Why Core Competencies

Background information

Core Competencies

A training curriculum for independent chairs, report writers and reviewers of:

children's serious case reviews
safeguarding adults reviews
domestic homicide reviews
mental health homicide investigations

What are the Core Competencies?

Who are they for?

This document is intended for independent chairs and report writers who are appointed at the final independent or 'overview report' stage of serious case reviews, mental health investigations and domestic homicide reviews. Those who conduct individual management reviews or internal investigations may nevertheless gain from the information it contains.

We include panel members, for example psychiatrists and other professionals who contribute to the review process, including the writing of reports.

The document is also designed for those who train and commission independent chairs and report-writers.

It may be of interest to the public, service providers and victims who wish to know what kind of training is provided for those who undertake this very responsible, difficult and often criticised task.

For those who wish to know something about reviews and investigations other than their own, we include a summary of the statutory background to each.

For those less familiar with the confusingly different function of reviews, investigations and inquiries we survey the purpose of each, discovering the essential similarity between them all.

Why are they needed?

There is a wealth of guidance produced for commissioners of serious case reviews, mental health investigations and domestic homicide reviews. The guidance governs those parts of the process that are within the control of commissioners and providers. There is always an immediate response to a serious untoward incident, moving on to an internal review within single agencies. Finally, depending on the severity of the incident, there may be an independent investigation. It is this final stage with which we are concerned here. This is the point at which much of the guidance ceases to have effect, precisely because, on appointment, responsibility is handed over to an independent chair and report-writer. It is here that the interface with the public begins. It is the report of this review or investigation which will be remembered. These chairs and report-writers stand separately from the organizations concerned - and properly so - this is the whole purpose of their independence.

Yet, this is also the point at which there is no one system or national standard for the training of chairs and report-writers. No core skills and knowledge are identified anywhere for such a specialised task. The purpose of this document is to bring these together as core competencies.

Independence

Independent chairs must of course be independent. It seems obvious. However, the definition of independence varies. It could mean the chair did not him or herself provide a professional service in the case being reviewed - the definition usually used for management reviews. It may mean independence of the entire service provider, including all lines of management. This was the definition used and criticised in the serious case review concerning Baby Peter Connelly. How could there be true independence when recommendations made by a commissioner chair were directed to the same commissioning body? Independence, it was asserted, should be independence of the commissioners themselves.

Whichever of the above definitions is used, organisational independence is not enough. Independence must be an absence of bias, both in fact and as reasonably perceived by others. For example chairs and report-writers must remain neutral and not swayed by their professional allegiances. The public and those on the receiving end of reviews and investigations must be confident of this objectivity, which must be nurtured by the training chairs and report-writers receive. It is the backbone of the core competencies.

Who are the chairs and report writers?

Many independent chairs and report writers come from the backgrounds they review. Social workers in children's services become chairs of serious case reviews. Police become chairs of domestic homicide reviews. Chairs of mental health investigations may have a management or nursing background. Some work for private organisations or have experience in inspectorates. Others are lawyers. There is no one register of such individuals. Many will be wholly or partly self-employed. As chairs and report-writers many will pay for their training themselves.

Most chairs and report-writers will already be working very competently in their own fields. They will come to integrated training seeking the added value of shared training with those from different backgrounds with different expertise.

Such training may not always be comfortable. An openness to fresh ways of working is required. The core competencies are developed to advance the skills and expertise of independent chairs or report-writers so that their approach is rounded, thoughtful and continually developing. In short, they will become adaptable, professional chairs and report-writers.

Training and accreditation

Our aim is to be on the side of the chair and report-writer, to support him or her with the development of their training, providing a source and network for independent advice during the isolating process of chairing and report-writing. The core competencies enable an individual to identify and track their training needs, developing and maintaining their professional chairing and report-writing skills. They will be able to transfer skills from one form of review or investigation to another, with training including the possibility of sitting in on different kinds of review, observing them in action, in order to learn. They will develop new contacts and receive support as they do this.

Although the core competencies are intended to support integrated training - that is, shared training for chairs and report-writers of serious case reviews (children and vulnerable adults), domestic homicide reviews and mental health investigations - the core competencies are able to support all forms of training and accreditation, whichever the provider, including specialist training.

Existing training

It is not surprising that training for chairs and report-writers has developed within separate specialist areas. Children's serious case reviews are commissioned by Local Safeguarding Children Boards, mental health investigations are commissioned within the NHS, serious case reviews for vulnerable adults by local authority adult social services and domestic homicide reviews by local Community Safety Partnerships.

Nor is it surprising that training initiatives by the above have often been aimed at commissioners and internal reviewers. However it is encouraging that both the Home Office and Department for Education have been keen in the last few years to provide training for independent chairs, reviewers and report writers (see details on Sequeli's website).

Unfortunately, there is potential for difficulty here - an inbuilt conflict of interest. Training conducted within departments and by specialist local services can focus inwards, favour caution, become defensive and risk being viewed as internal and biased even though that might not be intended.

So existing training is valuable, but there should be an awareness of the need for external independent training. The Core Competencies provide a backbone for training which is outward looking and which cuts across specialist divides.

Why Core Competencies?

Common purpose	Commissioning arrangements and procedures may differ, but serious case reviews, independent mental health investigations and domestic homicide reviews share one purpose; to learn lessons and prevent a recurrence of the incident. Any review or investigation may also need to fulfill the functions of an effective investigation under Article 2 ECHR.
Convergence of styles	A gradual convergence is emerging between the styles of serious case reviews (children and vulnerable adults), mental health investigations and domestic homicide reviews, each drawing on expertise from the other or from shared methodologies. Systems methodologies for example are transferable.
One toolkit	The goal of learning lessons may be achieved in different ways. Whatever the commissioning arrangements, individual packages need to be chosen for each review. Chairs and report writers must know the options available and the principles they are applying to their choices. They will need to justify every decision they make - to professionals, providers of services, commissioners, victims and the public. Core competencies support Sequeli's training materials supplying one broad toolkit across the specialisms.
Issues in common	The same agencies, similar issues for example domestic violence, hearing from professionals, involving families, publication, anonymity, writing recommendations and many more - the list of shared issues is long.
Sharing of expertise	Poor communication between services is a repeated finding of reviews and investigations. Yet the separate training and different procedures as between serious case reviews, independent mental health investigations and domestic homicide reviews holds a mirror to that of the services being reviewed. One might say 'reviewer, heal thyself'. Core competencies cut across the different forms of review and investigation, enabling chairs to understand, communicate, share expertise and learn from each other.
Improved training	Core competencies focus on fundamental skills and knowledge rather than just procedure. The model comes from the Tribunal Service, where core competencies are used to train members of tribunals as varied as planning and immigration. The core competencies allow planning of training and Continuing Professional Development so that individuals can, over time, build and maintain their training profile. Commissioners will be able to see the training undertaken. Core competencies will apply even when training providers vary.
Transferability	Training in core competencies provides transferable skills and knowledge which chairs and report writers can apply to more than one kind of review or investigation. This avoids the need for duplication of training.
Consistency	Training based on core competencies promotes quality and standards, helping to produce consistency within specialist reviews and between different forms of review and investigation.
Reviews to provide reassurance	With inquiries, reviews and investigations remaining high profile, with increasing numbers of private provider contractual arrangements and with some national guidance as to the direction of reviews still unsettled, for example, concerning safeguarding adults reviews and children's serious case reviews, the public will look even more closely to chairs of reviews and inquiries for independent comment - especially when there is economic pressure on services , the public will wish to be reassured that services intended to protect the vulnerable are not failing. Independent chairs, reviewers and report writers must be ever more experienced and competent, with training set out clearly for the public to see.
A lean structure	The idea of core competencies is simple. It permits recognition of competency amongst chairs, report writers, trainers and commissioners, whatever the setting. It is transparent, can be understood by the public and is economically straightforward in times of financial constraint.

All about learning lessons

What's in a name?

Are reviews, investigations and inquiries different? The core competencies in this document are based on the observation that reviews, investigations and inquiries have the same purpose whatever the setting, whatever the format and whatever the name. With the same goal, learning can be shared and many of the core competencies use the words inquiry, investigation and review interchangeably.

Reviews investigations and inquiries are not...

It is important to know what reviews, investigations and inquiries are not.

None of them interfere with or replace the outcome of criminal proceedings. They do not establish criminal responsibility, do not use the 'beyond reasonable doubt' standard of proof of criminal courts and no individual criticized in any report acquires a criminal record.

None of them reinvestigate or alter any decision made by Coroners. The purpose of an inquest is to establish by what means the deceased died. There are a number of possible Coroner's verdicts, namely natural causes, suicide, accidental death or misadventure, unlawful killing and open verdict. Verdicts are determined on the basis of a civil standard of proof (except for unlawful killing which is to a criminal standard of proof). No inquiries, investigations or reviews frame their conclusions in these terms. Although narrative verdicts can carry the rider 'aggravated', or 'contributed to' by 'lack of care' or 'neglect', and in some circumstances inquests must carry out a full and fair inquiry into the circumstances of the death or an 'effective investigation' in order to comply with Article 2 ECHR, this means some inquests have features of reviews, it does not mean reviews carry out the functions of inquests.

They are not care proceedings under the Children Act, they do not replace findings made in Children Act proceedings and do not themselves make findings as to significant harm to a child based on a 'balance of probabilities' standard of proof.

They are not civil proceedings concerning negligence, which are adversarial proceedings with parties and heard before a judge. No findings are made which have any standing as findings in a civil court.

They are not tribunals, such as immigration or mental health tribunals which make decisions as to the law within the strict framework of legislation.

They are not disciplinary proceedings, these being actions taken by specific organizations in connection with their employment of particular individuals, such proceedings conforming strictly to disciplinary procedures.

They are not hearings before any professional body concerning professional misconduct.

They are not complaints, these being processes instigated by aggrieved individuals and directed towards particular organizations, being taken forward according to the organization's own procedures.

They are not arbitration processes, these having a legal framework intended to resolve disputes between parties.

Nor are they a process of mediation which is aimed at resolving disputes before any legal action between aggrieved parties.

In fact, no inquiries, investigations and reviews are adversarial, there are no parties and therefore no winners or losers and no legal consequences arising from any findings or conclusions.

Finally, inquiries, investigations and reviews are not journalistic endeavors and have no remit to go beyond the terms of reference set for them.

Reviews investigations and inquiries are...

ALL inquiries, investigations and reviews set out their purpose in the same terms; that of learning lessons or preventing a recurrence of the serious untoward incident (our emphasis below)

Reviews

Serious case 'reviews' concerning children are a requirement as stated in the LSCB Regulations 2006 which at Reg 5(1)(e) set out an LSCB's function in relation to serious case reviews being 'undertaking reviews of serious cases and advising the authority and their Board partners on **lessons to be learned**'. *Working Together to Safeguard Children (2013)* goes further and sets up a national panel on serious case reviews to ensure that 'appropriate action is taken **to learn from serious incidents**' and 'that those **lessons are shared** through publication of final SCR reports' (page 69).

The Care Act 2014 at Section 44(5) makes it a requirement that 'Each member of the Safeguarding Adults Board must co-operate in and contribute to the carrying out of a review under this section with a view to— (a) **identifying the lessons to be learnt** from the adult's case.'

Section 9 of the *Domestic Violence and Victims of Crime Act 2004* makes domestic homicide 'reviews' a statutory requirement, **'with a view to identifying the lessons to be learnt from the death'** (Section 9(1)).

Investigations

The *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation,* published by the NPSA on 1 March 2010, applies to the whole of the NHS and describes the **'responsibility to learn from these incidents to minimise the risk of them happening again'** (Executive Summary).

Independent mental health homicide 'inquiries' were renamed 'investigations' in June 2005 when guidance was amended by the Department of Health. The guidance opens with the sentence 'It is essential that **all adverse health care events are 'reviewed' in such a way that lessons can be learnt'.** Current *Independent investigation of serious patient safety incidents in mental health services: Good Practice Guidance* also states that the independent investigation team should identify events leading to the incident as '**This allows the underlying causes of the incident to emerge so that organisations can learn and put remedial action in place'** (page 30).

Inquiries

Even the Inquiries Act 2005 (the framework for all statutory inquiries) states 'The aim of inquiries is to help restore public confidence in systems or services by **'investigating' the facts and making recommendations to prevent recurrence, not to establish liability or to punish anyone'**.(Explanatory Notes to the Inquiries Act 2005 Section 2(8)).

'Effective investigations'

ANY inquiry, investigation or review may also have to consider the implications of Article 2 of the European Convention of Human Rights (ECHR) which provides that everyone's right to life shall be protected by law. The state must not take life and must take appropriate legislative and administrative steps to protect individuals from threats to life when in their care.

When Article 2 may have been violated, the state must ensure its system, taken as a whole, provides for a practical and effective investigation. As long as a review or investigation adheres to its own internal principles of transparency, timeliness and proportionality it is likely to satisfy this requirement.

Under some circumstances the state must go further and initiate an effective investigation. This may apply where the victim and/or perpetrator has been in custody of the state, such as in prison, detained under the Mental Health Act, subject to the Deprivation of Liberty Safeguards of the Mental Capacity Act 2005 or where there is control and responsibility for the victim, as for a child in hospital. In such cases the investigation has to have a sufficient element of independence and public scrutiny.

The law in this area is complex and in practice each case is considered individually. A full Article 2 effective investigation may not always be needed and criminal proceedings, civil proceedings and inquests may satisfy all or part of the requirement.

Background information

The authors

Core Competencies is written by Professor Roger Bullock, Gillian Downham and Wendy Rose OBE.

Sequeli

Sequeli is a social enterprise not-for-profit limited company created by Roger Bullock, Gillian Downham and Wendy Rose in order to promote learning of lessons following untoward incidents in the public services. Together with their advisors, Sequeli's members have considerable professional, practice, legal, policy, training and research experience concerning mental health homicide investigations, serious case reviews and domestic homicide reviews.

For more details please visit **www.sequeli.com**.

Advisors

Roger Bullock, Gillian Downham and Wendy Rose have been supported in the writing of the core competencies by expert advisors from a wide range of backgrounds. Please visit **www.sequeli.com** to read the profiles of Sequeli's advisors.

History of the Core Competencies

The core competencies are a revision of ***A Scoping Paper for the Development of a Training Curriculum for Chairs and Report writers of Serious Case Reviews, Mental Health Investigations and Domestic Homicide Reviews*** by Gillian Downham and Wendy Rose OBE, written on 22 October 2009 (also available at **www.sequeli.com**).

The idea of integrated training for chairs and authors of mental health homicide investigations, serious case reviews and domestic homicide reviews arose during a Centre for Social Policy seminar at Dartington Social Research Unit in June 2009, where the paper ***Learning Lessons: Using Inquiries for Change*** by Gillian Downham and Richard Lingham, Journal of Mental Health Law, Spring 2009 had been presented. This proposed a shared methodology for implementing recommendations across mental health homicide investigations, serious case reviews and domestic homicide reviews. It was a logical next step to apply the principles of that integrated approach to training of chairs and report writers - the decision to write a scoping paper was made by Wendy Rose and Gillian Downham that day. (the paper *Learning Lessons: Using Inquiries for Change* is also available at **www.sequeli.com**).

The *Scoping Paper* was presented at a unique cross-agency national seminar held in October 2009 in order to gauge support for the ideas it contained. In fact, strong support was given to the principle of an integrated training curriculum for chairs and report writers. Those attending the seminar included individuals from the following organisations:

Independent Police Complaints Commission, Metropolitan Police Violent Crime Directorate Community Safety Unit, Independent Advisory Panel on Deaths in Custody, Home Office Interpersonal Violence Team, Department of Children, Schools and Families National Safeguarding Delivery Unit, Ofsted, NSPCC, University of Edinburgh NSPCC Centre for UK-wide Learning in Child Protection, Care Quality Commission, National Patient Safety Agency, Department of Forensic Psychiatry Broadmoor Hospital, Department of Health Inquiries Section, Sainsbury Centre for Mental Health, University of East Anglia Social Work Department.

In November 2009 the idea of a unified training curriculum based on the *Scoping Paper* received further strong support at a high level summit *Learning from SUIs and independent investigations in mental health and learning disabilities: a better way forward?* organised jointly by the Care Quality Commission, National Patient Safety Agency, The NHS Confederation, The National Mental Health Development Unit and Leeds Partnerships NHS Foundation Trust.

With continued encouragement from their many advisors in the fields of serious case reviews, domestic homicide reviews and mental health investigations, Wendy Rose, Gillian Downham and Professor Roger Bullock revised the *Scoping Paper* and created the *Core Competencies*. It grew and now contains many suggestions made by others, both as to content and style, answering the questions most frequently asked. This is its third revision and it is anticipated that it will continue to evolve in response to experience and the commentary of those who read and use it.

A more detailed account of the background to Sequeli can be found at **www.sequeli.com**.