Northumberland Safeguarding Children Board

Learning & Improvement Framework

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Contents

Executive Summary

NSCB as a body represents the active involvement and commitment of all organisations that have a role in ensuring that children and young people are protected and that their welfare is promoted.

One of its principle and statutory functions is to review all instances when there is a concern that joint working arrangements to safeguard children are not as effective as they are intended to be. This forms the bedrock of the primary function of the LSCB to promote effective joint working arrangements and to assess these arrangements on a regular basis to ensure that standards and expectations are met.

Accountability and responsibility for safeguarding children rests with each individual organisation represented on the Board and with the professionals they each employ. The Board on the basis of commitment and consensus articulates the "how" people will work together to protect children, provides support and guidance and encourages each organisation and profession to prioritise safeguarding activity and account for on the basis of annual evaluation the effectiveness of these arrangements both within their own organisation and in joint working arrangements.

The Board's Learning and Improvement Framework which is interrelated to its Performance and Quality Assurance Framework sets out the following:

- How the Board determines the effectiveness of joint working arrangements to safeguard children
- The ways in which it undertakes this
- How the Board will demonstrate transparency, accountability and a "culture of continuous improvement"
- The publication annually of a Board report which sets out the extent to which joint working arrangements to protect children are "sufficient" and how learning has informed this.

The framework and the document seek to be clear about the following:

- How the Board will undertake its role and function to review joint working arrangements
- How the Board will undertake its statutory function with regard to Serious Case Review
- What will be expected from all Board organisations/members, professionals and others involved in the life of children in terms of standards, review processes and actions required as a result of learning
- How the Board will develop its review function and how it will ensure this reflects the principles of learning to improve.

Finally it is important to acknowledge that expectations of organisations, professionals and bodies such as the NSCB are changing. There is an increased emphasis on transparency and accountability, which means that organisations and professions need to be able to continue to demonstrate that they do all they can to reduce error and unintended consequences. It also means that in order to maintain and build on the levels of trust and mutuality essential to effective cooperation and joint working they need to be supported in finding a balance between taking responsibility for unintended consequences and a response that assures all concerned that this responsibility has been fully acknowledged and acted upon.

For the NSCB there is a wider challenge in that it needs to set standards for and maintain on the basis of a mutual partnership an environment where all partners can be relied upon to address the root cause of events and actions so as to be able to actively demonstrate and reduce the risk of re occurrence and the prevention of tragedy.

This framework and the approach being developed by the NSCB recognise that the complexity and challenges of effective joint working to safeguard children can result in outcomes that are sometimes that are not always conducive to transparency or effective analysis of changes that have resulted from review. Put simply the framework will support all concerned in being clearer not just about “what” happened, but also “why” in order that professional and organisational accountability can be clearly identified so as to give each professional and organisation the opportunity to act on this alongside a broader commitment to changing systems, processes and joint working culture and arrangements.

In its Learning and Improvement Framework the NSCB has therefore not only to facilitate enquiry, review, learning and actions to improve. The NSCB must also create the conditions for holding partners to account, without compromising their commitment to working together effectively and if necessary differently. At the same time the NSCB must be in a position to provide parents, children, young people and the wider community with sufficient grounds for them to continue to trust in the organisations and professionals who undertake this difficult role and have to make complex and often sensitive judgements.

Introduction

Working Together to Safeguard Children 2015 (Chapter 4) states that:

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be 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.

These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

Local Safeguarding Children Boards should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

Each local framework should support the work of the LSCB and their partners so that:

- reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children and that this learning is actively shared with relevant agencies;
- reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;
- action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of serious case reviews (SCRs) with the public.

The local framework should cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children. Some of these reviews (i.e. SCRs and child death reviews) are required under legislation. It is important that LSCBs understand the criteria for determining whether a statutory review is required and always conduct those reviews when necessary.

LSCBs should also conduct reviews of cases which do not meet the criteria for an SCR, but which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. Although not required by statute these reviews are important for highlighting good practice as well as identifying improvements which need to be made to local services.

Such reviews may be conducted either by a single organisation or by a number of organisations working together. LSCBs should follow the principles in this guidance when conducting these reviews.

Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

The different types of review include:

- Serious Case Review (see page 75) for every case where abuse or neglect is known or suspected and **either**:
- a child dies; or
- a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child;
- child death review (see chapter 5): a review of all child deaths;
- review of a child protection incident which falls below the threshold for an SCR; and
- review or audit of practice in one or more agencies.
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;49
- final reports of SCRs **must be published**, including the LSCB's response to the review findings, in order to achieve **transparency**. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and
- improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children

SCRs and other case reviews should be conducted in a way which:

- 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;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings

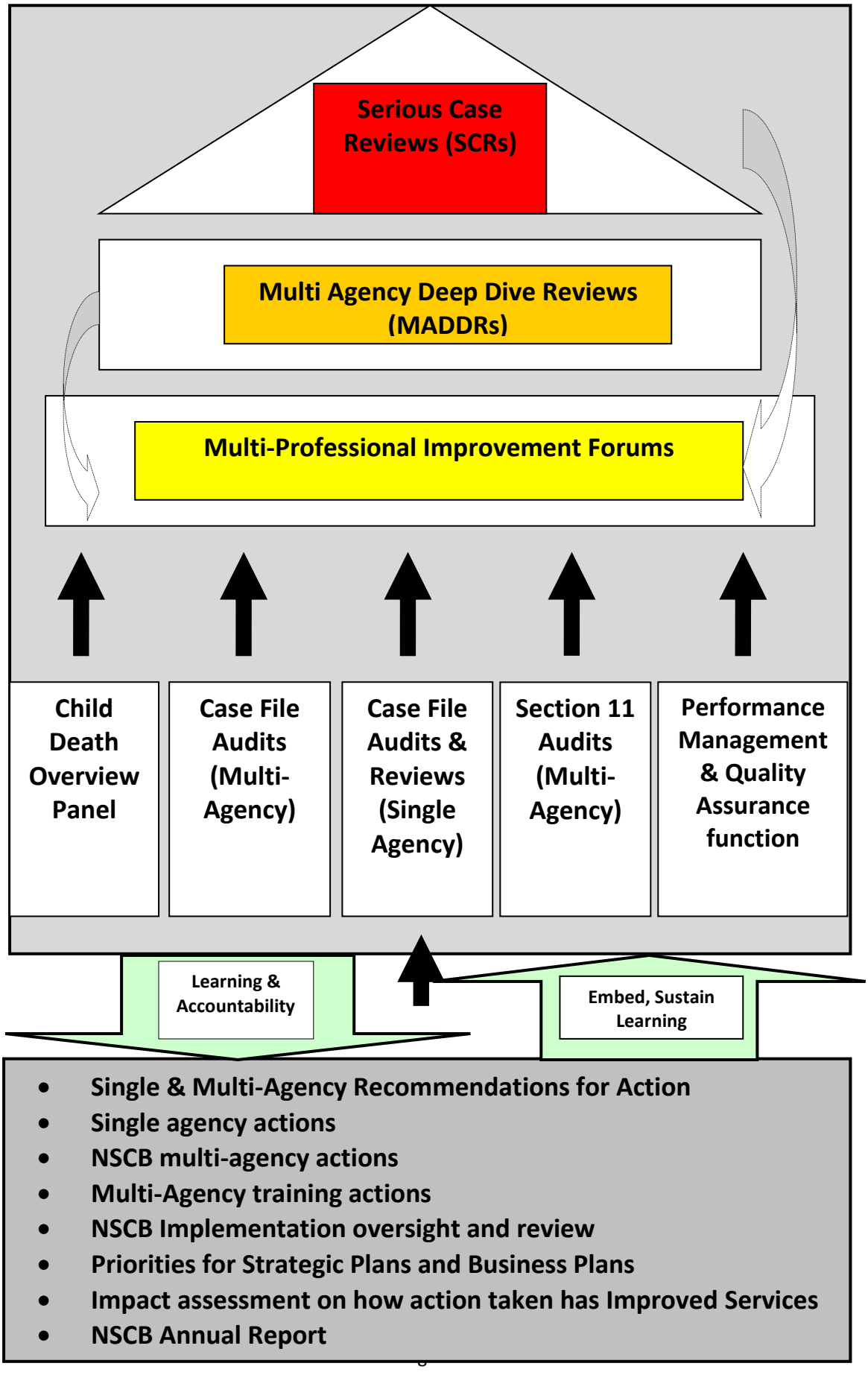
LSCBs may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro.

This document provides the NSCB and respective partner organisations the wider community with guidance on:

- the principles to be applied in any methodology used to identify learning and improvement;
- the framework which outlines the different types of case reviews;
- the thresholds for conducting the different types of reviews;
- the methodologies available to the NSCB to conduct case reviews[1];
- How NSCB will share and collate learning to ensure practice locally is fully informed by experience.
- How the NSCB will determine the effectiveness and impact of this activity

Learning and Improvement Framework

The following diagram represents the process the NSCB will use to conduct the different types of multi-agency case reviews, practitioner forums and audits:



information on each child who has died and to determine whether the death was preventable (i.e. had any modifiable factors) and decide what actions, if any, may be taken to prevent future such deaths. The committee makes recommendations to the LSCB or other relevant bodies, identifying patterns and trends in local data. The committee refers back to the LSCB Chair in circumstances where a Case Review may be required.

Case File Audits (Multi-Agency)

The case review sub-committee holds case file audit days on an annual basis. A theme is chosen and cases are examined by the members of the Case Review Group. The audits can and have led to the commission of a case review if the findings signal a concern about practice or about how agencies work together to safeguard children.

Case File Audits and Reviews (Single-Agency)

Any NSCB agency can request a case review if auditing or review of any of their cases reveal that a multi-agency case review is required to provide additional scrutiny which may lead to improvements in safeguarding arrangements and practices.

Performance and Quality Assurance Function:

The NSCB Quality, Improvement and Performance Sub-Committee maintains a multi-agency dataset and framework for monitoring and analysing performance across the agencies, in order to bring to the attention of the Board significant trends, indicators and variations in performance either on a single or multi-agency basis. The quality assurance function may therefore bring the need for case review to the attention of the Board and the Case Review Sub-Committee.

Section 11 Audits

A Section 11 Audit requires all NSCB partners to self-assess their arrangements for safeguarding children. The returns are then correlated and managed in terms of a Red – Amber – Green rating by the Business Sub Committee. This is reported to the Board and helps form a view as to the state of and sufficiency of joint working arrangements to protect children and promote their welfare. Under each of the headings included in the Section 11 Audit tool are further lines of enquiry and requests for evidence, which verifies the assessment and rating. Information shared as a result of the s11 audit may lead to further scrutiny of individual cases.

Principles for Learning and Improvement

The following principles should be applied by NSCB its partner organisations to all reviews:

- there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;

The principles should be weighed against the need to carry out a review which is time and cost proportionate.

PRINCIPLES	WEIGHING THEIR IMPORTANCE
Equity	Without fairness to professionals, the review may be seen as unjustly blaming. Without hearing the voices of families and perpetrators it may be seen as neglecting their views. Without taking equality into account it could be perceived as biased. Any could damage the credibility of the review.
Impartiality	There are degrees of independence. However, anything less than independence from commissioners risks the criticism that impartiality has been compromised. Conflicts of interest will need to be explained.
Thoroughness	Ask what information will be missed by limiting the scope of a review (failing to include all agencies, restricting analysis to the recent past or not hearing from users of services). Consider
Accountability	Full publication can serve a legitimate need for catharsis for victims, professionals, commissioners and the public. Reviews can be positive.
Transparency	Ask whether the public will conclude that any failures in taxpayer's services have been properly examined and appropriate recommendations made.
Lasting Improvements	The impact of learning from all reviews should be to improve services for children and families and on reducing the incidence of serious harm to children. The Safeguarding Board will hold each organisation to account for implementing and sustaining any recommendations made as a result of a review.

Initiation of Serious Case Reviews

Where the grounds are believed to be met for a SCR any agency may request that an SCR panel is convened to consider whether the known information meets the criteria. The panel will be chaired by the chair of the Case Review Subcommittee and be made up of senior managers from each partner agency. The request must be made using the referral form (see appendix 2) and sent to the chair of the case Review Subcommittee.

The final decision on whether to conduct an SCR rests with the LSCB Chair. LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB **may** still decide to commission an SCR or they may choose to commission an alternative form of case review. The LSCB Chair should be confident that such a review will thoroughly, independently and openly investigate the issues. The LSCB will also want to review instances of good practice and consider how these can be shared and embedded. The LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report.
Decisions on whether to initiate a serious case review should be normally made within one month of the NSCB being notified of the incident.

Chapter 4 (pages 75 -80) of Working Together 2015 sets this out in more detail and is reproduced in appendix C of this framework document (page).

The LSCB should let Ofsted, DfE and the national panel of independent experts know their decision within five working days of the Chair's decision.

Where a case is considered for a serious case review and the NSCB Chair decides the threshold is not met, additional information to justify the decision will be required to be provided to the National Panel of Independent Experts on serious case reviews. This is likely to include any decision regarding an alternative review where this appears to be more proportionate. Where the notification to the National Panel of Independent Experts on serious case reviews is to initiate a serious case review, the notification information should also contain the name(s) of the independent Lead Reviewer(s) appointed.

An independent review

According to *Working Together to Safeguard Children,* LSCBs must appoint serious case lead reviewers who are independent of the LSCB, the case under review and of the organisations whose actions are being reviewed. The appointment of the serious case review chair or the lead reviewer will be the appointment of the NSCB Chair. It is anticipated that all serious case reviews and MADDRs (levels one and two of the diagram on page 5 of this report) will be led by an independent lead reviewer.
To avoid conflict of interest, bias or failure to examine systems including those at commissioner level, the lead case reviewer will also be independent of commissioners of the review.

How we will commission a case review

Before the serious case review or MADDR begins, it will be necessary to establish exactly what will be commissioned by the NSCB, the purpose of the review and how the review will be conducted. Whatever procedure or methodology is chosen for the review, a framework, remit or other similar written statement should be agreed between the NSCB and the independent reviewer.
The draft framework statement will be consulted upon widely so it accurately reflects the work to be done. Families will also be asked to contribute their ideas.
The statement will be provided to all the organisations involved and to the family and will be attached to the published report as an appendix.

The content – what
"What" questions include what the SCR will do, tasks to be undertaken by the NSCB and independent reviewer, what contractual arrangements exist and what limitations there might be, for example, cost.

Accountability
The framework statement for the review will describe the system of accountability. As such it will be drafted taking into account three main functions, being to:

- Stand as part of the commissioning contract enabling the NSCB to determine whether the review to determine whether the reviewer the NSCB chair has appointed has satisfactorily completed the tasks, (ii) the reviewer to know exactly what responsibilities he/she has and (iii) the commissioners of the review to know what responsibilities and tasks are to be undertaken.
- Act as a public "to do" list so that all stakeholders can hold the review to account for any specific failures to adhere to the terms of reference.
- Provide a way for all stakeholders, including the public, to determine whether the terms of reference were adequate for the task – for example, whether the purpose, scope of the review and methodology adopted were appropriate.

The content – why
The purpose of the review should be set out with reference to Working Together but should go beyond a simple repetition of that, mentioning the particular circumstances of the review.
"Why" questions will include the reasons for commissioning decisions such as the scope (both how far back the review will go and how broad the information gathering will be), timescale or methodology being adopted, based on the principle of proportionality, taking into account time and cost. There should be an explanation for the anonymisation or redaction of the report.

The content – how
"How" questions cover the means by which the review will achieve its ends, including its chosen procedure and methodology with the issues it will examine, such as professional decision-making, national and local policies procedures, working practices, training and any specialist areas at issue.

The NSCB will produce a response to the completed SCR to outline how they will address any findings or learning arising from the review.

Who what how and why

SCRs 'should be conducted in such a way which:

- 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;
- Seeks to understand practice from the point of view of the individuals and organisations involved at the time rather than using hindsight'

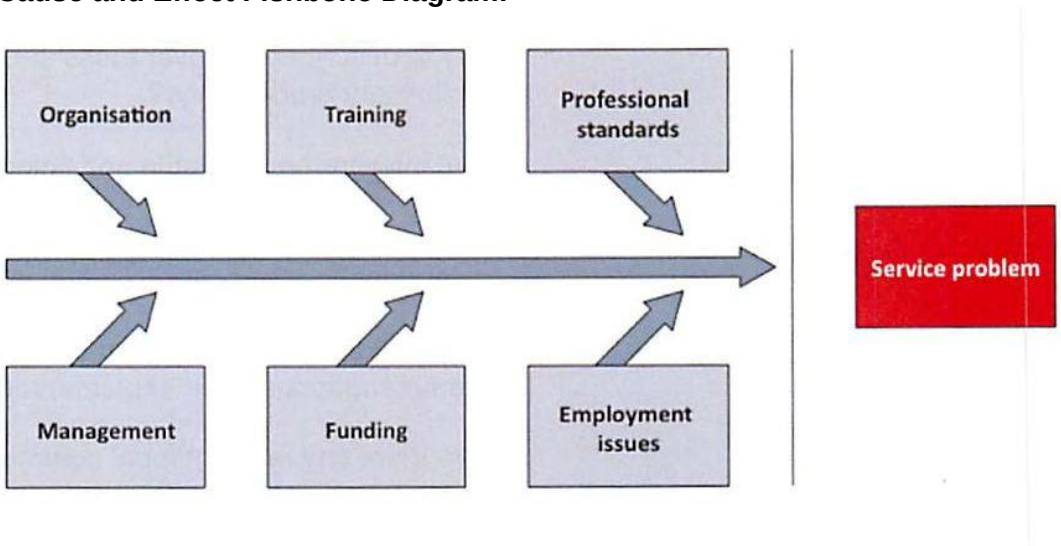
Hindsight bias and outcome bias

Hindsight bias occurs when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This tends towards a focus upon blaming staff and professionals closest in time to the incident.

Outcome bias occurs when the outcome of the incident influences the way it is analysed. For example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. If people are judged one way when the outcome is poor and another way when the outcome is good, accountability becomes inconsistent and unfair.

Reducing hindsight bias: can be reduced by using a method of analysis which examines how things were and perceived to be *at the time*, why decisions were made and actions taken *at the time*.

Cause and Effect Fishbone Diagram:



Views of Children and Families

Children's and families involvement is seen as placing the child in the centre of the process. NSCB holds the view that the family holds key information which will inform learning and contribute to the change process: child and family participation triangulates information and minimises assumptions being made solely on case records or agency reports. Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important

for ensuring that the child is at the centre of the process". The views of children and families should form an important part of the completed review.
Background communication such as making the initial contact and explaining the review process will be conducted by a named contact that can develop a supportive relationship with the family and maintain it throughout the review. The independent Reviewer will be responsible for hearing evidence from the family. The named contact will keep in touch with the family and provide regular updates but feedback about the findings of the review will be given by the Independent Reviewer.
The approach to the family should be open, compassionate respectful and compassionate. Straight forward and jargon free language will be used and there should be no moral judgement; the purpose of a serious case review is to discover how services can be improved. The review can be guided can be guided by the questions of the family and the reviewer is expected to ask if there is anything the child or family would like to see change.

Alternative forms of review/enquiry:

Multi-Agency Deep Dive Reviews

Multi-Agency Deep Dive Reviews (MADDRs) are reviews of cases falling below the SCR threshold. Cases can involve incidents where a child has been *harmed* and there are concerns about multi-agency practice, or involve incidents where multi-agency practice is considered to be good (after a child has been harmed or where a child has been prevented from being harmed) and agencies seek to identify the characteristics and enablers of that good multi-agency practice.

The NSCB criterion to follow in selected cases for a Multi-Agency Deep-Dive Review is:

A child is harmed through abuse/neglect and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard the child that could lead to significant and new learning that improves multi-agency communication, procedures, policy and/or practice.

The proposed methodology for MADDR should be a systems approach and the reviewer(s) should be independent from the organisations involved in the case or the NSCB. The NSCB must ensure all the appropriate methodological principles are met.

The Independent Chair of the NSCB acts as a Commissioner and is accountable for the process and outcomes of all reviews, irrespective of the type or status. The Chair will have oversight of all reviews undertaken by the NSCB.

Where a case gives rise to concern about learning already identified in previous case reviews, practitioner improvement forums or case audits, the NSCB should review, outside of the MADDR process, how that learning is being embedded to ascertain why the learning has not been sustained. The Case Review Sub-Committee is responsible for monitoring all such learning actions.

Individual Agency Reviews

Where a case is considered for a serious case review or multi-agency deep dive review but does not meet the criteria for either, as practice requiring further analysis and learning is limited to a single agency, the SCR Panel , Quality Assurance subcommittee, or case review subcommittee may recommend an Individual Agency Review. The methodology used to undertake a review and how the lessons will be

disseminated will be decided by the relevant agency and the findings and learning shared with the NSCB.

The Independent Chair would be involved as a Commissioner of the Individual Agency Review and will hold the specific agency to account in terms of completing the Review and disseminating any learning.

Specifically Commissioned Reviews (or Northumberland Reviews)

The Chair of the NSCB Case Review Sub-Committee may consider that a specific case warrants further scrutiny in order to establish the quality of multi-agency practice and to consider whether the case will give rise to any new learning that will improve multi-agency communication, procedures or practice.

As with MADDR, the proposed methodology is a systems approach, the reviewer should be independent of case-management or line management but do not need to be independent of the organisations involved in the case or the NSCB.

The principles of this framework must be met and the review will be commissioned through the NSCB Case Review Sub-Committee.

The review will begin by the compilation of a multi-agency chronology, will consult children and families and will conclude with a multi-agency workshop for all those involved with the case to disseminate learning and to agree key findings, which will be reported to the NSCB and the Case Review Sub-Committee. Learning from a specifically commissioned review will then be disseminated more widely through Professional Improvement Forums.

The NSCB has undertaken a specifically commissioned pilot review using the methodology described above. The next step for the NSCB is to develop this particular systems approach by training additional reviewers and investigating the possibility of entering into agreement with regional LSCBs so that those trained can independently carry out this function for other Safeguarding Boards.

Multi-Professional improvement Forums (MPIF)

The NSCB should hold a regular number of specifically convened forums for practitioners to discuss practice so that they can safely and openly consider, challenge and change multi-agency practice. The NSCB Performance & Quality Assurance Sub-Committee and Case Review Sub-Committee, or any professional, can identify themes through a variety of methods, including as outlined in the diagram on page 5 where findings from different review processes identify the need to consider practice. Equally, changes in national guidance, identification of best practice principles, concerns with the effectiveness of a policy/procedure, or a timetabled review of a policy/procedure could also be reasons for convening a forum.

Case Review Methodologies

Consistent with recommendations of Professor Eileen Munro, this framework outlines a systems approach to case review. A proportionate approach of *Intensive* and *Targeted* reviews is proposed. A flowchart to support decision making is at Appendix A. The focus is on the discharge of Local Safeguarding Children Boards' responsibilities to undertake reviews of serious cases as confirmed below and to promote the principles of a learning culture within a revised approach to ensuring that accountability results in measurable and sustainable improvement in joint working arrangements so that children and young people are as a safe as possible.

Significant Practice Events Chronologies

Robust and proportionate chronologies inform decisions to initiate case reviews and determine the scope and methodology for review. Each relevant agency will provide 'Significant Practice Event' chronologies to detail its involvement with the child who is the subject of the review. Whilst this framework embraces the value of local approaches to chronologies, a robust and consistent approach focussed on the following principles should be included:

- Risk – each Significant Practice Event (SPE) details the presentation of risk
- Response – the agency response is clear
- Partnership – understanding of multi-agency considerations is apparent
- Learning – the core of the methodology and chronologies should identify learning opportunities, in particular those which are significant or new.

Defining Significant Practice Events

The use of Significant Practice Events (SPE) chronologies is integral to ensure clear parameters of any review are agreed based upon the circumstances of the case. They will be used to support decision making on whether Serious Case Review criteria have satisfied; how case reviews can be discharged in a proportionate way; and how engagement with Case Groups should be configured. Agencies should consider the following when preparing SPE chronologies:

- Is this event one that changed/could have changed your assessment of the situation for the child?
- Is this event symbolic or indicative of a pattern of events that individually would not otherwise be considered significant?
- Is this a 'statutory' event e.g. child protection conference, court hearing or similar?
- Would this have been an event that the child perceived as significant in their life?
- Would this have been an event that a significant adult would perceive as significant in their life or the life of the child?
- Has this event got significance as a learning point for agencies?

The SCR Review Extended Panel

This panel will be convened when an SCR is being considered and must be made up of senior managers from relevant agencies. The role of the Panel is to form an opinion as to what type of review is required and make a recommendation to the NSCB chair. Where an SCR is agreed as appropriate the Panel will take responsibility for approving the report before the NSCB sign it off formally.

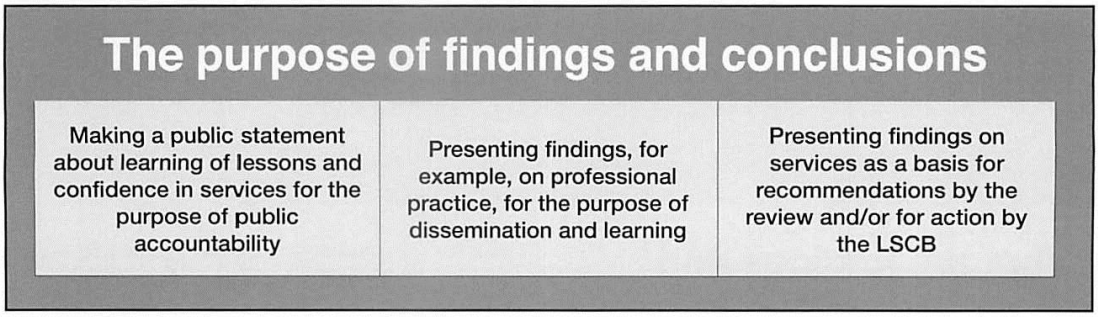
The Review overview Panel (RoP).

This Panel should be convened when a review has been commissioned. This may be an SCR or MADDR. The members of this panel should be identified by the SCR extended review panel and will usually include one representative from each agency involved in the SCR. The panel must be made up of staff with sufficient seniority to speak on behalf of their agency. The overview panel is responsible for overseeing the timely completion of the review and providing Quality assurance to both the process and the report. The panel will include the independent reviewers.

Findings and Recommendations

'Findings' come about as a result of the analysis of 'what happened and why'. The findings may identify patterns or issues. In utilising a systems approach, the reviewer will produce a report that identifies the findings and present that to the NSCB to work out what action needs to be taken. The reviewer should usually not make recommendations, but he or she has a responsibility for making 'findings' which can be useable by the NSCB.

The expression "findings of fact" is not appropriate for the review. Differing or disputed versions of the events should be presented in the report along with the discrepancies. If the lead reviewer favours one version of events over another, it should be stated, along with an explanation about how that view has been arrived at. Organisational differences may emerge and a more complex analysis will be required. A balanced view should be given. There may be information in the report that could form the basis for disciplinary proceedings. The aviation model of human error is a useful tool to determine if this is the case. This is explained fully at **appendix E: Managing human error within the context of disciplinary/capability procedures.**
This does not mean that the serious case review report should avoid any comment on error or poor professional practice. A review which fails to spot a serious professional error would rightly be criticised. However, any such finding should be accompanied by a full explanation of the context, in order to establish why that error or poor practice was allowed to persist.



Reassurance that services have improved

The framework for the review may include a requirement that the reviewer provide assurances that services have improved. In this case, the reviewer will be expected to see practical evidence that the necessary changes have been implemented. For example, the reviewer may be expected to see a new policy in operation along with recent audit results or a current mandatory training schedule for staff.
LSCBs should publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.

Publication of SCR Reports

Working Together 2015 states: "All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt

and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case."

How we learn from reviews

By providing structured opportunities through specific workshops and seminars and by including the findings from case reviews in the courses delivered through the NSCB training programme, the multi-agency children's workforce will develop their knowledge and practice. Through the NSCB Learning and Development subcommittee, a series of case review workshops will be delivered annually. Members of the subcommittee will continue to provide feedback from their agency about the effectiveness and impact of the dissemination of learning from case reviews. Workshop evaluations are made by all staff who have attended.

Supporting a Learning Culture

The NSCB recognises that professionals need time and space to reflect on their work in the light of new information.
Working Together Chapter 4 also sets out the following principles that "should be applied by LSCBs and their partner organisations to all reviews:

> *"There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice".*

Monitoring Review Recommendations

The NSCB Case Review Subcommittee is responsible for monitoring the implementation of any Case Review Recommendations.
Following a review, the NSCB will agree the recommendations, including a lead person from the agency concerned and a reasonable timescale for implementation. The recommendations will then be entered into the NSCB Thematic Tool. The Case Review subcommittee will routinely monitor the progress of the implementation of each of the recommendations and report back to the NSCB if progress is insufficient.

If the recommendations are not implemented within the agreed timescale or if the learning from a case review does not result in the necessary changes to practice or procedure, the NSCB will hold the responsible agencies to account by writing to their chief executive formally, to express their dissatisfaction with the agency's safeguarding arrangements. This action may result in the inspection body for the agency concerned becoming aware of the agency's failure to respond adequately to safeguarding issues.

Proportionate approach to Serious Case Review

The following table outlines the staged approached to Serious Case Reviews[2]. Specific attention is drawn to emphasis upon the process of analysis at the heart of the review.

Stage	Activity	Timescale
SCR extended review Panel Initial Meeting	SCR Extended review Panel meets to identify those agencies involved with the child and initiate pre-review processes following notification of an incident. Each member will come with a brief overview of the case from their agency perspective. Any parallel or overlapping review processes by other partnerships (e.g. Domestic Homicide Reviews, MAPPA SCRs, Youth Justice Serious Incidents or Health Serious Incidents) should be carefully considered, including any impact on criminal investigations processes.	Within 5 working days of the referral being received
Significant Practice Events (SPEs) Chronologies	All agencies involved prepare SPEs chronologies identifying risk, response, partnership and learning issues underpinning each episode.	
SCR extended Review Panel: Planning Meeting	Panel convenes to consider SPE chronologies and confirm whether it is considered that the Serious Case Review criteria have been satisfied. Based on SPE chronologies, Panel advise on TOR, scope and type of review and consider appointment of the independent or internal Lead Reviewer. The SCR extended review panel will agree and identify members of the review overview panel. Initial parameters of SPE Forums with Case Group are set. **½ day**	Within 5 working days of the initial meeting
Ofsted informed	The NSCB Independent Chair informs Ofsted of potential SCR	Immediately after the SCR planning meeting above
Engagement with National Panel of Independent Experts/ Peer challenge	NSCB Chair seeks peer challenge . NSCB Chair consults with National Panel regarding application of SCR criteria and inform of the appointment of Lead Reviewer(s).	A decision reached within 1 month of the initial referral
		Clock starts
Overview panel: Set up meeting	Overview panel, including reviewer, identify who will be part of the case group and agrees timescale and future overview meetings	Within 2 weeks of the final decision of the NSCB chair
Case Group:	Case Group lead information gathering process via Forums with groups of case	Within 4 weeks of the set up meeting

[2] Adapted from the Social Care Institute of Excellence (SCIE) Systems Methodology

Significant Practice Events (SPE) Forums lead by independent reviewer	workers on an 'episodic' basis which assembles appropriate groups of case workers as defined by the overview panel. This approach should create conditions for inter-agency learning including introducing the approach to case workers. The outcome from these concurrent Forums will be to build a co-ordinated picture of the case from the perspective of professionals. **Up to 4 days in total**	
Overview Panel Information Audit	Panel considers relevant documentation and outcome of any interviews with families/surviving children and triangulates these findings with those of the Case Group SPE Forums.	Within 6 weeks of the case group convening
Significant Practice Events (SPE) Overview Panel Analysis Meetings	Overview Panel convenes to evaluate emerging individual and systemic practice issues arising from review activity. Transferrable learning is identified and typologies proposed. **2 or more ½ day sessions.**	Within 2 weeks of the information audit meeting
Family and Child(ren) Involvement[3]	Lead reviewers to meet with family and child(ren) – the session should capture: • the lived experience of the child(ren) • understanding the SPEs and the professional and family responses • capturing the voice of the family and child(ren), including issues of justice • reflecting on how resolution, repair and change can be brought about in the future[4] **½ day session**	Dependent on Police action. Where there is no Police action then within 2 weeks of the analysis meeting
NSCB Progress Report	Overview Panel updates SCR extended review Panel membership on progress to date and confirms completion timescale.	By week 17
Draft report meeting	Reviewer presents final draft report to Overview and SCR extended review Panels. Amendments discussed and agreed	By week 20
Final sign off meeting	Reviewers report signed off by SCR extended review panel	By week 22
NSCB sign off meeting	Reviewer presents report to full NSCB. This session should provide opportunity to address any areas of conflict and confirm plans to share learning on a wider area basis	By week 24

[3] Family and child (surviving subject child(ren) and/or siblings) involvement at this stage in the process will require careful planning and where criminal proceedings are ongoing may require moving to a later stage in the process; for SCRs involvement should be complete prior to publication of the final report

[4] Objectives adapted from *A Study of Family Involvement in Case Reviews: Messages for Policy and Practice,* Morris et al, BASPCAN (2012)

Learning Workshop	Overview Panel presents learning to Case Group. Consistent with the systems approach this workshop should identify opportunities to improve multi-agency communication, procedures, policy and/or practice. This consultation should confirm both the typology of learning and that it is transferrable beyond the individual case. **1 day**	Within 8 weeks of NSCB sign off
Programmes of Action	Translation of findings into programmes of action that lead to sustainable improvements in practice and the prevention of future death/serious harm to children. Family Involvement - feedback, fulfilling any commitments like reporting action taken for change and evaluation of the process.[5]	Within 10 weeks of NSCB sign off

Sharing learning

Integral to the success of this framework will be the sharing of learning on a wide area basis to ensure transparency, accountability and consistent improvement to practice. As such, in addition to the statutory requirements on publication, the NSCB will seek to develop mechanisms to share, the outcomes of case reviews and MADDRs which do not meet Serious Case Review thresholds. In addition, there will be an expectation placed upon Lead Reviewers, via commissioning arrangements or other means, that concise Learning Summary documentation will form part of all review reports. A template for this is proposed at **Appendix B.**

The Case review subcommittee will collate the learning summaries to analyse and disseminate the learning from local regional and national reviews. Periodically the group will also evaluate how this framework is working and advise the NSCB of any changes required to this framework.

Implementation

A period of consultation and reflection should be undertaken in order to ensure the Framework is implemented successfully, with consideration of the following issues of particular importance:

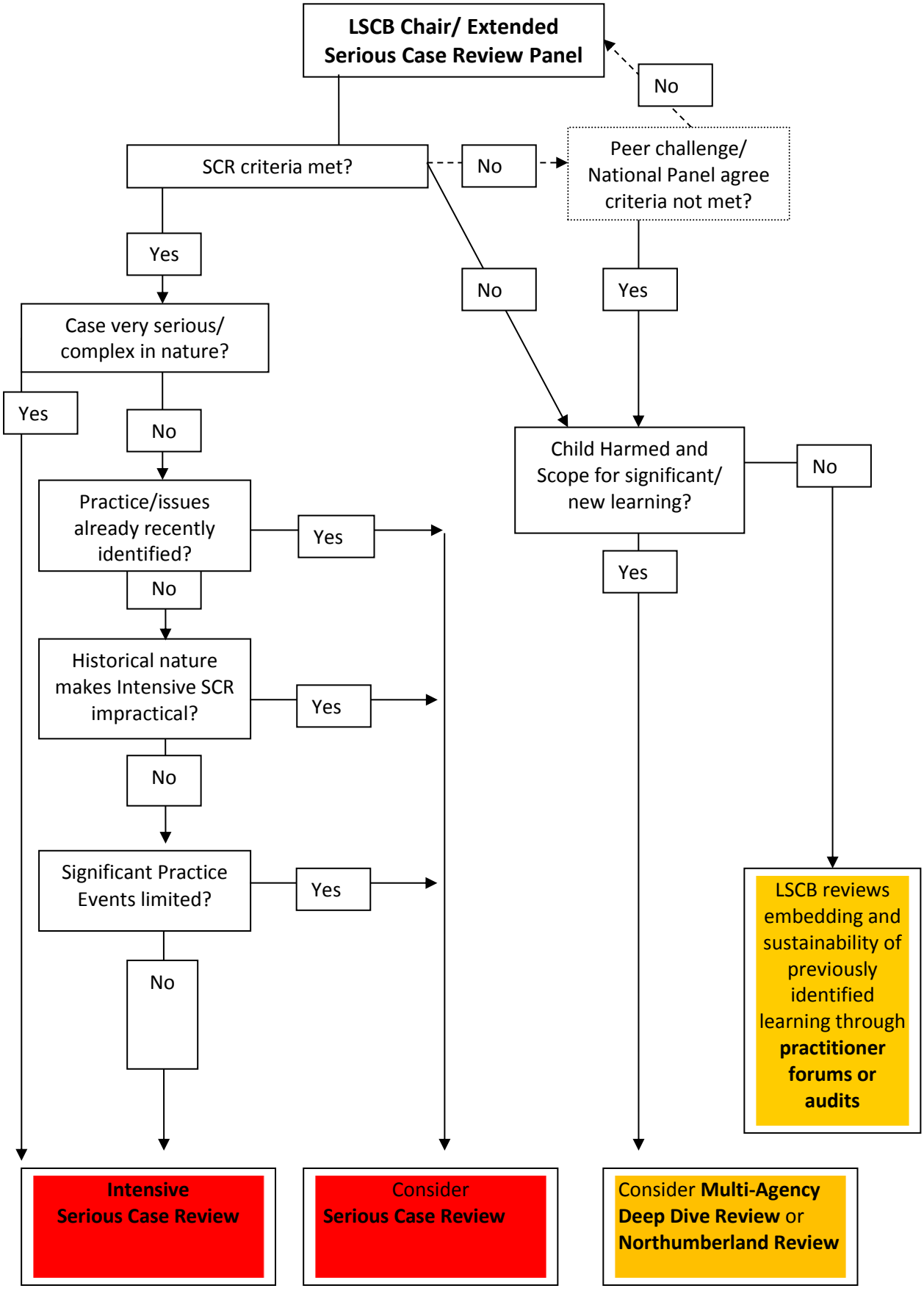
- Incorporating a systems approach – it is acknowledged that the systems approach to case review is underdeveloped in many areas. Some LSCB partners have experiences of methodologies they may wish to test against these methodologies.

- Training – in addition to identification of a series of training needs and appropriate provision to meet those needs, the early implementation of any systems approach will need to create conditions for learning of itself.

[5] Adapted from *A Study of Family Involvement in Case Reviews: Messages for Policy and Practice,* Morris et al, BASPCAN (2012)

- Typology of learning characteristics – in order to facilitate consistent sharing of learning on a local, regional and national basis, implementation will need to fully consider the agreement of a shared typology of learning characteristics.

Appendix A Case Review Threshold Flowchart



Appendix B Learning Summary Template

Date Form Completed	
Type of Review conducted	(Please include details of methodology, chairing/authoring, how case was selected)
Month/year of incident	
Review reference code	
What you learnt about the case: Key themes / early learning.	(Specific issues or general areas of concern or good practice)
What you learnt about the review/ methodology:	(What worked / didn't?; Who was involved, how long did it take, chairs, authors etc)
Key recommendations – single agency	(Indicate transferrable learning, not necessarily all recommendations)
Key recommendations - Multi-agency	(As above, focus on transferrable learning)
How do you intend to make changes? Who's doing what?	
How will you audit the impact? Ie. how will you know anything has changed?	
Any other comments, advice, suggestions – about the case, the method, embedding change or evidencing impact/ change	

https://www.nspcc.org.uk/Inform/trainingandconsultancy/consultancy/supportingproductsandresources/safeguardingthroughaudit_wda47786.html

APPENDIX C – taken from Working Together to Safeguard Children 2015

Serious Case Reviews

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5(1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

"Seriously harmed" in the context of regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- a potentially life-threatening injury;
- serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

Cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii)) must always trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii), unless there is definitive evidence that there are no concerns about inter-agency working, the LSCB must commission an SCR.

In addition, even if one of the criteria is not met, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the

subject of a deprivation of liberty order under the Mental Capacity Act 2005.

The final decision on whether to conduct an SCR rests with the LSCB Chair. LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review. The LSCB Chair should be confident that such a review will thoroughly, independently and openly investigate the issues. The LSCB will also want to review instances of good practice and consider how these can be shared and embedded. The LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report.

National panel of independent experts on Serious Case Reviews

Since 2013 there has been a national panel of independent experts to advise LSCBs about the initiation and publication of SCRs. The role of the panel is to support LSCBs in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory SCR criteria are met and to ensure that those lessons are shared through publication of final SCR reports. The panel also reports to the Government their views of how the SCR system is working.

The panel's remit includes advising LSCBs about:

- application of the SCR criteria;
- appointment of reviewers; and
- publication of SCR reports.

LSCBs should have regard to the panel's advice when deciding whether or not to initiate an SCR, when appointing reviewers and when considering publication of SCR reports. LSCB Chairs and LSCB members should comply with requests from the panel as far as possible, including requests for information such as copies of SCR reports and invitations to attend meetings.

The text which follows provides a checklist for LSCBs on how to manage the SCR process.

In doing so LSCBs will be exercising their powers under Regulation 5(3) of the Local Safeguarding Children Board Regulations 2006 which states that 'an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objective'.

Serious Case Review checklist

Decisions whether to initiate an SCR

The LSCB for the area in which the child is normally resident should decide whether an incident notified to them meets the criteria for an SCR. This decision should normally be made within one month of notification of the incident. The final decision rests with the Chair of the LSCB. The Chair may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the SCR process.

The LSCB should let Ofsted, DfE and the national panel of independent experts know their decision within five working days of the Chair's decision.

If the LSCB decides not to initiate an SCR, their decision will be subject to scrutiny by the national panel. The LSCB should provide sufficient information to the panel on request to inform its deliberations and the LSCB Chair or the Chair's representative should be prepared to attend in person to give evidence to the panel. In cases where an LSCB is challenged by the national panel to change its original decision, the LSCB should inform Ofsted, DfE and the national panel of the final outcome.

Appointing reviewers

The LSCB must appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance. The lead reviewer should be independent of the LSCB and the organisations involved in the case. The LSCB should provide the national panel of independent experts with the name(s) of the individual(s) they appoint to conduct the SCR. The LSCB should consider carefully any advice from the independent expert panel about appointment of reviewers.

Engagement of organisations

The LSCB should ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority should be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements. The LSCB may decide as part of the SCR to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review.

Timescale for SCR completion

The LSCB should aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort

should be made while the SCR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action to implement improvements and disseminate learning.

Agreeing improvement action

The LSCB should oversee the process of agreeing with partners what action they need to take in light of the SCR findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions.

Publication of reports

All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

Final SCR reports should:

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- be suitable for publication without needing to be amended or redacted.

LSCBs should publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.

When compiling and preparing to publish reports, LSCBs should consider carefully how best to manage the impact of publication on children, family members and others affected by the case. LSCBs must comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders. The timing of publication should have due regard to the impact on any ongoing legal proceedings, including any inquest.

LSCBs should send copies of all SCR reports, including any action taken as a result of the findings of the SCR, to Ofsted, DfE and the national panel of independent experts at least seven working

days before publication. If an LSCB considers that an SCR report should not be published, it should inform DfE and the national panel. The national panel will provide advice to the LSCB. The LSCB should provide all relevant information to the panel on request, to inform its deliberations. In cases where an LSCB is challenged by the panel to change its original decision about publication, the LSCB should inform Ofsted, DfE and the national panel of their final decision.

Appendix D Case Review Methodology documentation used when considering a Case for SCR

Northumberland Safeguarding Children Board

Case Review Sub Committee Meeting Notes
Consideration Request Form for Serious Case Review, Management Review or alternative methodology investigation

Please complete with as much information as you can and forward to robin.harper-coulson@northumberland.gscx.gov.uk as a password protected document or via another safe route.

Referrer (Name, Agency and Contact Details)		**Authorised by Senior Officer / NSCB Board Member (Name and Contact Details)**	
Date			

CHILD/YOUNG PERSON'S DETAILS

NB A separate form should be completed for each child, if more than one child in the family is the potential subject of a Serious Case Review

Family Name:		**Given Name:**	**Also known as:**
DoB or expected date of delivery:		Gender: Male ☐	Female Unborn ☐
Home Address (include Postcode):			
Social Worker's Name:		**Practice / Team Manager:**	
Health Visitor's Name		**Parent / Carer:**	
GP's Name & Address:			
School / Nursery attended:			
Children's Social Care/ Health / Education / Police / Other Case Reference Number: Please mark as appropriate:			
Siblings information if known:			

ASSOCIATED PEOPLE

Date, Brief Details Of Incident, agencies involved why consideration is required and what type of review you think is required – SCR / MADDR /Northumberland Review.	

N.B. FOR NSCB ACTION:

Date received		**NSCB Chair Notified of Request**	
Panel Meeting Arranged for:			
Panel Notified and Documents Sent Out.			

SCR Committee Discussion Regarding Agency Involvement with Family and Incident(s)

Date of Meeting:

Present:

Apologies:

In attendance:

Purpose of Meeting:

Agency Information re:

Recommendations:

Working Together 2015 Criteria To Determine Need For SCR

Q1 Has a child died (including death by suicide) **and** Yes No

Q2 Is abuse or neglect known or suspected to be a factor in the death Yes No

*Where the answer to both questions is **yes**, a **Serious Case Review should be conducted** into the involvement of organisations and professionals in the lives of the child and family.*

CRITERIA

A Serious Case Review **will be considered where**:

A child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development th abuse or neglect; or

A child has been subjected to serious sexual abuse; or

A parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; or

A child has been seriously harmed following a violent assault perpetrated by another child or an adult; **and**

The case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welf children. This includes inter-agency and/or inter-disciplinary working.

LSCB responsibility

Where partner agencies of more than one LSCB have known about or had contact with the child, the LSCB for the area in which the child is was normally resident should take lead responsibility for conducting any review. Any other LSCBs that have an interest or involvement in th case should co-operate as partners in jointly planning and undertaking the review. In the case of a looked after child, the Local Authority lookin after the child should exercise lead responsibility for conducting any review, again involving other LSCBs with an interest or involvement.

If the criteria is not met and the SCR Sub Committee agrees there are lessons to be learned they can propose an appropriate process for this to take place. In some cases, this may be a single individual management review (IMR) rather than a full SCR, for example where there are lessons to be learned about the way staff worked within one agency rather than about how agencies worked together, or a smaller scale audit

of an individual case that gives rise to concern but does not meet the criteria for a full SCR

Where a child has been seriously harmed answering 'yes' to several of the following questions is likely to indicate that a review could yield useful lessons.

Record response from each agency	Social Care	Health	Education	Police	Other Committee Members	Comments
1. Was there clear evidence of a risk of significant harm to the child which was:						
a) Not recognised by organisations or individuals in contact with the child or perpetrator or						
b) Not shared with others or						
c) Not acted upon appropriately?						
2. Was the child abused or neglected in an institutional setting (e.g. school, nursery, children or family centre, Youth Offending Institution, Secure Training Centre, children's home or Armed Services training establishment)?						
3. Was the child abused or neglected while being looked after by the local authority (LA)?						
4. Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?						
5. Did the child suffer harm during an unauthorised absence from an institution or having run away from home or other care setting?						
6. Does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted on appropriately, by another?						
7. Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures, which go beyond the handling of this case?						
8. Was the child the subject of a child protection plan, or had they previously been the subject of a plan or on the child protection register?						

	Record response from each agency	Social Care	Health	Education	Police	Other Committee Members	Comments
9.	Does the case appear to have implications for a range of agencies and/or professionals?						
10.	Does the case suggest that the NSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?						
11.	Are there any indications that the circumstances of the case may have national implications for systems or processes or, that it is in the public interest to undertake a SCR?						

Criteria for Serious Case Review met **Yes** _____ **No** _____

Does this case meet the NSCB responsibility criteria for NSCB to take lead responsibility? Yes _____ No _____
If no, which if any LSCB should? _____

Alternative Process Proposed **Yes** _____ **No** _____

Methodology to be used:

Agencies to be Involved in Review

Proposed Outline Terms of Reference

Date Submitted to NSCB Chair and Chairs Decision

Date SCR Notification Submitted to Ofsted

Appendix E: Managing human error within the context of disciplinary/capability procedures.

How organisations respond to failure significantly affects the culture and willingness of staff to reflect on their actions and learn from mistakes and errors. Dekker argues that organisations have two options when faced with an apparent failure. The first is to view every mistake as human error and essentially identify an individual as the problem. The second is to see human error as a symptom of a deeper systemic issue. To expand this slightly; a view of human error as being the sole responsibility of the individual encourages a process of explaining failure by seeking failure- a process focussed on seeking out inaccurate assessments, wrong decisions, and bad judgements, attributing blame on individuals, bad apples in an otherwise perfect system. The alternative focusses on a process that explains failure by strenuously and forensically exploring how assessments and actions made sense at the time given the context people were working within at the time. This approach is strongly advocated within Working Together 2013 and the systems methodology. It seeks to drive at the heart of why something happened as well as what happened. An organisational culture that encourages learning from a systems approach is more likely to get to the heart of the issues given that honesty, transparency and willingness for individual and organisational self-reflection are pre-requisites.

However, it is not possible to ignore human error where the outcome is as a result of a conscious and substantial disregard for risk or safety. In such circumstances it is entirely appropriate to take any necessary disciplinary investigative process.

This guide is intended to assist NSCB partners when exploring the culpability of individuals when a case goes wrong and is subject to a multi-agency case review within the terms of the learning and development framework. The intention is also to reassure staff directly involved in these cases that each partner adopts a balanced proportionate approach in such circumstances. This model is adapted from the FAIR process conceived by Baines and Simmons (airworthiness and safety solutions).

Flowchart Analysis of Investigation Results (FAIR)

Each organisation has a duty to examine the circumstances when something goes wrong. Not all circumstances will be clear at the initial stages and may only emerge over time. However there will be prima facia evidence available from the very earliest of stages which should inform a decision of what to do next.

The flowchart attached (appendix 1) poses a number of questions which can act as a guide in determining what motivations might have been at work when decisions or actions were made. Those boxes coloured green or orange would indicate that the organisational response might be directed at improving the individual's performance though competency based support and or considering organisational changes so as to mitigate the likelihood of a recurrence. Those boxes which are red indicate that the organisational response might appropriately be directed through disciplinary action. It is only a guide and the level and depth that each question can be explored is likely to change over time particularly as the facts about actions taken throughout the course of a case under review will emerge gradually. Organisations may want to

revisit earlier decisions regarding the appropriateness of actions at specific points throughout the review process.

The scale develops in increasing culpability from an 'Unintended action resulting in an unintended consequence' through 'Intended Action with unintended consequence' through to 'Intended Action with intended consequence'

Unintended action resulting in an unintended consequence. This is likely to be an error where rules weren't deliberately broken and the correct plan or intervention was taken but resulted in a bad outcome.

Intended Action with unintended consequence. This is likely to be a mistake though unintentional rule breaking or more seriously intentional rule breaking as a result of the situation/context but the motivation was for organisational gain. In this situation a very careful exploration of whether the decision or action was justifiable in the circumstances will be needed.

Intended Action with intended consequence. This is likely to be intentional rule breaking with the intention of sabotage or as a result of recklessness for personal gain or advantage.

A number of checks and balances can be adopted throughout this process which might help to guide the organisations decision.

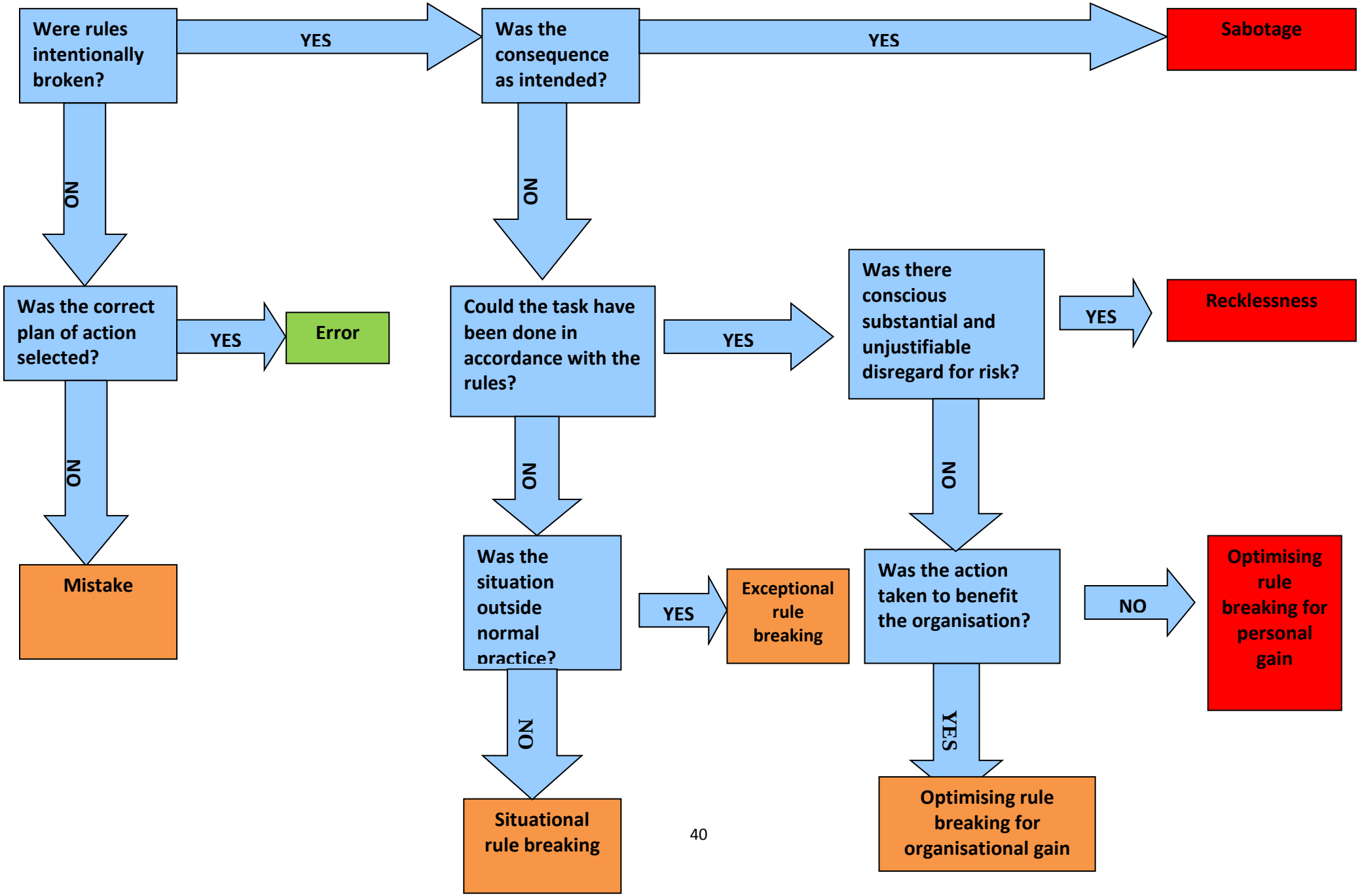
1. Substitution test: - also known as the Bolam test. Would another peer with the same competency, education, and experience have behaved the same way/ made the same decision/ taken the same action? In other words would a responsible body of co professionals agree with the action taken?

2. Routine test: - Has this event happened before to a) the individual or b) the organisation?

3. Proportional punishment test: - What 'safety' value will punishment have? - Consider unintended consequences on the staff group and organisation- do the gains justify the losses?

4. Intervention: - What needs to happen to reduce the likelihood of recurrence at a) an individual level and b) an organisational level?

Managing human error within the context of disciplinary/capability procedures



Appendix F: The Systems Approach – a summary:

Human errors are consequences not just causes

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

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

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

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