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Title

Feasibility and acceptability of the 'Never Events' method in the context of multi-agency child protection: findings from an exploratory study

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Abstract

This report outlines an exploratory study that investigated whether the 'Never Events' system – first used in healthcare contexts to identify and investigate (preventable) incidents that cause serious harm or death as a result of human error – could be adapted in the context of UK multi-agency child protection. Using a sequential design, two online surveys were carried out that explored practitioners' (n=46) views about the feasibility of adopting the Never Events model and what, if any, incidents or events could be investigated plausibly using such a model. Practitioners were drawn from a purposive sample. An inter-disciplinary panel of senior practitioners (drawn from nursing, public health, social work and child mental health services) discussed the surveys' findings and the list of proposed child protection Never Events. The findings indicate that the complex, judgement-based nature of child protection contributes to difficulties creating shared understandings about what constitutes harm and the extent to which multi-agency systems can share decision-making and responsibility for the way they identify and support families. Thinking through and discussing the relative strengths and limitations of the Never Events model may nevertheless be a valuable exercise in interprofessional training and local service design.

Introduction

The exploratory study reported here investigated whether a quality monitoring method used in health care could be usefully adapted in the context of multi-agency child protection in the United Kingdom (UK). Over the past forty years there have been significant changes in political and cultural expectations about the degree to which public institutions can be expected to mitigate and prevent risk and harm to children (Rothstein, 2006). Comparative international research indicates that countries that offer a narrower understanding of their responsibilities towards children and families – often in the context of neoliberal social and economic policies – tend to frame child protection in terms of preventing serious 'forensic' levels of harm and offering a basic social safety net (Parton, 2014). This is in comparison to countries that adopt a more holistic understanding of familial welfare (rather than protection), that is combined with a state-focused drive to reduce the impact of social and economic inequalities on children and adults. In the former group of countries, that includes the UK, there has been a tendency to seek explanation and responsibility for harm to children in the perceived failings of the child protection system and its practitioners (Frost, 2016). This focus on individual workers is in part fostered by a lack of critical debate and understanding about the strengths and complexities of child welfare and protective systems (Sidebotham, 2011). In addition, the under-theorised, poorly evaluated and fragmented nature of knowledge about 'what works' in child protection has made it difficult for professionals to challenge the way that their work is measured and qualified (Munro, 2009).

Multi-agency working has been a site of considerable policy and practice attention in UK child protection over the past two decades, with a notable focus on improving communication and decision-making, and embedding integrated working and referral pathways between key agencies (DfE 2018). Nevertheless, there is limited evidence to suggest that these changes

have fundamentally improved joint-working practices and the collective ability to prevent (Hudson, 2009). It has also proved difficult to re-frame interprofessional collaboration as a form of expertise, underpinned by interdependent relationships; instead it tends to be understood as a technical task (Hood et al, 2017). It is against this backdrop that the 2011 Munro Report called for systemic change in UK child protection, characterised by: placing greater trust in professional and family-led expertise, re-emphasising the role of collective learning and reflection (rather than investigation and blame) and the need for strong organisational leadership and accountability (DfE, 2011). In the decade since Munro (DfE, 2011), different professions– principally social work, education and health - have sought to implement it's findings, with mixed success. One consequence of which is a notable increase in the use of systems-focused practice and critical learning fora, implemented at the local level (e.g. Jenkins et al 2017; Ashley, Armitage & Taylor, 2017).

Never Events

The Never Events system was first developed in the United States and, from 2008, has been adopted by the UK National Health Service (NHS). Never Events are serious incidents that have caused, or have the potential to cause, serious harm or death. Examples of Never Events include: wrong-site surgery, patient falls due to poorly restricted windows and administration of medication by the wrong route (NHS 2018a). The Never Events model draws on principles of a 'systems-focused' approach to quality and governance (Mehuston et al, 2013; NHS 2018b) – as also championed by Munro (DfE, 2011). Underpinned by principles in mechanical and aeronautical engineering, the approach takes as axiomatic that 'errors' have multiple causes and whilst individual mistakes are one source of failure, most errors are caused by latent conditions in a person's environment or social structure (Reason, 2000; Mehuston et al, 2013).

Methods

Study design and research setting

Using a sequential design, two online surveys were carried out that explored practitioners' views about the feasibility of adopting the Never Events model and what, if any, incidents or events could be investigated credibly using it in the UK child protection context. We convened a group of ten senior practitioners to discuss the surveys' findings and their implications for practice. The study was carried out in the UK.

Participants (sampling and recruitment)

For Round One, participants were recruited from health, social work, child mental health and voluntary sector children's services where practitioners specialised in, or regularly encountered, issues relating to child welfare and protection. We shared study information with central 'gatekeepers' who then cascaded the information amongst their networks. We are therefore unable to determine our respondent-rate. Forty-six participants took part in Round One, 34 identified as female and 12 as male; the two most common participant groups were, perhaps unsurprisingly, health and social work. Ten participants elected to take part in the second round survey and we invited ten senior practitioners to attend the panel discussion as part of Round Three.

Data collection and analysis

The Round One questionnaire asked whether participants thought the application of a Never Events list in child protection was an acceptable idea that warranted further exploration. If participants answered yes/maybe, they were invited to share examples of possible Never Events. Descriptive statistics were used to analyse participants' demographic and

professional data. For Round Two, participants were given illustrative examples of potential events (based on responses from Round One) in each of the seven categories and asked to rank these categories in order of their suitability to be considered Never Events and explain their reasoning. The qualitative data from both rounds were coded and analysed using a thematic approach, as characterised by Braun and Clarke (2006). In Round Three, we convened an interdisciplinary panel of senior practitioners to discuss the surveys' findings and the list of proposed child protection Never Events.

Ethical considerations

The study received ethical approval from the University of Stirlimg research ethics board. Key ethical issues included ensuring the anonymity of, and support for, participants when asking them questions about 'errors' and accountability in child protection as we recognised, that the topic could evoke emotional responses from practitioners, particularly those who had had experience working with and/ or being part of investigations into serious harm to children (Peckover, Smith, & Wondergem, 2015). Participant information sheets encouraged professionals to reflect on these issues before consenting to take part, and to contact the research team should they have questions or concerns after taking part in the study.

Results

Round One

In response to the question 'do you think that a Never Events list is of potential use in child protection?' 37 participants answered 'yes' or 'maybe'. One participant answered 'no' and eight participants did not answer this question. There was no clear association between participants' professioanl background and their response. However, when participants were grouped as either 'health' or 'non-health', it was evident that a higher proportion of 'health'

participants' identified that the model could be adopted or adapted in the child protection field. This finding may reflect that health practitioners are likely to be familiar with the concept and operationalisation of Never Events and this enhanced their confidence offering a positive opinion about its feasibility.

Participants who answered 'yes' or 'maybe' were invited to provide examples of potential Never Events. Our analysis identified seven core categories and these are outlined alongside illustrative examples in Table 1.

Insert Table 1

Several participants identified potential limitations or disadvantages of adapting Never Events on the ground that it was unclear what it would 'add' to current systems of reporting and investigating. They also commented that the model could be too simplistic to capture the complexity of child protection practice. This is illustrated by Participant 8's comment that child protection practice required:

> *"Nuanced judgements and decisions, based on a wide range of factors… Putting things on a Never Events list may have the effect simply of making the process of blame, usually of social workers, easier."*

Reflecting on these comments, we began to consider what might be the potential barriers for different groups of practitioners in collectively conceptualising harm to children as predictable or preventable.

Round Two

Ten participants were asked to rank the proposed categories in order of 'most' to 'least' appropriate and to share the reasons for their decisions. The findings suggest that individual 'failures' or 'errors' were considered amongst the most avoidable and that failures to work in a child-centred way were amongst the most serious, as illustrated by the following statement:

> *"It is just as important that the child is able to see and feel that 'something can be done' by meeting with and asking about them, as it is to be child rather an adult focussed in one's investigation and assessments"*. Participant 2

There was a greater degree of consensus between participant responses when ranking the 'least' appropriate type of Never Event. Five out of ten participants suggested that although human error could not be eliminated, robust systems of monitoring and learning can feasibly reduce such errors resulting in serious harm or death. As Participant 10 commented, *"if organisational culture is good, leadership is safe, strong and effective then safe practice follows."* Nevertheless, participants consistently identified that the dynamic nature of child protection practice made it challenging to implement a system that required a high level of diagnostic clarity and definitional consensus. This could in turn lead to the blaming of individuals when 'errors' were neither intentional nor preventable, as illustrated by the following comment:

> *"Indicators of harm are particularly challenging to identify and action. No professional intentionally misses indicators of harm and given the often hidden nature of risk and abuse this is inevitably going to lead to missed opportunities"*. Participant 1

Thus, although there was agreement that interprofessional working could be strengthened by shared systems of reporting and investigation, participants did not think the Never Events model was sophisticated enough to account for the complexity of factors affecting inter-agency child protection.

Round three

In Round Three, we convened a discussion panel to share and critically discuss the synthesised findings of Rounds One and Two. One of the advantages most frequently associated with the Never Events model was, participants suggested, that it would provide greater visibility to safety and quality issues in child protection. This was in turn thought to help to drive up collective expectations about what could be learnt from problems and systemic failures, in a similar way to other areas of health and medical care. During the discussion it nevertheless became evident that members of the group had different views about what a Never Events list would 'look like' and what its purpose would and could be outside of a health context. This engendered debates about what was 'preventable' and when, if ever, there was sufficient evidence to make such a judgement in relation to child protection and welfare. Finally, participants also questioned how a system of shared accountability and responsibility could be practically operationalised across agencies given their different governance structures. Their observations about the limited, and sometimes poor, levels of communication and trust between agencies underpinned concerns that it was hard to foresee a 'no blame' and collective response.

Discussion

This study highlights that, irrespective of the conceptual integrity of the Never Events system, the way that it is operationalised is highly dependent on its cultural and

organisational context. Participants' responses reflect that the evidence, reasoning and expectations of this clinical governance model are not likely to be replicated in a non-clinical and/or multi-agency context. Underlining the importance of sensitivity to intra-professional values, concepts and vocabulary (Morrisson, 2010) we also found that the terminology of 'Never Events' could be problematic, not least because for non-health professionals, the term 'never' may have seemed unnecessarily definitive and to have unhelpful moral undertones. It was thus difficult for practitioners to foresee how the model could be operated across organisational and disciplinary boundaries when collaboration is principally understood as a technical activity, bound by existing thresholds of what constitutes risk and harm to children (Hood et al, 2017).

Despite these limitations, it is noteworthy that study participants consistently endorsed the idea of having a more developed mechanism for collaborative learning and governance in child protection. In addition, many people welcomed the idea that 'errors' in child protection would be awarded more critical attention and that this would foster greater parity between child protection and other areas of health and medical care. With this in mind, there may be scope for further exploration of an (adapted) Never Events model in areas of practice where there is an existing, established body of empirical evidence and close working practices (e.g. because people work for the same organisation or within an established multi-agency partnership). For example, non-accidental injury to young infants or referral and support processes following medical examination after suspected child sexual assault.

Study limitations

We invited professionals to participate in the study because the principal topic was how risk and error are understood and acted on. We recognise that the study thus drew on a certain type of 'expert' and one whose voice is already awarded more power and privilege than most people who engage with child protection systems and organisations – i.e. those children and families with lived experience of support and protective measures (D'Cruz & Gillingham, 2017). It would be beneficial if future work foregrounded the views and experience of children and families and, using a larger sample, enabled comparison between professionals' and families' views of what 'types' of harm and risk are preventable and important.

Conclusion

This study found that the Never Events model is unlikely to be endorsed by practitioners if it was adapted in the multi-agency child protection context. This is principally because of the level of certainty, shared understanding and complex operational arrangements the model requires to work across different service and professional boundaries. Nevertheless, we found that participants welcomed the opportunity to critically discuss their views about preventable harm. They also provided innovative, insightful responses to the potential strengths and limitations of an adapted Never Events model in the spirit of improving collective responses and shared accountability. With the aim better privileging the lived experience of children, parents and practitioners when designing systems designed to prevent and mitigate risk (Munro, 2009; Hood et al, 2016), thinking through and discussing the relative strengths and limitations of the Never Events model may therefore be a valuable exercise in interprofessional training and local service design.

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