

Fachtagung zum Strafvollzug  
Olten, Freitage 16 Oktober 2009

■ **Wie lernen “multi-agency-systeme” aus dramatischen Fällen?**

- Lessons from aviation via child welfare

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**Outline**

- Background to SCIE project
- Understanding the human role in good or poor practice; contrasting theories of causality
- The systems case review process; key features

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## Why do we need new methods of learning in child welfare?

- A long history of investigations into child abuse tragedies – Serious Case Reviews & public enquiries
- yet findings are familiar and repetitive
- this raises questions about their value for improving practice
- similar circumstances in aviation and other high-risk industries led to development of the ‘systems approach’
- Implausible to put the error down to laziness or stupidity
- gets to the bottom of ‘why’ accidents occur allowing for more effective solutions

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## Developments in the health sector

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



*National Patient Safety Agency*

- No equivalent in child welfare
- Relevance to child welfare in theory
- Munro (2005) ‘A systems approach to investigating child abuse deaths’ *British Journal of Social Work*, 35, 531- 546
- Nothing on how it would work in practice
- Victoria Climbié tragedy gave extra impetus
- So the SCIE project to develop the systems approach for child welfare inquiries was born



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## Blaming not explaining: problem exemplified in recent high profile case

“as a social worker people keep asking me about Baby P – ‘how could this possibly have happened?’ And all I can say is – there must have been reasons ... it’s complicated”



## Without adequate explanations...

- incredulity quickly turns to anger and condemnation of those involved - hard to believe that a motivated, well-meaning, competent worker could act this way
- so conclude must be the result of stupidity, malice, laziness or incompetence
- YET reasonable to assume that most people come to work each day wanting to help children, not to allow them to be harmed;
- practitioners rarely intend to make mistakes
- so better explanations are required
- the systems approach is explicitly designed to address these ‘why’ questions

## How has the model been developed?

- not 'off the shelf'; detailed developmental work to adapt it
- a review of the safety management literature (Munro 2008)
- tried out in practice; two pilot case reviews
  - valuable feedback provided by staff at all stages
  - fine-tuned the model based on this experience

## 3 key adaptations

- Limitations of the knowledge base:
  - we do not know how to mend damaged children or families like we know how to fix broken cars
- Working with families
  - Professionals interact with families and these relationships can influence their thinking positively as well as negatively
- Multiple-agencies, professions and locations
  - Adds to the complexity of the analysis of how they work together and contribution each makes to the final outcome

## SCIE Guide 24

Authors: Sheila Fish, Eileen Munro & Sue Bairstow

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



## Part 2

- Why do things go wrong?
  - Understanding the human role in poor (and good) practice;
  - contrasting theories of causality

## Lessons from aviation

- Traditional person-centred investigation

vs.



- System-centred investigation

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## Why do things go wrong? The person-centred approach

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

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## To reduce human error, we

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

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## Appealing but a false charm

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

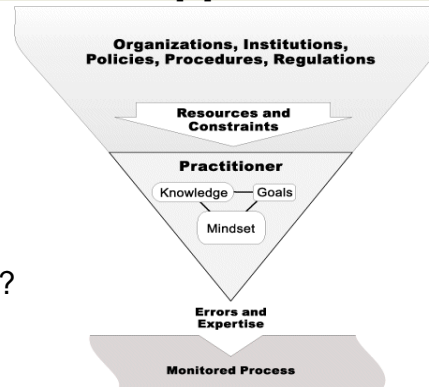


The domino theory of  
causation social care  
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## Why do things go wrong? The alternative system-centred approach

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



Components of the socio-technical system from Woods D. & Hollnagel E. (2006) *Joint Cognitive Systems*. London, Taylor & Francis.

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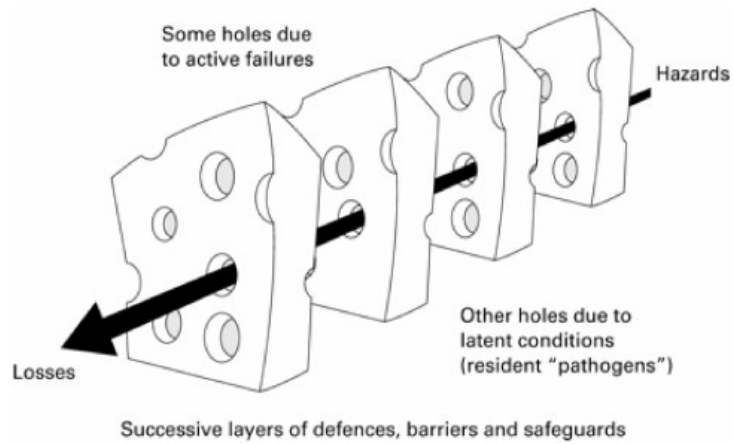
## Basic assumptions of systems thinking

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

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## Reason's Swiss cheese model



## Complex emergent model



## Starkly contrasting views of how to understand the human role

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

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## Part 3. The systems case review process

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## How the systems model can be used

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

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

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

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## Where you want to get to

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

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## Typology of patterns

### 1. human-tool operation

e.g. the influence of assessment forms

### 2. family-professional interactions

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

### 3. human judgement/reasoning

e.g. failure to review judgements and plans

### 4. human-management system operation

e.g. resource-demand mismatch

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

e.g. referral procedures and cultures of feedback

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

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

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## 1. Patterns of human-tool operation

- Tools: frameworks & forms -assessment forms, databases, decision aids.
- Old view: tools as passive objects that help professionals do the same tasks as before but do them better or faster.
- New view: tools become active agents in shaping practice, so that they are best seen as co-agents, altering the nature of the task the human does.
- E.g. may have a clumsy user or badly designed system or mix of the two

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## Software as active participant

- Lancaster University ethnographic study of ICS shows how it shapes practice (mainly in negative ways).
- Broadhurst K., Wastell, D., White S., Hall C., Peckover S., Thompson K., Pithouse A. Davey D. (forthcoming) Performing 'initial assessment': identifying the latent conditions for error at the front-door of local authority children's services. *British Journal of Social Work*,

## 2. Patterns of family/professional interactions

- You can deliver a pizza ...
- Some attacks on thinking:
  - Aggressive parents
  - Deceitful parents
  - Parents who displace the focus of concern
    - Arousing compassion
    - Scapegoating a child/partner
  - Parents who vary between 'just about' adequate and unacceptable
- What types of interaction would children, young people or family members highlight as helpful or as having a destructive influence?

### 3. Patterns of human reasoning

- Designing a safe system means taking into account people's psychological limitations and typical human errors of reasoning:
  - Failure to review judgements and plans
  - Drift into failure
  - Attribution error
  - Tunnel vision
- It is difficult to police our own biases so safe systems build in strategies for detecting and correcting these.

### 4. Patterns of human-management system operation

- Resource-demand mismatch
  - Difficulties accessing expert assessments
  - Gaps in service provision
  - Threats to preventative services
- Performance indicators & covert organisational messages
  - Trade-offs between competing priorities; overt and covert messages
  - Conceptual blurring
- Supervision
  - Threats to supervision of a turbulent environment

## 5. Patterns of communication and collaboration ...

### ... in response to incidents/crises

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

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## 6. Patterns of communication and collaboration ...

### ... in assessment and longer-term work

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

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## Benefits of such a typology

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

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## Key features of the process

1. Multi-agency from the start; looking at individual agency involvement and prioritising the interactions
2. Draws on 2 data sources: includes in-depth 1-1 conversations, as well as documentation
  - o without family members key perspectives will be missed but user involvement is under-developed in the model
3. Involves high degree of collaboration
  - o Introductory meeting to explain the approach
  - o Sharing of draft reports
  - o Feedback meetings for dialogue about analysis and broader relevance

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## Conversation structure summary

- With increased experience can be used flexibly to guide the discussion
1. Introduction
  2. Hearing their story/narrative
  3. Identifying turning points or 'key practice episodes'
  4. Clarifying their 'local rationality'
  5. Discussing contributory factors
  6. Highlighting things that went well
  7. Their ideas about useful changes
  8. Summing up
  9. Reflections on conversation process

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## Contributory factors

- Include all the possible variables that make up the work place and influence practice
- *Not* just policies, procedures and protocols, as in "Are the right systems in place?"
- Also includes the 'softer' factors like team and organisational cultures, priorities, overt & covert messages etc.
- Govt departments and inspection agencies also part of the system

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## Summary of framework for contributory factors

- Front line factors:
  - Aspects of the family
  - Personal (staff) aspects
  - Aspects of the role
  - Conditions of work
  - Own team factors
  - Inter-agency / inter-professional factors
- Local strategic level factors
  - Organisational culture and management
  - Resource allocation
- National/government level factors
  - Political context and priorities;
  - ICT systems
  - Inspection regimes and performance indicators

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## Organising and analysing the data involves

- 1) Expanding the 'chronology'. To understand 'local rationality' we need to go beyond the facts & highlight people's differing perspectives
  - Assemble narrative of multi-agency perspectives
- 2) Identifying "key practice episodes" (significant to the way the case developed or was handled),
  - Judging the adequacy of practice in these episodes
  - And highlighting contributory factors
- 3) Continual checking back & exploring further
  - participants provide a vital check on basic accuracy
  - also need to validate the analysis & prioritisation of issues by the reviewers

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## Developing recommendations

- Nb. Recs not synonymous with solutions
- Systems models suggest three different kinds of recommendation:
  1. clear cut
    - E.G. creating a consistent rule re. cc-ing people into letters
    - Ensuring that all voices are heard, especially workers who are actually going into families' homes
  2. require judgement and compromise
    - E.G. more attention in supervision to detecting errors of human reasoning requires more time – can that be obtained by cutting back on other tasks?
  3. need further research
    - E.G. difficulties in capturing risk well in a Core Assessment indicates a need to research how widespread the problem is and if necessary experiment with alternative frameworks and forms. Would take time but be of national benefit



## Feedback from participants

- not always a comfortable process
- gained a lot of insights about the work of my colleagues from other agencies
- got a better understanding of how influential and pervasive organisational culture is on face to face practice



## Feedback continued

*“This way of carrying out reviews does feel much more empathetic both to professionals and family, also more wide ranging and about normal human behaviour rather than endless policies and procedures – were they present, and who didn’t follow them?”*

*“The recommendations feel much more constructive and practical – the aim to address real difficulties of shopfloor workers – not to make a whole lot more work developing new processes almost for the sake of being seen to do something”.*

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## Summing up: What the benefits are

- SCRs
  - Transparent methodology
  - Rigorous analysis; nuanced understanding
  - Process is a learning exercise in itself
  - Aids cumulative learning from a series of SCRs
- Learning *before* tragedies occur
  - providing vital feedback about the “real difficulties of shop floor workers”
  - &/or chance better understand what good practice looks like

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## Next steps

- High levels of interest
- Need to build up
  - pool of people with experience and expertise in using the systems approach
  - the repertoire of case review examples
- SCIE is offering:
  - 1-day training event in this approach on a regional basis
  - a regional offer to train & support local pilots
  - Hoping also to facilitate a community of practice network to share the learning
- [sheila.fish@scie.org.uk](mailto:sheila.fish@scie.org.uk)

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