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Evaluation of the Significant Incident Learning Process (SILP) for undertaking Case Reviews

Executive Summary

Dr. Siobhan E. Laird

Centre for Social Work

University of Nottingham

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Policy Context

HM Government (2013:65) replicated in the current HM Government (2015) policy guidance requires each Local Safeguarding Children Board (LSCB), the body responsible for overseeing multiagency cooperation, to protect children at a local level and to implement a local *learning and improvement framework.* This framework must ensure that when a child who is known to social care or other key public sector agencies dies or is seriously injured there is 'a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children'. This is achieved through the mandatory commission of a Serious Case Review (SCR) by the LSCB to examine the circumstances surrounding a child's death or grave injury.

Munro (2010), drawing on innovations in the field of health care, proposed that a systems approach be adopted to Serious Case Reviews as this explores not only what happened and why, but seeks to understand how professional decisions and actions are influenced by policies, procedures, practices and cultures. Vincent (2004:242) avers that this method of case reviewing acts 'as a "window" on the system', revealing how ostensibly disparate parts of a system interact with each other to shape both good and poor frontline practice. A systems approach recognises that the standard of professional practice is influenced not only by their competence or capability, but also by the nature of the tasks they perform, the tools to support them (such as assessment formats or data sharing procedures) and the environment in which they operate (Institute of Medicine, 1999:2). It therefore examines the whole context in which professionals make decisions and take action and how different aspects of this context facilitate or constrain effective professional judgement and practice.

The Significant Incident Learning Process

Review Consulting, a private sector organisation, has designed a systems methodology of case reviewing predicated on the approach advocated by the Munro Report (2010) known as the Significant Incident Learning Process (SILP). Originally developed by Paul Tudor, an independent safeguarding adviser, and Leicestershire & Rutland LSCB, SILP is delivered by Review Consulting, which to date has conducted almost 100 case reviews utilizing the SILP model commissioned by many LSCBs in England (see http://www.reviewconsulting.co.uk/). SILP is a whole systems approach which: directly hears the voice of frontline practitioners involved in critical events; examines how their interaction with different workplace systems affects understanding, decision-making and action; and explores how these different systems interact across agency boundaries. SILP is also designed to be less resource intensive in relation to case reviewing compared to more traditional approaches (for a description of traditional models of case reviewing see http://www.cheshirewestlscb.org.uk/?page_id=142).

Terms of Reference

During 2014 a Local Safeguarding Children's Board commissioned from Review Consulting a Significant Incident Learning Process (SILP) for a case review in respect of events surrounding the death of a care leaver. This was not a Serious Case Review. However policy guidance set out in HM Government (2013:67) *Working Together to Safeguard Children,* and latterly HM Government (2015), requires all formal case reviews concerning the death or serious injury of a child known to social services to meet the same criteria as those applied to Serious Case Reviews. Moreover, Review Consulting has already conducted a number of Serious Case Reviews employing the SILP approach.

Dr. Siobhan Laird, assistant professor at the Centre for Social Work at the University of Nottingham, was asked by Review Consulting to undertake an independent evaluation of their SILP review already commissioned by a Local Safeguarding Children's Board in relation to the criteria for case reviews set out in HM Government (2013) *Working Together*, best practices identified by Rawlings et al. (2014) *Barriers to Learning* and the requirements for Overview Reports identified by the National Panel of Independent Experts on Serious Case Reviews (2014) *First Annual Report.* Since this independent evaluation was commissioned the government issued a further revision to *Working Together*. However, HM Government (2015:74) issued under section 7 of the Local Authority Social Services Act 1970, which is now current statutory policy guidance, replicates the criteria for Serious Case Reviews set out in HM Government (2013:67) and therefore this independent evaluation remains germane to the current policy context.

Methodology

This case review involved thirteen different agencies from across several local authority areas, including the police, education, children's services, mental health services, adult services, probation, prisons and housing with 31 professionals attending the Learning Event and 25 the Recall Day. The table below sets out the criteria against which the SILP was evaluated.

Table of Evaluation Criteria

Barriers to Learning	Working Together	National Panel of Experts Report
• less resource demanding, more timely, and more engaging of frontline practitioners • more succinct and shorter • promote learning rather than blame	• Recognises the complex circumstances in which professionals work together to safeguard children • Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did	• A sharp focus on what caused something to happen and how it can be prevented from happening again • A concise account of critical points in the management of a case

• promote reflection and analysis • Key themes and learning identified within the reports and highlighted locally and nationally.	• Seeks to understand practice from the viewpoint of the individuals and organisations involved • Is transparent about the way data is collected and analysed • Makes use of relevant research and case evidence to inform the findings	• A detailed analysis of what went wrong and why • Clear learning points and recommendations that are addressed to named people or organisations • A focus on what the lessons should be for the services concerned • Prepared to highlight relevant failings and good practice and policy at all levels

The table below sets out the methods adopted at each stage of the SILP process and the use of comparative data from Serious Case Reviews held on the NSPCC archive. Confidentiality was a prime consideration in this independent evaluation, as it concerned highly sensitive information regarding child protection matters and inter-agency relationships. For this reason minimal detail of the subject matter of the case review is discussed in this evaluation. All necessary consents were obtained and the research design received ethical approval from the University of Nottingham.

Table of research methodology

SILP Stages	Method of Data Gathering
Learning Event	• Observation of face-to-face element of learning event • Textual analysis of digitally mediated exchanges • Telephone semi-structured interviews with a purposive sample of participants • Telephone semi-structured interview with facilitator of learning event
Recall Day	• Observation of recall day • Telephone semi-structured interviews with a purposive sample of participants • Telephone semi-structured interview with facilitator of learning event
Production of final Overview Report by the independent consultant	• Semi-structured interview with author of Overview Report • Textual analysis of Overview Report
Data analysis	• Evaluation of SILP processes and Overview Report against criteria
Comparative measures	• Comparison of timescales for conventional Serious Case Reviews against SILP

Findings Regarding the SILP Process

More engagement of frontline practitioners: involves their presence at a multi-agency forum to discuss events surrounding a child's death or serious injury, but also in a format which actively supports practitioners to reflect on events and articulate their perspective. How they are prepared, encouraged and facilitated to contribute to a case review is crucial to their actual engagement with it. Both the Learning Event and the Recall Day were attended by safeguarding leads, Agency Report writers (predominantly frontline managers) and practitioners from agencies which had worked with the young person. The sense of exposure induced by a relatively large group of 25-30 people attending the Learning Event and Recall Day combined with sensitivities around the young person's death generated high levels of anxiety at the outset. Participants were put at ease by the SILP trained lead reviewer facilitating, who explained the SILP systems methodology, foregrounding its emphases on learning rather than blame and providing reassurance to the apprehensive.

The lead reviewer also encouraged candid discussion concerning events and contentious issues, probed contradictions and identified action points for the retrieval of missing information. Throughout they held the meeting to task, preventing interruptions which side-tracked deliberations and exploring specific issues in detail. The preceding scoping period was used to identify any highly contentious issues between agencies which were at the Learning Event and Recall Day then addressed via the lead reviewer/chair in order to avoid defensive confrontation in an already emotionally charged atmosphere. The fact that most professionals attending case reviews are familiar with multiagency forums meant that this approach worked effectively to extract, explore and synthesise information despite the large gathering. It was however a setting in which professionals from some agencies contributed more vocally than others. There was a high degree of consensus that the Learning Event and Recall Day constituted emotionally safe environments and that the SILP process encouraged and promoted the engagement of frontline professionals. One drawback was some discontinuity in the professionals attending the two meetings, which meant additional effort to re-create the safe environment achieved during the initial Learning Event.

Transparent about the way data is collected and analysed & *Seeks to understand practice from the viewpoint of the individuals and organisations involved:* At the outset each agency was required to commission an appropriate frontline manager to produce an Agency Report setting out their organisation's involvement with the young person. All those attending the Learning Event had either contributed to their own agency's report or read a final version of it. They had also read those of all the other agencies involved in the case review. While a number of attendees alluded to some quite challenging messages in other agency reports or facts or views with which they disagreed, they thought that the round table discussion during the Learning Event had enabled them to listen to other perspectives, seek clarification and articulate disagreement. As noted by Morris et al (2012) elsewhere the introduction of the family voice during the Learning Event heightened emotions and caused some discomfort. The draft Overview Report was circulated to professionals prior to the Recall Day where open discussion invited further comment resulting in some minor amendments on production

of the final Overview Report. During both multiagency forums the lead reviewer chairing facilitated the emergence of points of contention and disagreement between agencies and individuals, while preventing these from becoming unproductive exchanges of claim and counter-claim. There was consensus that the SILP process produced an Overview Report which reflected the experiences and views of those nearest to events.

Recognises the complex circumstances in which professionals work together to safeguard children: Thirteen different agencies were involved in the case review reflecting the web of multi-agency involvement with the young person. All the evidence gathered by the evaluation testifies to the efficacy of the SILP model in investigating complexity, particularly in relation to multi-agency interfaces. The Learning Event was extremely effective in uncovering the web of inter-related causes and factors which culminated in a young person's death. Attendees recounted the many insights into the interdependent systemic and individual aspects involved in work with the young person.

Promotes reflection and analysis: The requirement for frontline managers to produce Agency Reports, which many attendees had contributed to, meant that professionals came to the Learning Event with a high degree of thoughtfulness surrounding the events leading up to the young person's death. Further reflection and analysis was aided by the prior circulation of all the Agency Reports to each attendee so that they could view all the information and perspectives of every agency involved. The high degree of preparation of attendees for reflective and analytical engagement meant that the facilitating lead reviewer was then able to capitalise on this using four critical episodes as starting points for a series of specific questions. These culminated in wider enquiries into the operation of services and inter-agency collaboration extending the analysis already produced in agency reports.

Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did; a detailed analysis of what went wrong and why, including individual errors and system failures: Complex issues, such as how different referral processes and thresholds for services among a range of agencies resulted in some opportunities to assist the young person being missed, were explored through a series of sequenced questions which were put to the whole meeting and could therefore be simultaneously considered from a multi-agency perspective. The use of increasingly focussed questions put to an open forum of all the involved agencies proved a powerful technique for investigating how the complex interplay of presumptions, procedures, policies, inter-agency interactions and practitioner engagement with the young person had resulted in particular outcomes or omissions. The processes of the SILP involved in the Learning Event were very effective at identifying systemic failings and in presenting challenges to agencies to reconsider how an issue which on first examination appeared attributable to individual practice had roots in organisational and inter-agency structures.

To highlight relevant failings and good practice and policy at all levels, not just those at lower levels; process to promote learning rather than blame: The processes of the Learning Event and Recall Day focus on learning rather than blame. Attendees were able to clearly

identify a range of new learning from the case review. Good as well as poor practices were identified throughout. Nevertheless some attendees remained preoccupied by who was to blame. All the evidence from this evaluation suggests that the SILP model promotes learning as opposed to blame and that frontline professionals at the Learning Event become very clear that this is its primary focus. However, the culture of blame in organisations and wider society is a deeply embedded one and exceptionally challenging for any case review process to entirely eliminate. SILP has potentially an important role to play in changing this organisational and often professional preoccupation with culpability rather than learning.

Findings regarding the Final Overview Report

Is transparent about the way data is collected and analysed: The final Overview Report reflected the inputs made through Agency Reports and contributions made during the Learning Event and Recall Day. Attendees took full ownership of the Overview Report and none of the findings were disputed, although a few thought more blame should have been apportioned in it.

Criteria of the National Panel of Experts Report: In addition to the six criteria set out by the National Panel for Overview Reports, this section also considers two of the criteria detailed in Rawlings et al. (2014) which are subsumed within those of the National Panel, namely *key themes and learning should be identified within the reports and highlighted locally and nationally* and that *reports should be more succinct*. In relation to producing a more concise and succinct report while avoiding a detailed history of what happened to the child or young person, this is achieved. Description is minimised in the Overview Report, resulting in a tight explication and analysis of the main factors, decisions and interactions which culminated in the young person's death. The three criteria requiring the identification of: causes; what went wrong and why in relation to systems and individual performance; and good and poor practice, which are all closely interlinked, are the principal focus of the section devoted to key episodes. The use of key episode exploration is successful in revealing causal chains of events, systems failings and poor practice at different organisational levels. There is a balanced focus on what has occurred at the level of frontline practice and what is attributable to factors, including policies, procedures and decision-making, at higher levels alongside the interdependency between these. Lessons to be learnt are clearly adumbrated and derived from the analysis, although these tend to be drawn predominantly from poor, rather than good practice.

More succinct and shorter: The SILP Overview Report is 33 pages in length. This can be compared with Serious Case Review reports produced by conventional Serious Case Reviews conducted under HM Government (2013) and contained in the NSPCC online repository for 2014. The length of these reports is in the range 58-134 pages, with an average report length of 81 pages. The evaluated SILP easily meets the criteria of greater brevity.

Makes use of relevant research and case evidence to inform the findings: No references were made to research findings during the Learning Event, which focused on establishing the facts,

explicating causal chains and exploring the interactions between individuals and systems in a multi-agency context. Likewise, no research findings were discussed at the Recall Day. But the final Overview Report does make reference to research findings and case evidence.

Processes should be less resource demanding and more timely: The Overview Report author was asked to compare her costs for completing this SILP with her average costs for completing a conventional Serious Case Review. She quoted figures which, when analysed, indicated that her costs for this SILP review were 56% those of an average conventionally conducted Serious Case Review. This estimate needs to be read with the proviso that the costs of Serious Case Reviews, regardless of the approach taken to them, will greatly vary depending on the nature, complexity and number of agencies involved in events leading up to a child's death or grave injury.

The timescale from commissioning of the SILP case review to the submission of the final Overview Report was four months. This enables a degree of comparison with information regarding timelines contained in Overview Reports from conventional Serious Case Reviews conducted under HM Government (2013) and placed in the NSPCC online repository for 2014. However it should be noted that the Overview Reports contained in the repository are Serious Case Reviews and they give dates of the decision to proceed with an SCR and not the date on which it was actually commissioned, which would have been later. Therefore the comparison is a rather rough one and should be read with a degree of caution. Of those Overview Reports which provided dates, the time period between that of the decision to commission (as opposed to actually commission) an SCR and the acceptance of the Overview Report by the LSCB was in the range 7 – 11 months, with the average being 10 months. This would indicate greater timeliness regarding this SILP review.

Conclusion

Triangulating the data collected from the contemporary account, interviews and the textual analysis of the Overview Report provides strong evidence that the SILP model is very successful in engaging frontline professionals and delivering a transparent process of information gathering and analysis which takes as its starting point frontline professionals' perspectives. Evidence also convincingly establishes that the SILP model supports the investigation of highly complex inter-agency interfaces and dynamics alongside inter-related causal chains of events and avoids hindsight judgements. It promotes a high degree of reflection and learning both in relation to systems and individual practice. It offers some balance between the focus on good and poor practice, although it has the potential to provide more systematic and detailed recognition of good practice. SILP clearly identifies failings in systems and practices at all levels. Compared with established approaches to Serious Case Reviewing requiring IMRs, it offers a more timely review culminating in a concise Overview Report, which focuses on analysis rather than description. Finally, it provides an opportunity for direct input by practitioners and frontline managers into the Overview Report recommendations.

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