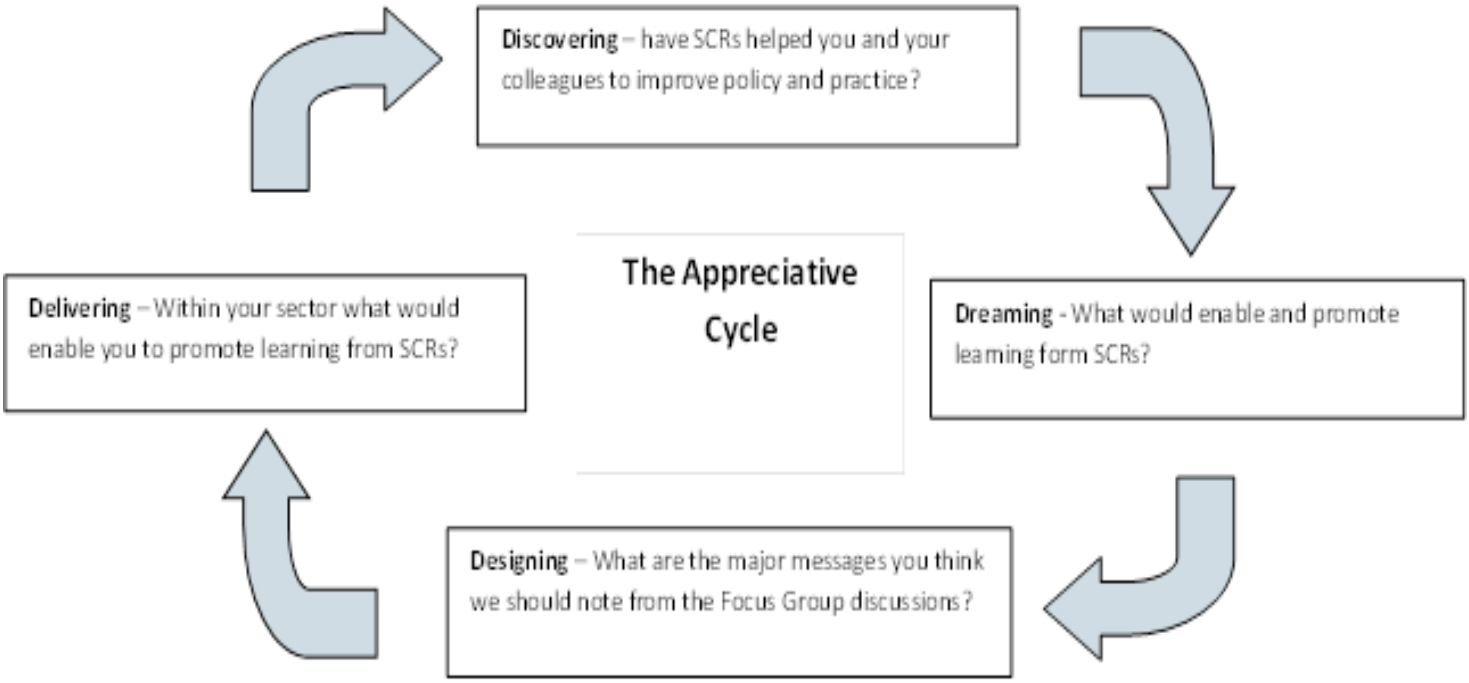
Q3Q3. What currently works best	Q4Q4. What are the main barriers to learning	Q5. How can learning from SCRs be improved and embedded in practice
Good Practice	**Barriers**	**Enablers**
Communication and learning		
Communication strategies	Barriers to information sharing	Learning from biannual reports is important, but it is also important to make changes in the SCRs process
Accountability		
Securing quality through QA activity / action planning	Accountability and continuity Bureaucracy	Dealing with resources variation at different LSCBs Accountability/quality assurance and measuring impact of SCRs.
Multi-agency working		
Sharing learning in the context of partnerships and multiagency work	Multi- agency work issues Training limitations	Engagement with learning Learning linking with training More multi-agency approach is required Early intervention to be the focus of different services

Culture of learning		
Developing a culture of learning with front-line practitioners locally	Time and action fatigue	Systems methodology (SCIE and the systems thinking of learning together) to be further embedded
Institutional issues, Blame		
Avoiding blame	Attitudes / development of defensiveness	Removing the blame and promoting a safe culture locally and nationally. Attitudes to risk to be reconsidered
Publication		
Publication processes	Political and media spotlight Lack of systematic summarising	Thematising / collation and analysis and dissemination of SCR learning
Relationships		
Strengthening relationships	Limited involvement of front-line staff	Increase families' involvement in the process.
Supervision		
Supervision	Resource challenges	Supervision of front-line staff in particular

FOCUS GROUP DISCUSSIONS AND THE PRE AND POST REFELECTIVE QUESTIONNAIRES DATA ANALYSIS

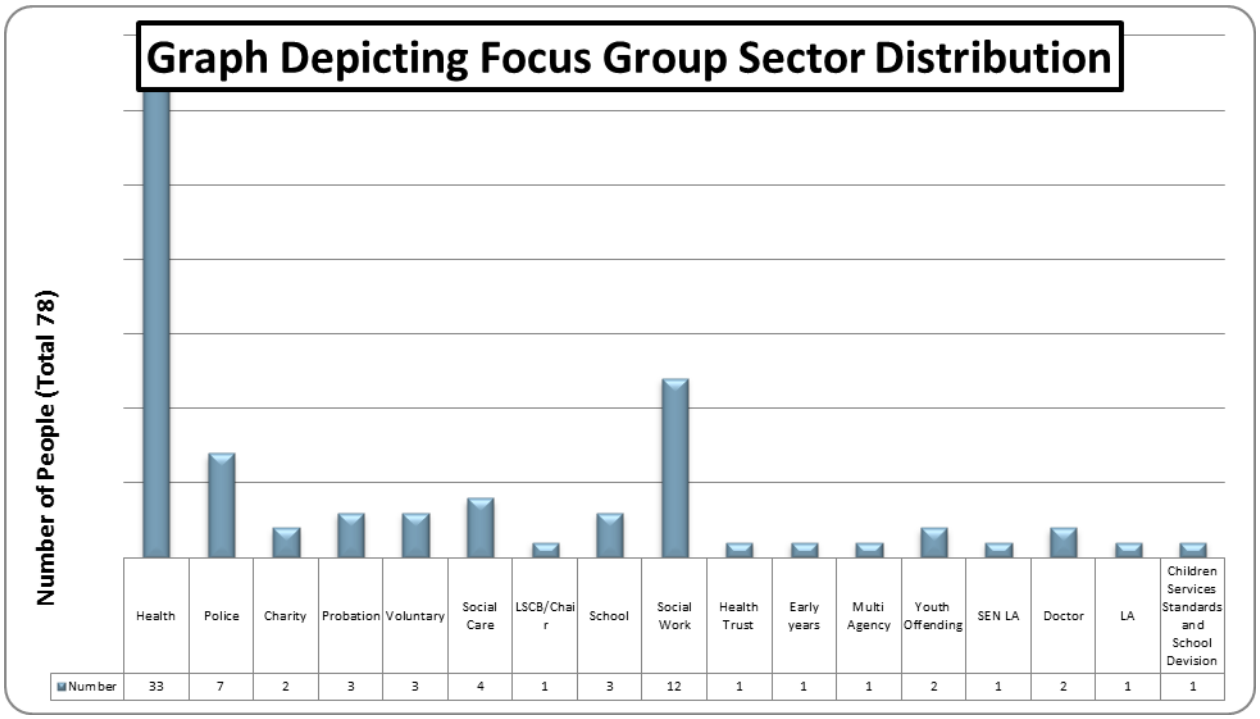
Appreciative Inquiry (AI) was used as a tool for the focus group discussions and the pre and post reflective questionnaires. The AI model is commonly used as a change management process using the positive experiences of an organisation or group to bring about change. According to Marshak and Grant (2008) AI is influenced by theories of discourse and narrative especially when applied to organisational change. AI also supports the notion that more widespread, voluntary, multi stakeholder engagement in co-constructing a culture change that supports a shared vision of where members of that shared vision want to go in the system is more likely to succeed.

Figure 6: The Appreciative Inquiry Model



In total 78 participants attended the focus group discussions (strategic and operational) from a range of disciplines and sectors. The following diagram illustrates the distribution of attendees from a range of occupations and disciplines.

Figure 7: Graph depicting sector attendance across all focus groups



It was ensured that the attendees represented rural and inner city services, agencies and professions including the Private, Voluntary and Independent (PVI) sectors. All groups, strategic and operational, were invited to attend voluntarily by the local LSCB Chairs according to LSCB's guidance and definitions.

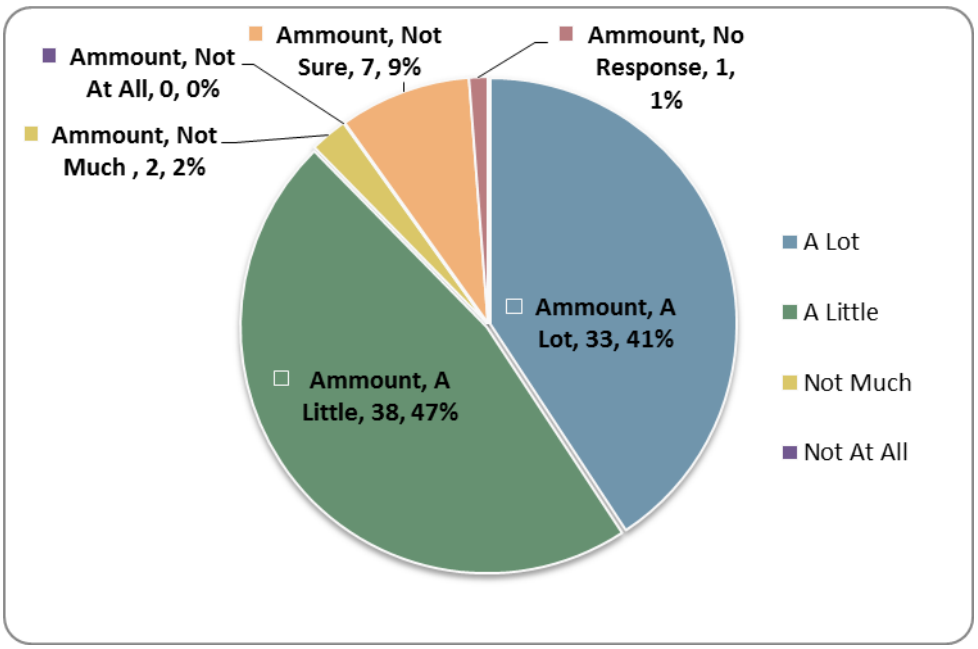
PRE-FOCUS GROUP QUESTIONNAIRES **(see appendix 1 for blank copy)**

The questionnaire was designed for two purposes. The first was to create an opportunity for participants to focus on the area for discussion (focussed mindset) and secondly to enable the capture of participants' knowledge and understanding prior to possible construction of ideas within the focus group environment. The prominent themes were captured following analysis by two of the researchers.

Table 3: Prominent Themes Arising from the Pre Focus Group Questionnaire

Prominent Themes Arising from the Pre Focus Group Questionnaire
• The strongest theme emerging from the pre focus group operational and strategic questionnaires is that **all** practitioners need to be included in **training** including front line practitioners and **the PVI sectors.** • A second strong theme is that of **communication** which includes **information sharing** and **recording**. Participants in the operational group were concerned that there is a lack of oversight at strategic level. • **Shared learning** was highlighted as needing review in terms of interprofessional

and interagency practice expectations. • **Processes and procedures** were identified as problematic both within and across disciplines and sectors.	
Findings from the Pre Focus Group Questionnaire The following illustrates some of the original data that illuminates the prominent themes above.	
(Question 1 and 2) Job Title and Sector - Operational	The data identified that each operational focus group was composed of a range of frontline practitioners from services working with children and families including the PVI sectors. • Probation services. • Police • Schools. • Local authority education advisors. • NHS community health services. • NHS mental health services. • NHS ambulance services. • Local Authority children's services. • Local Safeguarding Children Boards. • Head Teacher. • Doctors - GPs, Paediatrician & Forensic • Voluntary organisations working with children.
(Question 1 and 2) Job Title and Sector - Strategic	The data identified that each strategic focus group was composed of a range of leaders and managers from services working with children and families including the PVI sectors. • Police. • Probation services. • Schools. • Local authority education advisors. • NHS community health services. • NHS mental health services.

	• NHS ambulance services. • Local Authority children's services. • Local Safeguarding Children Boards. • Head Teacher. • Doctors - GPs, Paediatrician & Forensic • Voluntary organisations working with children
(Question 3) Have Serious Case Reviews (SCRs) helped you and your colleagues to improve child protection policy and practice?	The data below showed that 88% of participants attending all four focus groups did acknowledge that SCRs helped to improve child protection policy and practice. Only 2% thought it did not help much. 9% were not sure. 1% gave no response. **Figure 8: Pie Chart Outlining Responses to Question 3** 

(Question 4) If you ticked A or B please tell us how serious case reviews have helped to improve child protection policies and practice.	In terms of how SCRs have helped to improve policies and practice the section below reflects the responses. Bold type has been used to illustrate prominent themes. *Operational* **Training** A strong theme coming through for both strategic and operational practitioners is around training and communication issues. • "Voluntary Community Service organisations do not always understand the relevance of learning from SCR's in their work. This **reflects a limited understanding of many smaller VCS organisations of their critical role in the protection and safeguarding** of Children and young people more generally. We **now include in our training."** • "It has enabled us to implement and change policy and practice. We have adapted **training needs/requirements** as teams | Services | SCR have identified specific themes. It has **identified gaps in knowledge and Service provision which** the safeguarding team have been able to support during change." • "New procedures have developed and existing ones revised. Development of concealed pregnancy procedures. **Additional training for staff** has been commissioned i.e. hostile and uncooperative patients. Dissemination of lessons learned and **new approaches to front line social work teams have impacted on improvements** in social work practice." • "Our designated and named professionals feedback learning from SCR's through this and possible more through **discussion together of the actual cases and peer review of reports** unfriendly summary of risk. New system hopefully to enable more attendance at Child Protection conference when this is essential. Learning we have adapted and developed policy. **Clarity about which cases** should be seen for **" Child Protection Medical Training."** • **"As an emergency service we do not hold information on people/children so attend incidents with limited knowledge** and report what we see. Information/lessons learned (SCRs) have **assisted in shaping policy and procedure and training case studies** as we cover a large area."

- "SCR's have resulted in changes to 1) policy + procedure, e.g. neglect guidance 2) **Training - learning informs multi + single agency training**. 3) Specific responses e.g. working with hostile and resistant carers. 4) Practice changes e.g. signs of safety model. 5) Development of local protector's e.g. Mental health pathway."

Strategic

Training

- "Due to two SCRs within my service pathways, into and out of, have since changed recording. Changed identification of need of child protection training and communication within cases. **Training levels have been amended and recognised** and requiring high levels of training i.e. level 3/2. **Supervision arrangements renewed** group safeguarding and agenda for supervision changed Support from safeguarding renewed and amended. **Family workers embedded in the team."**
- **"How information is collated, linked and shared. How data is input on** to the **system**, what information is required. How training is delivered the importance of training and who requires it."
- "From the recommendations we were **able to identify a gap in safeguarding supervision** to health visitors, school nurses. We put in a bid for additional funding and developed a model of **3 full time staff to deliver safeguarding supervision."**
- "Review of domestic violence policy. **On-going training**. Thinking practically around asking Domestic Violence questions. **Consideration of outreach services**, for mental health especially."
- **"Opportunity to reflect on practice to use this in supervision and when planning input** with families. Areas of practice which have been identified e.g. domestic abuse. The understanding of the **impact of this has developed from research but also SCR. Importance of record keeping** has also been highlighted and communication."

(Question 5) If you ticked C to E please tell us what you consider to be the barriers to learning from SCRs.	In answer to question 5 the barriers to learning from SCRs were centred around prominent themes of training and communication. The following sample of quotes is indicative of the responses. *Operational* **Training** • "There is a need to **reflect on how you can improve practice together**" (Focus group 2) • "We need local **training together**" (Focus group 2) • "**Training needs to be tailored** for appropriate levels." (Focus group 1) • "I have worked here for 5 years and this is only the second time I have been able to discuss **multi agency issues** with other practitioners." (Focus group 4) • "**Dissemination and training into third sectors** presents additional challenges as there is no infrastructure present in large statutory organisations." (Focus group 4) • "**Training to fully embed multi agency working of the team around the family**. Workshops and events underpinned by learning from SCRs." (Focus group 3) • "We are doing a good job but sometimes we make mistakes and must learn from them. We need to **work more fully in a multi-agency way**. It's difficult not to feel defensive when a child dies because no member of staff wants it on their conscience. We need to acknowledge the complexities of working with people." (Focus group 1) • "**Mandatory training or attendance at learning event** following SCRs." (Focus group 1) **Communication** • "**Cross sector communication strategies** to ensure messages are shared." (Focus group 1) • "**An interagency communication** and shared learning, expanding on recommendations from SCRs." (Focus group 1) • "**Open discussions** to move away from 'blame culture.' **Transparent decision making** and more training of a **multi-agency approach**. It facilitates networking and this makes

	communication more effective." (Focus group 2) • "**How information is collated, linked and shared. How data is input on to system**- what information is required." *Strategic* **Training** • "**Training Delivery to front line staff** - Instructional Information (which forces policy and practice to be made available via the intranet) - awareness broadcasts to address quality issues 'falling short' of the requirement for training input." (Focus group 2) • "Capacity within the workforce dedicated to safeguarding within the organisation to further develop supervision for staff. Ability to **free staff to attend training and seminars**" (multi disciplinary). (Focus group 1) • "**Understanding of why we do things the way we do - human factors**. This training has only been delivered to managers - should be delivered to frontline practitioners. **Understanding themes** - why are the same things happening across all areas? • "**Training on themes** should be part of workforce development." (Focus group 2) • "**Wider multi agency training to consider outcomes from SCRs**. Emphasis on implementation and strategic planning rather than focus on 'the report'. Time for practitioner to **reflect together** on learning." (Focus group 4) **Communication** • "The same recommendations keep coming up. **Information sharing scares people**." (Focus group 3) • "Raised awareness of safeguarding archetypes - the compliant mother (Peter Connolly), the hidden child. Cumulative reports emphasise important lessons but sadly SCRs so often repeat lessons we already know should be followed, in practice - **poor communication features every time**." (Focus group 4) • "Need an **interagency way of communication** that covers

	shared learning and concerns from SCRs." (Focus group 1) • "**More effective communication strategies (internally/LSCBs).** Greater auditing of recommendations from previous SCRs to ensure that they continue to be embedded into practice. Greater staff participation in the process. **National/regional targeted communications strategies**." (Focus group 3) • "Informing staff of key messages and as a result change some practice e.g. non access visits, **how to follow up, when to follow up. Males in the house, often not seen,** raising awareness for practitioners, **hard to change practice though in 9-5 services**. Implementation of unborn baby protocol and teenage pregnancy pathways." (Focus group 3) • "**Too many recommendations (from SCRs)** which often generate new procedures. **Often front line practitioners do not know why the new procedures are in place**." (Focus group 1)
(Question 6) What would enable and promote learning from SCRs?	In response to question 6 the analysis indicated strong themes of 'shared learning' and 'processes and procedures' as enablers to learning. *Operational* **Shared Learning** • "**Clarity around the nature of the learning** - suitable opportunities to deliver the learning using 'experienced' facilitators/teachers - **Safeguarding formally recognised** as a priority." • "**Training and sharing experience** with Services | teams involved. More understanding of SCR's and the implications for services." • "Focus groups - **Shared learning across organisations**. Regular Briefings. - Training (multi-disciplinary). - **Clear guidance on recommendations which need to be put in place**." • "**Clear, Concise messages. Timely messages**; delay in publishing learning makes it remote from the incident. **'Translation' of messages for smaller Voluntary**

Community Service groups."

Strategic

Processes and Procedures

- "Further time out of practice in some cases to allow staff to feedback and inform their practice. - **Clinical Supervision - Safeguarding Supervision**.
- "Clear dissemination of lessons learnt and how this affects practice - **Clear guidelines to put into practice."**
- "Communication between safeguarding of service where incident occurred. To have the **appropriate level of manager involved in managing change** required as identified within SCR. To ensure that all SCR issues that are identified are rewritten into policy, pathways and **embedded in practice through appropriate supervision**."
- "If **Serious Case Review learning was effectively categorised** + disseminated this would help to ensure that messages were spread to frontline staff on a regular basis."
- "National **field work of SCRs included across agencies** and easier access to this information.
- "More emphasis in team meetings have time and resources. **Visitors from safeguarding board to team meetings in other sectors**. NOT emailing out a newsletter/long update that staff are unlikely to have the time to read."
- "**Keep the momentum going** so people don't forget recommendations."
- "**Cascade learning throughout organisations** - use of case studies. Share information between + inside organisations. **Website - Anonymised case studies**."
- "**Increased engagement of front line practitioners in SCR's from the outset**. Use of work-based methods of dissemination, e.g. supervision, peer mentoring, team meetings, web-supported learning."
- "Involving more agencies in the learning from experience workshops (school staff and police to attend). **Quicker involvement of practitioners**, it always seems to take a long time to filter down and it can be after policies have changed."

(Question 7) Within your Sector can you identify specific strategies that would enable lessons from SCRs to be embedded in policy and practice?	The following sample of quotes reflects the four prominent themes that arose in the previous questions. *Operational* **Training** • "**Across sector practice groups** - Training - Communication strategies to ensure messages are shared." • "**More training about learning outcomes**." • "Team **sessions development opportunities group supervisions**. Training within our own sector/service and within the context of training others (external)." **Communication** • "**Lead, who should be given information from every SCR** and this can then be cascaded to all teams and we could all learn from other areas of SCR's. **Policy and procedures** • "**Include specific guidance for 3rd sector organisations** that have both a paid and volunteer workforce." • "**After each SCR for policies to be regularly reviewed.** More consultation between frontline staff and senior managers (who we normally don't even meet!) For awareness of service constraints and the **need for more findings to implement policies properly**." • "**Standing items on team meetings agendas**. Learning days. Newsletters/updates." **Shared learning** • "Discuss SCRs at team meetings and in reflective supervision."

	Strategic **Training** • "**Supervision** – Appropriate levels of training and correctly identified problems of training. Interrogation of appropriate members of teams. Consistent support from management and peer groups." **Communication** • "**Front line practitioners need to understand the reasons for the recommendation** and therefore need a sense of what happened in the case. Unless the case was in their own area they would not get this." • "**How information is shared, what is recorded, and who has access to** it. This will identify where and how problems arise in the protection of children and vulnerable people. It will assist in the implementation of any future training packages." **Policy and procedures** • "**More focus on outcomes/recommendations** that are meaningful with strategic themes practice linked to overall LSCB role in what is good/ good enough/not good enough. - **more developed and explicit powers for LSCB** with clear and responded capacity to evaluate parties services and hold reports." • "Info fed back to team in monthly meetings (Verbal & Written) - **Lessons learnt translated into policies to ensure they become embedded into practice."** • "Practice of ensuring all aware of lessons learnt. **Specific group to identify guidelines** and …… a practice which includes safeguarding team to ensure that polices and practice are up to date are reflect the needs of young people for child protection." • "**A policy team to analyse national local SCRs** and then to amend policy accordingly."

	Shared learning • "Needs to be understanding of the challenges staff face in safeguarding work throughout organisation **better understanding of roles within multi-agency teams**." • "**Creating a strong relationship between designated and named professionals and doctors/nurses to ensure we are all on same wavelength.** We need to be aware of possible loss of transparency between foundation trusts and between commissioners and providers as t**ransparency and honesty is tied to analysis and change.**

FOCUS GROUP (FG) DISCUSSIONS

The focus group participants were asked to reflect together about the barriers and enablers to learning from Serious Case Reviews (SCRs). The two focus group facilitators enabled participants to discuss openly using as few prompts as possible but guiding the discussion through the AI process.

One focus group (labelled 1 to 4, see Appendix ?) in each geographical area was composed of senior and strategic managers from services working with children and families. The other focus group (labelled A to D, see Appendix ?) was made up of frontline practitioners and managers from across agencies and professions.

Each focus group lasted an hour and the discussion was digitally recorded and then transcribed. Two FG facilitators sat in the circle with the participants and two people sat outside the group (out of eye contact) to capture manually key themes arising from the discussions. Content analysis was independently undertaken by two members of the research team by reading and re-reading to identify themes. The two independent research members then met and agreed on coding of the transcribed discussion. The data was triangulated with another member of the team at a later stage.

The text below highlights the prominent themes which emerged from the focus groups. There was a considerable consistency across the four geographical areas, and also across the focus groups of senior strategic managers and the focus groups of frontline practitioners and their immediate managers. No significant differences in the themes have been identified by area or focus group type. This emphasises how the themes are consistent and common and this triangulation of area and focus group type indicates the reliability and validity of the themes in considering the impact of serious case reviews.

For each theme there is extended presentation of the verbatim statements of the participants in the focus groups, which can be found in Appendix 2, due to the volume of evidence relating to the nature of AI focus groups. The richness and range of comments illustrate the experience and reflective thinking contributed by the focus group participants from across a wide range of professionals and workers and from differing status roles within a wide range of agencies. Their comments are well informed from direct experience of being participants within and recipients of the serious case review processes.

Prominent themes from focus group discussions

Barriers to Learning

When talking about **barriers**, the focus group participants commented on the ***context*** and the *content* of the serious case review process.

There were three main concerns about ***context***. Firstly, the **impact of the public cuts, increasing workloads** and **organisational change** made it difficult for workers both to give appropriate attention to serious case reviews and also to deliver best practice.

Secondly, there were very many concerns about **the blame culture promoted by the media and replicated by national politicians and within some organisations**. This encouraged defensiveness, and undermined learning, when participating within the serious case review process and a general fearfulness about the implication – being named and shamed by the media with all the risks of public vilification and vigilantism – and of loss employment and careers. The requirement now that serious case reviews be published in full was a significant in feeding and fuelling the media and politician-led blame culture, and also because it made families involved in serious case reviews more vulnerable.

Thirdly, the **inherent complexity of child protection** was noted, and that this may go unrecognised within serious case reviews and by the media and politicians, and may also lead to unrealistic simple solutions which never then delivered positive outcomes.

In relation to the ***content*** of serious case reviews themselves being a barrier to learning and to improving child protection there were a number of dimensions.

Firstly, the serious case review process was seen as **time-consuming, and taking resources away and a distraction** from seeking to deliver good contemporary child protection services.

Secondly, the **prevalent outputs of serious case reviews**, including numerous recommendations, complicated and extensive action plans, policy changes and more procedures, **were seen as unhelpful and often too complex to implement**.

Thirdly, the standard serious case review **process was felt not to engage with frontline practitioners and frontline managers,** that it was a process where they felt it was done to them, and with the outcome that they had little sign up to or ownership within the process and that the outputs of the process were seen as not relevant by them and may indeed be a hindrance.

Fourthly, although attention might be given to local serious case reviews **undertaken elsewhere**, nationally they were often unknown unless they became the subject of national media attention, which was hit-and-miss and driven by sensational media reporting.

Enablers to Learning

The **enablers** to serious case reviews being more likely to contribute to the enhancement of child protection were the converse of each of the above. There were particular comments about the SCR ***process*****,** about its ***product*** and about how the then ***drive impact*****.**

Firstly, there were comments about the **timeliness** of the SCR process, speeding it up and making its outputs more quickly available.

Secondly, the importance of **engaging frontline practitioners** as active participants in the process, while the review was being undertaken, when recommendations were being shaped, and in driving impact.

Thirdly, the **systems model of undertaking SCRs** was seen as much more engaging, less blame focussed, and more likely to be reflective and to generate well-informed conclusions.

Fourthly, SCR **recommendations should be smarter and fewer**, and indeed locally and nationally the emphasis should be on **identifying and highlighting themes** and key messages rather than an avalanche of detailed overwhelming recommendations and action plans.

Fifthly, **learning and training needed to be multi-faceted**, promoting multi-professional working but also tailored to the needs and focus of different workers, different levels of seniority, and different agencies. There needs to be a matrix of training and learning.

Sixthly, **national as well as local learning** needed to be captured, but this would require collating and synthesising the large number of reports nationally and preparing and disseminating in **themed reports**.

There was also, seventhly, a need noted to **embed and to check** that this embedding had taken place, the learning and improvements to be generated by SCRs, with a follow through, and an auditing of, impact.

And finally the particular **importance of front-line management and supervision** was noted, but that different professions and agencies may have differing commitments to, and understandings of, supervision.

POST REFLECTIVE FOCUS GROUP QUESTIONNAIRES

The post reflective focus group questionnaires were completed immediately after the FG discussions. The participants were enabled to spend some time independently reflecting on what they thought were the key messages emerging from the discussions. The prominent themes arising have been captured in the table below. A sample of direct quotes is presented under each question and is indicative of responses.

Table 4: Prominent Themes Arising from the Post Reflective Focus Group Questionnaire

<table>
<tr><td colspan="2">Prominent Themes Arising from the Post Reflective Focus Group Questionnaire

• Review content and timing of the SCR report (emphasis on key learning themes to move away from ‘blame culture’ and defensiveness and considered review of what aspects are released for public and media scrutiny).
• Policies and procedures to incorporate elements of flexibility to enable professional judgement.
• Resources to provide appropriate personnel, training and time to embed lessons, within and across agencies and professions.
• Include clear lines of accountability for inspectorates within disciplines to ensure lessons have been disseminated and recommendations have been actioned where appropriate.
• Provide compulsory cross disciplinary forums for discussion and reflection of SCR learning to embed a learning community culture.
• Mandatory child protection training for all workers (rather than this being discretionary and optional).
• Providing a framework to listen and learn from frontline practitioners.</td></tr>
<tr><td colspan="2">Findings from the Post Reflective Focus Group Questionnaire

The following illustrates some of the original data that illuminates the prominent themes above.</td></tr>
<tr><td>(Question 1 and 2) Job Title and Sector -</td><td>The data identified that each operational focus group was composed of a range of frontline practitioners from services working with children and families including the PVI sectors.</td></tr>
</table>

Operational	• Probation services. • Police • Schools. • Local authority education advisors. • NHS community health services. • NHS mental health services. • NHS ambulance services. • Local Authority children's services. • Local Safeguarding Children Boards. • Head Teacher. • Doctors - GPs, Paediatrician & Forensic • Voluntary organisations working with children.
(Question 1 and 2) Job Title and Sector - Strategic	The data identified that each strategic focus group was composed of a range of leaders and managers from services working with children and families including the PVI sectors. • Police. • Probation services. • Schools. • Local authority education advisors. • NHS community health services. • NHS mental health services. • NHS ambulance services. • Local Authority children's services. • Local Safeguarding Children Boards. • Head Teacher. • Doctors - GPs, Paediatrician & Forensic • Voluntary organisations working with children
(Question 3) On reflection, what do you	In terms of what was most helpful in promoting learning from SCRs the section below reflects the responses. Bold type has been used to illustrate prominent themes.

see as most helpful in promoting learning from SCRs?	• "**Embedded information** cascaded to all **services**." (Focus group 1) • "Being clear about what needs to change and regularly redefining the recommendations, ensuring they are being effectively implemented. Cascading the learning around all agencies and in particular **future practitioners**." • "Providing summarised accessible **information for frontline staff/volunteers** about the meaning of lessons for practice." (Focus group 1) • "**No blame culture** - Constructive feedback" (Focus group 1) • "Cascading information - **sharing info with wider organisations via internet**, not just intranet sites. Time - staff have huge demands on them not allowing for learning." (Focus group 3) • "To discover themes, ideas and lessons that affect good practice **- make practice safer a chance to learn from ones mistakes**." (Focus group 1) • "Ability to deliver key **messages within organisations in a 'non-blameworthy**' manner. - Ability to "cut through" the detail and get to the real emerging themes (current & historic)." (Focus group 2) • "Shared understanding of incident **need for supervision within my agency**. Stronger links with LSCB's." (Focus group 3) • "SMART identification of **themes which directly link to work force development** and then comprehensive **evaluation of impact**." (Focus group 3) • "**Sharing information** focusing in on areas of good practice. Looking at the context of staff working environment staff shortages bureaucracy performance targets." (Focus group 2) • "Targeted learning. Practice forums. Joint partnership working. **Strategic partnership. Planning infrastructures**." (Focus group 4) • "Using the SCIE process and looking at **systems rather than blaming individuals**. Multiagency feedback and workshops. **Multiagency case discussions/audits."** (Focus group 4) • "Learning passed on via individual team **briefings in a summary report**. This ensures all staff have knowledge of

	issues." (Focus group 4) • "**Appropriate training** lessons learned from local and national SCRs." (Focus group 3) • "Improved **open communication between professionals** (and direct practice with families) being transparent and also having **confidence to challenge**. Have difficult conversations when necessary." (Focus group 4) • "**Dedicated website**- (similar to Ofsted) with **access to Executive Summaries/learning points**. Analytical support nationally in annual plan- agencies can then support in training/supervision." (Focus group 4)
(Question 4) What are the major messages that you think we should note from the Focus Group discussion?	Bold type has been used to illustrate the major messages that the participants wanted noting. A major concern particularly for the front line practitioners is **that due to re-structuring jobs have been lost and roles changed often affecting the culture and ethos** that had been built up over time. Sometimes staff had been in place for longer than 6 years therefore knew the families well in their local area. The **loss of this cumulative knowledge can hinder effective communication and information sharing.** • "**Efficient use of stretched resources** is a particular issue and local arrangements (forums, systems, etc.) can only go so far to deal with the complexities of the breadth of needs. **Local culture in organisations needs to be positive and challenging** from top down." • "**Resources are a major contributor**. Changes to practice should be **guided by evidence**. More opportunity to discuss/**share in multiagency forum**. Challenging is important- clients/colleagues/ourselves. Need more opportunity to share learning from SCRs this may take many forms depending on service need. Information sharing - complexities." • "Policy makers to make practical achievable **models of working that tells partners what they <u>must</u> do and what they <u>may</u> do**. This will have a realistic model for working together, communication and workloads. The same issues must be brought up in many SCRs, **why are there no legislative and policy guidelines** to tell people to work together? At a time of drastic cuts if senior managers are

	allowed to make their own model/or ignore directed model things will get worse, less communication, less working together when at this time if we work smarter and effectively together it will cut costs and better safeguard children and families across multiagency." • "**Good practice in information sharing** in some areas (Police). - Should be duplicated or all professional bodies. - SCRs are blame-driven for practitioners. - SCR learning is kept at strategic level and not altered/interpreted for front line staff." • "Importance of **information sharing**. Policies and procedures that enable good practice and support practitioners services to deliver**. Standardised approach to policies** were possible, some agencies work with more than one local authority board." • " 1)**'Challenge' as a culture is important.** 2) Enabling the **front line to drive change** is important i.e. not just to be expected to react to change. 3) There is more scope from **learning from multi agency approaches**." • "Dissemination of information across agencies. **Information needs to be shared both vertically and horizontally**." • "Can the government **capture the 'top ten' repeating issues."** • "Embed improve practice not just for short periods but permanently. Hold regular sessions for workers/managers to **ensure messages have gone through**." • "SCIE methodology. Impact evaluation. Learning from national activity. **Reaching front line staff. Reflective practice**." • "Themes that come out of SCRs that need resolving at a higher /national level i.e. CAMHS/AMHS transitions and CAMHS in-patient facilities. To **only use old SCR methods in exceptional cases systemic model wouldn't work**." • "**Training** needs to be more **tailored for appropriate levels**." • "We should look at the **SCIE process for more SCRs and possibly an adult safeguarding and DHRs**. That there is no similar national report such as the confidential enquiry for maternal deaths published 3 yearly that could allow more national learning to occur." • "Further work needed on identifying national themes and taking some **accountability** as a Board to ensure this is done

	locally." • "SCR process in whatever form can be effective in disseminating learning and changing practice but depends on who is involved and how process is approached." • "**Politicians are not part of the safeguarding team and they should be**. If children are paramount in society, why don't they get more funding included in the SCR process? SCR is too cumbersome and should be rapid, intense and quick and system based. **Scrap SCR publication. Focus on local learning and national learning which should be thematic and review based**." • "**SCRs should only need to be published in an executive summary**. Resources have a huge impact. Honesty and trust can be at different levels in different organisations. M**edia are detrimental to SCR learning.** More emphasis on safeguarding children." • "SCRs are very costly and maybe not sustainable however the **need for multiagency assessment/reflection/learning is** needed. Importance of **resources** for safeguarding board to continue and to hold organisations to account in relation to safeguarding practice. Potential risks ahead with service cuts across all sectors, so less prevention and early intervention work, could lead to more child deaths or serious injuries." • "Often a very **defensive culture exists** especially after Ofsted inspections. They do nothing to promote learning. Staff criticised, blamed and move on therefore hard to retain staff to do the work."
(Question 5) Any other comments?	Question 5 enabled participants to add further comment to ensure their voice had been heard. • "This was extremely interesting and reiterated to me the **importance of training and effective communication**." • "Able to discuss with health. A document similar to CIAF that we can phone to ask **who are the supporting professionals?**" • "Given working together is a collaborative process in terms of **SCR it requires a consensus that has to be carefully led and managed which essentially is self-regulatory**. The role

	of independence is central to keeping a degree of balance of accountability and fairness. And would benefit from future consideration in terms of the form it takes and the impact it has or could have." • "Major **barriers are around small. Voluntary Community Service organisations** and wider workforce not being involved or having lack of resources to train/develop their workforce. (Often who are voluntary)? **Cuts to training/ staff development also hinder sharing."** • "**Change needs to be positive** not develop fear and management + big shock effect. As said staff want to get in right and are open to positive change in area to find more effective practice." • "I'm happy to **help train any politicians** for those who want it in safeguarding." • "Interesting to have taken part in focus group and look forward to seeing outcomes of the work." • "How about **learning from CDOPs nationally**- have they made a difference and prevented child deaths?" • "**Process must be transparent** in order to engage staff and not hinder the learning. Clarity around the purpose of SCRs and practical dissemination into practice. Better **clarity for all regarding disclosure would be very helpful."** • "Really useful discussions with experienced colleagues- lots to think about in work with my team." • "**Shared multiagency risk assessments**. Develop **training on shared thresholds** and shared language. A very useful discussion" • "**Allocated time** and responsibility needs to be given to allow **productive learning** and effective change to practice." • "Enjoyable. Thank you." • "**Face to face training sessions will improve interagency working."** • This is one of only 2 multi agency forums I have been able to be involved in here in .... (outside of ICPCs) - there should **be more [multi agency forums] for staff and front line managers."** • "How the safeguarding team promote SCRs and the **need for**

	greater understanding of SCR process." • "I kept thinking of the learning/grounding that I got from P....*et al,.* as a Social Work student and well beyond. Is there something from this **comparative text that could be developed again but linked to more recent SCRs?**

CHAPTER 5: INTERIM REPORT REFLECTIONS

Throughout this research participants across the country demonstrated a willingness to consider new approaches to learning from Serious Case Reviews nationally, regionally and locally. They offered unrehearsed information and spoke openly about the professional challenges they face in the current climate of financial cutbacks and policy transitions introduced by the current coalition government. Throughout the focus group events the ICCIP SCR team were welcomed and we made it our business to value and respect their roles, views and concerns. We confirmed our honest desire to learn from their experiences as individuals and the sectors they work in. We assured them we would take back to the DfE their views, key messages, themes and ideas for working more effectively when learning lessons from SCRs.

Although the participants were invited to take part voluntarily through the LSCB Chairs it is quite likely that participants either chose to take part because of personal interest or experience or were enabled by their workplace to take the time to attend.

The first output will add to the body of knowledge and understanding of how SCR lessons learned are embedded in good practice and will provide specific examples of where this has been effective. It is anticipated that the evidence collated will determine whether organisations have the current means to embed policy into practice in light of recent and significant structural changes in different disciplines, agencies and sectors. Analysis of the qualitative data is reported in summary form with examples drawn from direct quotes from the participants but pulled together across all the different data sets to present an overall picture. While there are many disparate and complex messages distilled from the data collected, there are some themes that are common to all the different layers. The main themes revolve around SCR Publications, learning culture and training and systems approach to policy and procedures.

Working in the complex area of safeguarding requires all practitioners to have exceptional skills that are quite often ‘hidden’ in that they are the results of an individual’s values, experiences, training and problem solving attributes that will affect the way they interpret a particular child, young person or family’s circumstances as harmful and whether they perceive referral to be the end of further involvement or a step towards protecting the child and safeguarding the welfare of children and families. The focus group discussions demonstrate how interprofessional, interpersonal and organisational factors in the system are complex and influential on frontline practitioners when making crucial judgements and decisions. Who listens and who acts. Further research is necessary to explore in more detail *how* decisions are made under pressure, particularly at the point of decision making, and *why*.

Limitations of the study

A number of important limitations need to be considered regarding the present study. The most important limitation lies in the fact that the study is relatively small in terms of the number of participating local authorities (four areas in different parts of England), but this was dependent on capacity, timings and funding available. The intention was for in-depth data to be collected, so this justifies the relatively small number of focus groups discussions. However, the Survey Monkey data base, which was characterised by excellent return rate (82.6%), gave the researchers the opportunity to draw on the same issues on a larger scale.

We acknowledge the current study has examined the topic from the perspectives of professionals only, without including parents and children. This is due to the fact that the study was exploratory of certain themes that indicate why lessons learnt from Serious Case Reviews (SCRs) by cross disciplinary professionals have not been embedded in policy and practice and identify insights that may produce a potential action plan for future policy. Therefore the current research was not specifically designed to evaluate factors related to parental involvement and children's voice in the process. This has been recently explored by Morris, Brandon and Tudor (2012).

Additionally, with a small sample size, caution must be applied, as the findings might not be transferable to all SCBs. A reality check was however carried out through the juxtaposition of local data with the outcomes from the Survey Monkey.

Regarding the data collection procedure, although we made sure we created a safe environment for our participants with experienced facilitation and provision of different types of opportunities for input during the process, we remained aware of the group dynamics that develop in situations were different professionals discuss and debate. We attempted to minimise these by having operational and strategic focus group discussions separately. There is also awareness that due to practical limitations, not all FG discussions took place before the summer resulting in the Daniel Pelka's case review emerging before the last discussion. Participants' perceptions had been affected by it and referred to it.

As with any study, bias in the way information is collected and interpreted is inevitable, but the group boasts a multi-disciplinary approach that allows each member to challenge the findings from their point of expertise and bring richness into the data analysis that was always cross checked by at least two members of the research group.

The unseen and the unheard

In common with the work by Sidebotham *et al.,* (2011) several disciplines (mainly health and social work) in this research mentioned the issue of the 'hidden man' of the household who may or may not be a relative. Brandon *et al.* identified in their Biennial

Analysis of Serious Case Reviews (2003 – 2005) that “Apparent or disguised cooperation from parents often prevented or delayed understanding of the severity of harm to the child and cases drifted. Where parents made it difficult for professionals to see children or engineered the focus away from allegations of harm, children went unseen and unheard.” Focus group discussions in this research found that grand parents and siblings are also often left out. According to Sidebotham (2010) Serious Case Reviews, which represent a small proportion of children may not be the best way that individuals, organisations and groups from different disciplines can learn to pre-empt a death.

Conclusion

The Government has set out its vision for the services that should be on offer for parents, children and families in the foundation years. ‘Supporting Families in the Foundation Years’ (Department for Education (DfE) and Department of Health (DH) July 2011) describes the system needed to make the Government's vision a reality and explains the role of commissioners, leaders and practitioners across the range of services for families particularly for younger children. In terms of lessons learned from recent delivery of services in order to reduce poverty, health and education inequalities it is essential to increase and sustain investment and identify where prevention can challenge barriers to successful delivery which often rely on the hidden skills of people working in the children and young people’s workforce.

The information gained from this study can inform and be used to identify and provide examples of good practice and audit procedures for relevant key personnel across different disciplines, professions and agencies including those in the Private, Voluntary, Independent (PVI) and Third sectors.

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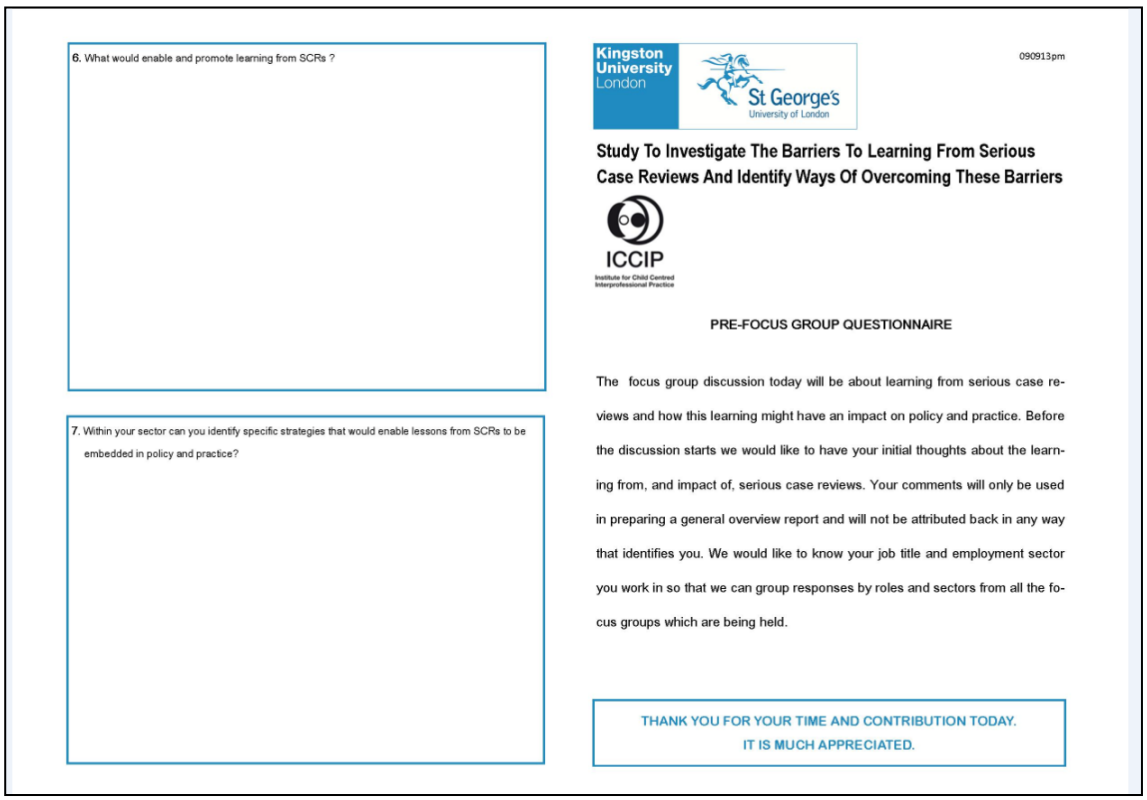
Appendix 1

Pre and Post Questionnaires



6. What would enable and promote learning from SCRs ?

7. Within your sector can you identify specific strategies that would enable lessons from SCRs to be embedded in policy and practice?

Kingston University London

St George's University of London

090913pm

Study To Investigate The Barriers To Learning From Serious Case Reviews And Identify Ways Of Overcoming These Barriers

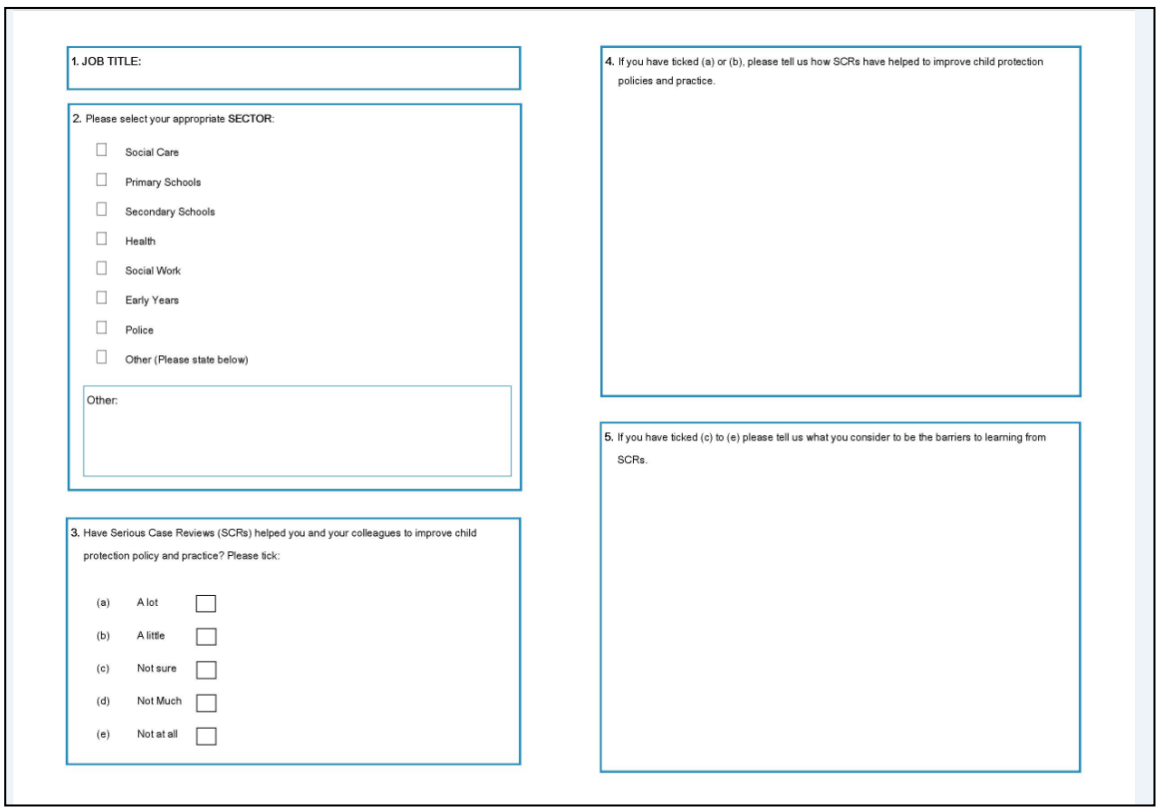
ICCIP

Institute for Child Centred Interprofessional Practice

PRE-FOCUS GROUP QUESTIONNAIRE

The focus group discussion today will be about learning from serious case reviews and how this learning might have an impact on policy and practice. Before the discussion starts we would like to have your initial thoughts about the learning from, and impact of, serious case reviews. Your comments will only be used in preparing a general overview report and will not be attributed back in any way that identifies you. We would like to know your job title and employment sector you work in so that we can group responses by roles and sectors from all the focus groups which are being held.

THANK YOU FOR YOUR TIME AND CONTRIBUTION TODAY.
IT IS MUCH APPRECIATED.



1. JOB TITLE:

2. Please select your appropriate SECTOR:

- ☐ Social Care
- ☐ Primary Schools
- ☐ Secondary Schools
- ☐ Health
- ☐ Social Work
- ☐ Early Years
- ☐ Police
- ☐ Other (Please state below)

Other:

3. Have Serious Case Reviews (SCRs) helped you and your colleagues to improve child protection policy and practice? Please tick:

(a) A lot ☐
(b) A little ☐
(c) Not sure ☐
(d) Not Much ☐
(e) Not at all ☐

4. If you have ticked (a) or (b), please tell us how SCRs have helped to improve child protection policies and practice.

5. If you have ticked (c) to (e) please tell us what you consider to be the barriers to learning from SCRs.

260713am

Study To Investigate The Barriers To Learning From Serious Case Reviews And Identify Ways Of Overcoming These Barriers

ICCIP
Institute for Child Centred Interprofessional Practice

POST-FOCUS GROUP QUESTIONNAIRE

THANK YOU for participating in the focus group discussion. As we noted before, your comments will only be used in preparing a general overview report and will not be attributed back in any way that identifies by roles and agencies from all focus groups which are being held.

THANK YOU FOR YOUR TIME AND CONTRIBUTION TODAY.
IT IS MUCH APPRECIATED.

1. JOB TITLE:

2. Please select your appropriate **SECTOR**:

- ☐ Social Care
- ☐ Primary Schools
- ☐ Secondary Schools
- ☐ Health
- ☐ Social Work
- ☐ Early Years
- ☐ Police
- ☐ Other (Please state below)

Other:

3. Have Serious Case Reviews (SCRs) helped you and your colleagues to improve child protection policy and practice? Please tick:

- (a) A lot ☐
- (b) A little ☐
- (c) Not sure ☐
- (d) Not Much ☐
- (e) Not at all ☐

4. If you have ticked (a) or (b), please tell us how SCRs have helped to improve child protection policies and practice.

5. If you have ticked (c) to (e) please tell us what you consider to be the barriers to learning from SCRs.

Department for Education

Appendix 2

Extended Presentation of the Verbatim Statements of the Focus Groups Participants

Barriers to Learning

A theme which emerged in each of the focus group discussions was about workloads and being very busy which squeezed out the time for learning, to embed learning and to act on the learning. The following quotes are indicative of the responses.

"… there is no time to sometimes reflect on learning or to take in other than team meetings or something or a specific training, it's in tiny brief snaps in supervision." (Focus group A).

"Because of the time pressures and the constraints they say 'If you're lucky you'll get a team briefing, and if you're not you'll get a cascaded email saying this is Child W or whatever and this was the learning from it'. And with the best will in the world a lot of people still don't have enough time because it's one of a million emails that you're getting on a weekly basis so you have a quick look and file it straight away" (Focus group B).

"[The SCR report] does come out so late and everyone's pressure of work. And I think it's very easy to skim over without actually affording the time and giving priority to the time to actually really sit and consider how it does affect our practice" (Focus group C).

"How do you combine the time of a workers from one agency and another so that they can both be in the same place at the same time, and know that they're spending their time well, when they have got umpteen other things to do, is a day-to-day challenge" (Focus group D).

"They don't go out there thinking 'I am going to miss this risk, I am not going to pick up on this threshold', you know, they want to get it right, but actually the demands that are placed upon them, it can sometimes be overwhelming" (Focus group 1).

"… if the same themes are coming through, how do we challenge those things and is it that maybe we don't have enough time to reflect and learn." (Focus group 2).

"I think people are busy [and its] 'Keep your heads down', and we are not actually looking at some of those families to see how well things are working." (Focus group 3).

“It’s very difficult to really focus [workers] in on [SCRs] because of workload. I think the workload is a big problem for us – the amount operationally they have to do and to learn at the same time – it’s a real rub I think” (Focus group 4).

SCRs themselves are seen to add to already busy workloads and that the process of undertaking the SCR becomes the major focus and is itself costly:

“I think from the serious case reviews one of the problems about learning from it is that staff don’t always get to know about the reviews and I think it would be beneficial really for them to have more time out of practice to be able to attend them and learn from them “ (Focus group A).

“So there is something about the way we write a case review, the way we writer those reports, the ways they are shared and I know the member of staff I had who was writing [the IMR], she spent about six weeks kind of totally and utterly focusing on it, you can’t take it away from how big they can be and the impact on your own work.” (Focus group 1).

“[An SCR] has incredible resource implications and takes an incredible amount of time … just the case review process on one case takes hours and weeks of time” (Focus group 1).

“We [a police force that covers several local authority areas] have a team that do nothing but write IMRs [individual management reviews].” (Focus group 2).

“I think … we spend a lot of time in terms of presenting the overview report, and not enough time in terms of how we are going to deliver and present the findings to frontline staff in our own constituent agencies.” (Focus group 3).

“Well, I think I am going to say the first heretical thing here. I think the whole serious case review process is hugely cumbersome. I think it’s far too cumbersome, and the outcome for a serious case review is also cumbersome, most of the time.” (Focus group 4).

“And that’s a simple balance between [name of staff member] getting on and doing the day job and then being taken out for dozens of hours in the course of the next six months to focus on the death of one child, which is entirely an appropriate thing to learn from, but in that way frankly people feel driven to [do the SCR] rather than motivated to learn” (Focus group 4).

The processes and outputs of SCRs are also seen as not necessarily helpful, and especially the overwhelming numbers of recommendations they often generate and the consequent new procedures:

“I think people need to understand why policies and procedures have changed … We do get very much fixed into ‘We are doing this now’ but it’s the understanding of why we’re doing that” (Focus group B).

"You might have somebody quite high up who has taken all the measures on board and are re-writing the policy and re-write the procedure without actually asking the person who is the front-line worker in practicality what would work" (Focus group B).

"I'd say you are unlikely to read a 150 page report unless it's specifically in your job … we just don't have the time" (Focus group B).

"I think sometimes maybe [recommendations] are just sort of put there for the sake of putting them in there, which then makes it a lot of work and it might not necessarily make that much difference" (Focus group B).

"When they make the recommendations there's loads of them so it becomes almost unmanageable" (Focus group B).

"Being responsible for managing a service that was implicated in a serious case review, it was more about making sure that we were ticking the boxes and responding and kind of making sure that was done rather than probably unpicking some of …'Well how could we have done this better?'" (Focus group B).

"I think for me it's the length of the serious case review process because the experience is that if you start a serious case review it might finish 12, 18, 24 months later, by which time actually we have lost all our staff … all the staff who were involved will have gone … but it has a [negative] impact on what is going on and that's the general process, it's not a quick process and you have got a smaller chance for any learning to come from it" (Focus group C).

"Unless you have got an organisation that is truly a learning organisation and it's got a learning culture, I don't think that embed the learning … You might introduce a bit of training here or might introduce a policy or procedure there but it doesn't really soak in and permeate because we don't have a learning culture to start with" (Focus group C).

"We are at a risk through the lessons of serious case reviews of asking practitioners to do specific things when actually we don't want them to have a list of a hundred and odd questions to ask in an assessment when actually what we want the good quality practitioners who will ask the right questions and draw out the salient pints in a particular case or family they're dealing with or with the child they are concerned about" (Focus group D).

" We can always develop new procedures, but there's a limit to what new procedures can achieve …actually most practitioners have a code of practice, a professional practice, and we need to appeal to that and to their sense of being professional and being able to deploy their judgement with confidence." (Focus group 2).

A major concern expressed with strength by many participants in these four focus groups was about the stance of the media and the 'blame culture' and how this was now fed by the contentious requirement that reports be published in full, and

how this may now be having a presumably unintended consequence of promoting defensiveness:

“I suppose what I mean is in terms of people kind of withdrawing into their own organisation or defending or you know what I mean. Just kind of looking at it from the blame point of view” (Focus group B).

“It’s getting a balance between accountability and not having staff in fear of admitting that they are struggling or don’t understand something” (Focus group C).

“I know we are talking about learning, but it feels like blame to people working, like ‘You should have done something differently, this is your fault” (Focus group C).

“The blame or whose fault it was might be distracting from some of the reflection” (Focus group D).

“It’s the people that are in government, our local authorities, we are fearful of the media, there’s the repercussions isn’t it? I think that’s the fear” (Focus group D).

“It’s not put in context that this happens so rarely that we need to know why because we don’t want it to happen again even this often, but this is not what we get is it from the media representation or the headlines? We get ‘It’s the professionals that have made mistakes, not the people who have seriously injured or killed a child’, so it is the national … the context isn’t it?” (Focus group D).

“You see I think it is two conflicting problems in what we are trying to improve is professional behaviour, so we are actually kind of saying ‘We do know when things go well why they go well and we want all professionals to be functioning at a better level, and then we also have an accountability structure where, to be honest, that is then about blame … These two things I think are absolutely counterproductive and if the two are mixed both happen very badly because you get the lack of transparency which you can’t get any accountability and can certainly deflate all learning because of fear, so I think we have to be really clear on this” (Focus group 1).

“ At the last LSCB meeting something was talked about the legislation changing … and things not being anonymised and made public, and there was some concern that it might stop people actually taking part in a review.” (Focus group 3).

There were also comments about the impact of cuts and organisational change:

“I think it is very difficult for health visitors because their caseloads are so large, you know, they don’t have … even 15 years ago people would have known probably all the families on their caseload but now where we’re working a corporate caseload, you don’t have that same individual knowledge of the families and you know, you get a one-off referral [to have contact with a family]” (Focus group D).

“You can’t do the work of six [workers] when you’ve only got three” (Focus group D).

“I am just concerned that the way various organisations are changing doesn’t help. We’re going to end up more competitive and less collaborative ... It’s never been brilliant and it’s going to get worse is my worry” (Focus group 1).

“I am concerned about the impact of all the changes that are going on and staff morale is a major issue” (Focus group 1).

“I am very aware that staff on the ground have experienced what we are going to call cost efficiencies ... and suddenly the whole partnership has gone” (Focus group 1).

“As an organisation we are shrinking constantly ... we have a limited capacity to attend training ... it’s just not physically possible” (Focus group 4).

“The last element is that the government doesn’t get the size of the problem. The NSCPCC wrote a policy document about the back end of last year and they made it very clear from their statistical analysis of interviews they had done that for every child that is currently under a child protection plan, there are eight that should be, and they estimate that the cost to the country in just doing that alone properly was at least half a billion pounds ... So another systemic theme is ‘Please politicians wake up and spend more money on the resources because that’s why we keep discovering the same problems in the serious case reviews” (Focus group 4).

There were also comments about the inevitable complexity of child protection work and that this was not necessarily acknowledged within or informing serious case reviews:

“We have been too driven by process actually and I think some free thinking can be really helpful because often people do not fit into boxes so families need to … you know, it’s a dynamic focus working with families” (Focus group C).

“Because there’s actually too much information and something quite crucial, the theme all the way throughout got missed completely because everything else just overloaded all the professionals involved” (Focus group C).

“For me there’s an issue about the complexity of these cases and where the focus lies … you are working with a family and there may be some multi-layered issues” (Focus group D).

“I think we maybe need to be mindful of the support that staff from all areas need around having those difficult conversations that can be very challenging and not just from really difficult families, but from articulate families who know how to put arguments forward” (Focus group D).

"In a dynamic situation where it's all about individuals and relationships it's much harder to make people do things differently all the time, because each situation is so different" (Focus group 1).

"I think it's sometimes easier when you can make procedures very precise to make it safer so that people make less mistakes (you know, to use that word), but it is much harder when you are in someone's house and you are talking to human beings who behave differently or are unpredictable, so I think it's about trying to create a kind of culture where we understand this is about human factors and it's about how people relate to each other, and how people make judgements and what kind of evidence they use to formulate those judgements" (Focus group 1).

"I think what we have found is in some very complex cases where you have got very challenging parents, it's even more difficult because [it is difficult] to get past the parents to try to speak to the child" (Focus group 2).

I think it is not a quick fix and it's not necessarily about serious case reviews, it's about the culture within this country that is different in other countries, and about the way children are seen and safeguarding by – how that really is everybody's responsibility rather than a little tune we sort of trot out from time-to-time. So I don't think tinkering with serious case reviews is going to actually make something fundamentally different" (Focus group 4).

There were also comments that the same issues keep being identified in serious case reviews and that people become immune from the impact of the SCR findings:

"You kind of read a serious case review and think 'Oh gosh, here we go again, another failure in information sharing' and we keep saying to each other 'It's always information sharing or it's whatever', but then we don't really do an awful lot about it" (Focus group B).

"But I think we sadly do the same thing, the same messages come out time and time again about communication and things like that so yeah, I don't think there has been any movement really" (Focus group C).

"We have become almost completely desensitised in terms of some of these issues because they are repeated. Every time we sit down and have a conversation for a serious case review, we come to a set of quite well-rehearsed conclusions. I just wonder whether we have just become desensitised in the sense that expect them to be there, because if we were to create the sort of Top 10 nationally and locally in terms of things that are always in action plans, they would be very familiar, we could all probably do it now if we went around the room" (Focus group 3).

“There are some core things that sort of flow through those lessons every time that you can always come up with before you have even written it and they’re much harder to change because they’re really big systemic national things” (Focus group 3).

“I think the national issues as we know are constantly repeated in serious case reviews all over the country so [the lessons from a SCR] are not unique” (Focus group 3).

“I spoke to the independent author and said ‘Have you done a number of these?’. He said ‘Oh, only 50’, and I said ‘That’s interesting, is there any theme?’. He said ‘Sometimes you can just change the names’ and I thought that’s such a damnation of the whole process because they cost a big … thousands and thousands of pounds I would think if you take all the senior leadership time that has to go into doing it, it takes six months to do by which time – and I don’t mean to be disrespectful of the dead – but everybody has moved on” (Focus group 4).

“[SCR findings] are where they have been for 10 years, still, and they’re not any less ponderous, nothing has fundamentally changed because we are bashing against the same barriers which are information sharing, complexity …” (Focus group 4).

Issues were also raised about the local barriers to learning from reviews nationally:

“We do keep feedback but it’s more for the kind of ones that have hit the press” (Focus group A).

“But I look at the local ones because that’s on our intranet and they’re on there, so you can easily look at those. I see a headline and I think ‘Oh that seems interesting’ then I will Google it and find it that way, but unless you know it exists you’re not going to find it. So I would be prompted to … or sent the link to be able to look at the national ones of relevance, or at least the themes that come out that are brought together every two years” (Focus group B).

“I really feel they should be published on a regional basis” (Focus group B).

“Except I would say the learning is pretty national, isn’t it? We might learn certain things locally but there are common themes aren’t there nationally that you sort of take with you? I am just not sure how aware even I am, but that most people are, of what the learning, the sort of key learning points are” (Focus group C).

“[Learning from SCRs elsewhere] is not consistent, you know it is those that are high profile that somebody recognises there could be some learning – it’s not systematic” (Focus group 2).

“But I think there’s a big role isn’t there that the media plays, and the attention of politicians for certain subjects …but it’s all ad hoc isn’t it. You might learn something

which is very relevant to the rest of the country but whether that will be transmitted to the rest of the country is all ad hoc, there is no structure" (Focus group 3).

"You might get the learning locally, but having an impact nationally when you have got an inbox tray that's like that anyway, and that simple email message about please remember to make sure you talk to the doctors and nurses properly when you have got to … it won't get there" (Focus group 4).

Enablers to Learning

Some of the enablers were about changing the SCR process itself, including simplifying and speeding up the review process.

"I think there is something about the timing of the learning as well as the messages which come out and certainly … I feel there must be an optimum time for messages to come out in terms of if they come out too soon I think people would still be very emotional and it would be quite emotive in terms of the case, but I also think that sometimes by the time messages come out, it's so long after the event that it doesn't feel relevant anymore" (Focus group 1).

"You know, sometimes reviews can go on and on and necessarily there is a timescale with it, but I think if we can get prompt feedback to staff who have been involved and get lessons out there quickly, then that's really going to embed learning" (Focus group 3).

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Numerous comments were made about what we often described as the 'SCIE' [Social Care Institute for Excellence] systems model of reviews, although very recent and still rare and not necessarily used in its full form, being more constructive than the long-standing traditional model based on IMRs [individual management reviews] feeding an overview report:

"And because that [SCIE] process includes practitioners more than just writing an IMR, you know, you have got to have focus groups as part of the review, then it should be easier to identify and get over some of those hurdles and make it more meaningful, and then of course that would cascade downwards through the process by having multi-agency case reviews, where you have a learning event to discuss what happened and

propagate, well, you know, this is what happened, this is what frontline practitioners have said, and this is what we're going to do about it" (Focus group B).

"The ease of using the system's approach where you are having frontline practitioners in a multi-agency group, focus group, where you can identify certain parts, key themes, areas that … where things could have changed- that was far more beneficial and the end product was a lot better learning, and a lot better vehicle for learning" (Focus group B).

"We looked at the case through the SCIE model which was hard work doing it alongside the serious case review but we looked at the case and we used a different approach and staff comment still that that felt less accusatory, it felt less as if you were on trial" (Focus group 2).

"The most recent case we reviewed we used the multi-agency learning again so we had practitioners and managers actually looking at the case and looking at the timeline and reflecting on it. That's been a lot more positive from the practitioners' perspective, being able to reflect with the other workers in that case" (Focus group 2).

"I think that's where the SCIE methodology will change that because there's much more ownership … we looked at a recent case and had all the workers in the room together and there was a lot more ownership around forming those actions and that was really powerful actually, really powerful" (Focus group 3).

"Having done two of those [SCIE] reviews I am a real convert to them because they do actually make really substantive evidence to lift the blame culture, to talk about systems and structures, and I felt we were indulging in something which was going to have real benefits because we were looking at things we could do at senior level, changing systems, not worrying about bombing the frontline staff" (Focus group 4).

In particular, the engagement of frontline practitioners throughout the review process is seen as important:

"I think the problem was sometimes, isn't it, that you go to that and you're at a certain management level, but it's the people on the front line who don't do it – they don't get to go to [the events] " (Focus group A).

"For me this is the first time I have got together in a long time with people who are all involved in the work that we do, and also I'd like to get together more with people that are frontline, you know, and have these discussions" (Focus group B).

"So when you're implementing changes for policies and procedures, if you had like a little task group that was frontline workers from the different agencies who could say 'That would work, that wouldn't work … I think that would be a much better way of doing it and then the frontline staff could disseminate it to their colleagues who are aware of pressures and time and how that would work. I think it just needs looking at it from kind of the bottom up rather than somebody at a higher level writing a policy" (Focus group B).

"And I think it's about the policy writers listening [to frontline workers}. You know, like the case you brought, you know, yes we're told to share this information, you know, but when there are problems with that, that needs … there needs to be a system of feeding that back, back up" (Focus group B).

"You know, sometimes I don't know what some of my managers look like and they're reviewing our service and I keep thinking I wish they would come and just come with me for a morning and see what we actually do" (Focus group B).

"I think for me serious case reviews, they don't come down to my level of staff. I am not a person who gets the policies and procedures and I don't really know why they are being instigated. I am assuming it's because something has happened and it's been decided we are doing stuff in a different way, but it's just told to us … It would be good to know why you are doing something – I think that would help" (Focus group C).

"If we are going to prioritise [learning from SCRs] we have got to feel that it's useful for our practice to do so" (Focus group C).

"What is missing from the serious case reviews is that I never have a conversation when somebody is challenging me and saying 'So what are you going to do differently in your practice'" (Focus group C).

"How do you get feedback from the frontline staff as to whether they can implement that in practice? And to some extent if you adopt models as we did for the most recent review, we did involve that group of practitioners in thinking through the recommendations as well as looking at the case, and probably it's something that we need to consider more" (Focus group 2).

"I am not sure when we develop our action plans whether we actually involve the frontline practitioners in asking them, 'This is what needs to change, what do you as a frontline practitioner need to do, or how do we support you to realise that change?', and very often it's about re-writing a policy or reviewing a policy, but actually we don't ask them what would really impact on their practice, so just changing a policy ticks a box bit it doesn't always change their practice" (Focus group 3).

"We are quite weak in terms of the Safeguarding Board, in terms of bridging the gap between the strategic forum and frontline staff and frontline learning. It is really about how do you bring alive those national issues and make sure they're integrated into our practice and our training development programmes" (Focus group 3).

"With the systems methodology they were part of helping us do the report as well so they contributed to that bit too. So I think they did feel they owned it more than they had before" (Focus group 4).

Making the review reports and recommendations 'smarter' in terms of highlighting (fewer) key themes was also seen as potentially positive:

“The recommendations could be prioritised – not prioritised time-wise, I don’t mean that, they have all got to be followed, but which are the most … if there is a stronger element to one” (Focus group B).

“May be the Board itself needs to just identify key themes” (Focus group B).

“Get the right people around the table and be sensible about your action plan, but then creative and how you are going to deliver it” (Focus group D).

“There’s a real danger that this industry that we’re in makes things which are complex, perpetuates complexity and actually for me a lot of it is cutting through and saying ‘Well actually there are some golden rules, there’s some basics – it doesn’t matter what agency you work in – I want to know that you are confident and that your workforce knows the basics like see the child on their own, and think about what you have just dealt with” (Focus group 1).

“The brief that’s given to independent authors is not good enough frankly, that actually what you want your independent authors to say is ‘Well right, now what are the key themes” (Focus group 1).

“I think a positive from the SCIE serious case review methodology was that it clearly allowed us at the very end of that process to sort of distil some of those themes, some of those issues. I think we were far more selective in terms of what we carried forward from the serious case review into an action plan” (Focus group 3).

“The more issues and concerns that are affected in action plans, the less likely they are to have any impact whatsoever … It’s really how we can I think improve the impact in terms of being more precise, in terms of those concerns and issues” (Focus group 3).”

A major enabler in terms of learning from serious case reviews was seen to be training provided by LSCBs and also within agencies. But this was not simple and straightforward. First the training needed to be strategically led, targeted and differentiated to both different professions and workers and, secondly, to different organisations, and it had to be made relevant and meaningful to those receiving the training:

“It was a multiagency group about lessons learnt from a serious case review and we had obviously had all the agencies there and it was really good but then what I think would be really good is to then … The lessons that you learn from that needs to be brought down to your agency, so everyone is really clear like what changes we have to do in health or whatever, so that it’s really clear” (Focus group A).

“It’s just how you can put a training package together and who needs that training because it’s not always … not everybody within each role needs a certain element of training, you know, we specialise” (Focus group A).

"So for me, I personally think the best way … is to have some sort of multiagency learning event – not only involving practitioners as a debrief who were involved in that review, but to have regular scheduled ones so that you can propagate – not only the learning from your area but any serious case reviews within say the north west coast of the UK because let's face it, the main, the current themes that run through most of the serious case reviews that I see are roughly the same" (Focus group B).

"We need to come together as multi-agencies and sort these things out together, but I think to each agency, what the lessons are of the learning, it has to be meaningful to you in that agency and how it's going to affect practice" (Focus group B).

"How the tiers at a serious case review work – you have got like a national level, then there's even a strategic level at sort of a local authority – you know, it's like the police, a very senior level in health – but then there's a ground level as well, like you are saying, with parents and the frontline practitioners, is how does that information sharing get done in a way that's appropriate to all the next tiers?" (Focus group D).

"People can attend training and we can raise awareness, but do we actually provide people with the skills to challenge and to do the job" (Focus group 2).

"[Within schools] critically the head and the senior management team are the target audience [for learning form SCRs], but then there are responsibilities because there are other people within schools who have specific roles who need … and that's where CPD [continuous professional development] comes in" (Focus group 3).

There were, however, comments about the capacity to deliver and to receive training for large and busy workforces, so another enabler was having the capacity and time for the training to take place:

"It needs to be timetabled. It's awful but it's the reality. And then it's good because you get a discussion about your service with colleagues and you can discuss it and say why it's been implemented, and you can talk about the constraints and ways around it as a professional group" (Focus group B).

"I think there was an issue about you can't train every single person so there is some cascading there" (Focus group 1).

"At the end of the day the Board has a limited capacity presently to say 'Well actually you really didn't do that as well as you could have done, you know, you only put 30% of your workforce into the refresher training" (Focus group 1).

And a third factor related to training was to also use it as an opportunity for multi-professional learning and development:

"The move away from taught courses and learning to e-learning, you remove all that networking" (Focus group C).

“So I think this sort of forum and multiagency training is great but it doesn’t seem to happen enough, and I think we need to ensure that we have got a similar understanding of our prospective roles and again, that might be something that’s really strained in these current hard times, but I think it’s important to promote that multiagency/ interagency understanding” (Focus group D).

“The most recent case we reviewed we used multi-agency learning again so we had practitioners and managers actually looking at the case and looking at the timeline and reflecting on it” (Focus group 2).

“[We have a] practitioners forum … which is again another mechanism in terms of actually hearing the voice, the views of the practitioner and multi-agency and then using that in terms of implementing any changes” (Focus group 2).

“You look at the workshops, I think all the strategies of the workshops, you get all the agencies together, and rather than me take that back into my own agency, very insular, to have them actually working together is fantastic, but try to spread that over a large geographical area, that’s the difficulty” (Focus group 3).

There were also comments arguing for a national collation and synthesis of the learning from SCRs and with themed reports to be published (but also note the comment below about case stories making it more memorable):

“I think it would be helpful to know where to get it in an easy way, you know, if there is a place where you could have … or even, I don’t know, and I suppose somebody would have to do this somewhere, but kind of themes that were relevant, and then you could draw down what kind of things have gone on within a certain theme, you don’t know because it’s so big, who else might be doing it” (Focus group B).

“I think from my experience what people remember is that sort of human story, the like case histories, you know, rather than just saying these are … you know, we looked at 450 serious case reviews and these were the main themes that came out of all of them. I think it’s important to capture that as well, but what people go away and remember from training or some sort of feedback is an actual case history where they can visualise what that family was like and what it was, you know, and what the learning is from that … It makes it stick in your head more” (Focus group B).

“There isn’t a sort of a database is there or a kind of, you know, place where you can go and just … a central type of portal that you can kind of look at where all this is and you almost need it to be a whole national unit almost that’s giving out these kind of messages, key messages” (Focus group C).

“I am thinking of HMI of Probation who come in an inspect YOTs. They have got thematic inspections, and they have released a document around some of the general learning from specific thematics and I am wondering whether there is some scope for doing something like that around a serious case review” (Focus group 3).

But there was a concern that more attention needed to be given to organisational culture and creating learning organisations, embedding learning and changes in practice and auditing that this is taking place:

"It's all very well if you are under a Notice of Improvement [to say] 'Well we have done X,Y and Z', 'Well this is more training, you have done a policy which everybody has read, you have done e-learning, you have done this, you can instantly prove that x per cent of the workforce have done this. Whether you can prove they have changed their practice or not is another matter and actually is that follow-up ever done and how do you evidence that … Developing professionalism is a more long-term thing and it's about a learning organisation and doing things differently, that isn't easy to prove and it takes a sort of bravery on the part of everybody …we know we might get into trouble for it, but let's just see where this is going, and it also links with being supportive right the way up through the organisation" (Focus group C).

"I have been involved in multiagency training. I have been involved in delivering messages from management reviews and serious case reviews and when you're sitting around doing the scenarios it definitely influences people at that moment, but it's how you get the assurance that it will carry on influencing them … I don't know where it goes and I don't know how you do that evaluation in 3 months, 6 months, 12 months to ensure that it's still embedded" (Focus group 1).

"Those changes to practice should be embedded forever and what we tend to do is we do things right for a little while because we have just had a serious case review but then it slips back" (Focus group 2).

"… and also in terms of sort of checking on the impact of that training, so we are now putting in a mechanism in terms of … six months later we are going to be checking whether that is actually making a difference than just a one-off" (Focus group 2).

"We can try and find a way of getting the messages out which makes real sense to everybody, and do some testing!" (Focus group 4).

And the importance of impact at the frontline, partly through frontline managers and their supervision of practitioners, was stressed, although it was noted this is not consistent or embedded in all agencies:

"We do it [learning from SCRs] is our safeguarding supervision" (Focus group A).

"That way we do the multidisciplinary clinical meetings is always ask the same questions about children and child protection [and in] the safeguarding supervision … it's taken a huge amount of time to embed it" (Focus group A).

"I think when there is a serious case review, that that information should be disseminated to all the workers in the Trust really and people should be able to learn about the review so that they can reflect on their own practice and learn from it" (Focus group A).

“The bit that we’re missing looking at the solutions I think needs to involve those practitioners who are doing it day-by-day, so that they have to take ownership \of that” (Focus group B).

“In some ways we almost need our workforce to be brave as well and sometimes takes risk, and actually for our managers to support that, and that can be done obviously with really effective reflective supervision” (Focus group C).

“If you’re having regular supervision you’ll feel empowered to work well [professionally]” (Focus group C).

“I think the support for … to managers/supervisors in working with their staff and being able to recognise where there are barriers to our working, effective working, is really important because I think there is the emotional thing that comes along for staff who are working directly with parents and young people and other professionals, and that’s been my experience” (Focus group D).

“Make sure that [practitioners] have the confidence/ resources to manage those difficult conversations [with families] and also take it back for supervision” (Focus group D).

“What I would like you take back is that you can just value actually reflection and the work we do on the frontline, and the time that it takes to do that as well, because I think that goes against us sometimes organisationally” (Focus group 1).

“I think senior managers need to know [the lessons from SCRs] but clearly the first line manager, the practice manager, they’re the ones who actually see the day-to-day, they’re the key driver but obviously they need to know as well in terms of where [the lessons are] coming from” (Focus group 2).

“The odd thing is schools might have the least involvement in a serious case review but actually have the most contact with the children involved … Well I suspect if you ask, if you said to them ‘What is a serious case review, most people in the school probably wouldn’t know to be honest” (Focus group 2)

“And constantly in reviews and recommendations, people are saying ‘Well why didn’t the GPs pass on the information?’ but actually they have no idea, they’re not part of the process where people go, they have no one they can hand the information to” (Focus group 3).

And although, as noted above in paragraph 6, more procedures were not necessarily helpful there were also comments about how policy and procedural change had been positive:

“We had a case where [the SCR] did affect policy and pathways, and from that serious case review it did alter the way we practised as health visitors. They developed a policy

so that we knew exactly what we had to follow, that's the pathway isn't it?" (Focus group A).

There were comments that some services and workers were less, if at all involved, in learning and having the means to learn from serious case reviews and that this should be addressed:

"If there is a serious case review get it disseminated out to everybody and I know the Trust is really good at like, you know, everybody being informed … but those voluntary agencies on the outside of the statutory mechanism it doesn't happen for them" (Focus group A).

"I work in schools and I work with a lot of teachers and each school has their own safeguarding teacher, and it's very hit and miss as to who knows what" (Focus group B).

"The recommendations that are relevant to an ambulance service are probably few and far between" (Focus group C).

"I think there's a huge part of the workforce who still aren't in it and don't actually frame what they do in terms of safeguarding and protecting children, so when you're actually trying to get the messages of the learning out to parts of the workforce who don't ever see themselves as a part of this agenda in the first place, you have got … you have sort of double challenges really … I think it's pertinent in the VCS [voluntary and community sectors]" (Focus group 1).

"I think there is work to be done around designated teachers … I can never understand why education didn't adopt the same as health in as much as they have got named professionals for safeguarding" (Focus group 2)

Department for Education

Reference: DFE- RR340

ISBN: 978-1-78105-398-0

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

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