Doing 'Serious Case Reviews' : the views and experiences of NHS named and designated Safeguarding Children professionals

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Introduction

Serious Case Reviews (SCRs), undertaken when a child has died or been seriously harmed where abuse or neglect are a contributory factor and there are concerns about how agencies have worked together, are an important feature of contemporary child protection in England (Parton 2004; 2006; HM Government 2013; Munro 2010). The rationale underpinning SCRs is for agencies to learn lessons in order to improve intra- and inter-agency working to safeguard and promote the welfare of children. However, due to political and media scrutiny of the child protection system, particularly when things go wrong, they often drive policy and practice reforms locally and nationally (Munro 2004; 2010; Parton 2004; 2006). The value of SCRs has been questioned due to the similarity of recommendations and concerns that, rather than learning wider lessons, it is frequently public service organisations and front-line professionals who are blamed for errors of judgement or practice (Dale *et al.* 2005; Fish *et al.* 2008; Rose & Barnes 2008). In an attempt to overcome these problems, an alternative approach for reviewing cases, based upon systems analysis and endorsed as part of the Munro Review, is now being introduced in England (Fish *et al.* 2008; 2010; Munro 2011, p. 12; Department for Education 2011). This focuses upon the identification of underlying local factors that may influence practice more generally rather than the specifics of a particular case.

Whatever methodology is utilised it is clear that undertaking SCRs are substantial exercises (Brandon *et al.* 2009), and while there has been considerable interest in examining the outcomes of SCRs (Sinclair & Bullock 2002; Rose & Barnes 2008; Brandon *et al.* 2008; 2009; 2010) there has been little research interest in the everyday work processes associated with their production. To this end, this paper reports the findings of a small study undertaken

within the NHS which aimed to explore the views of specialist staff (Named and Designated Doctors and Nurses for Safeguarding Children) about their involvement in SCR processes.

There are differences across the UK in how serious cases are reviewed (see Vincent 2009); this paper focuses upon England and commences with a discussion of how SCRs have developed.

Background

The development of the case review process

An overview of the development of the SCR process illustrates how safeguarding children has become increasingly regulated and proceduralised (Munro 2010). As 'Working Together' guidance (DHSS 1988; DH 1991; 1999; HM Government 2006; 2010) has become more expansive (Parton 2011), so too have the requirements for SCRs to be undertaken. Case reviews were first introduced in 1988 *Working Together* (DHSS, 1988, para.9.1), and reiterated under Part 8 of *Working Together Under the Children Act 1989* (DH 1991 para. 8.1); this required that reviews be undertaken into the deaths of children where abuse was confirmed or suspected or likely to be of major public concern. The completed overview and individual agency reports were to be sent to the Department of Health, and although it was stated that Area Child Protection Committees (ACPCs) should "monitor and implement changes, details of which should be published", there was no specific guidance about doing this. The 1999 guidance introduced the title 'Serious Case Review' (SCR), the requirement for an executive summary action plan, and for reviews to be undertaken when cases give rise to concerns about inter-agency working (DH 1999).

In 2006, following the public inquiry into the death of Victoria Climbié (Laming 2003) and as part of a wider policy and legislative reforms, 'Working Together' guidance was once again revised (HM Government 2006). The 2006 revision placed stronger emphasis on involving families in the SCR, and required independent authors to write the overview reports. The guidance also made specific reference to a publicly available executive summary and indicates the minimum content required. Crucially the 2006 'Working Together' states the purpose of Serious Case Reviews is to learn lessons as well as identifying what changes are required to improve practice (HM Government 2006, p 170). This emphasis on learning lessons was further strengthened in the 2010 Working Together (HM Government 2010, pp 144) published in response to recommendations made by Lord Laming following the death of Peter Connelly (Laming 2009). Key elements include the effective dissemination of lessons and timely implementation of recommendations. Alongside this, the concept of 'independence' of the overview report author is also strengthened (HM Government 2010, para. 8.33). The revised document also requires the publication of an executive summary and provides detailed guidance about this. Laming (2009) also recommended a more robust evaluation of SCR reports, and this was undertaken by Ofsted who graded the SCR Overview Reports from 'inadequate' to 'outstanding'.

Since the election of the Coalition government in 2010 there has been some important developments in relation to SCRs. These include the discontinuing of Ofsted grading (Loughton 2012) and a commitment to full publication of Overview Reports (Loughton 2010). A revised 'Working Together', published in March 2013 (HM Government 2013), introduced the requirement for a national panel of independent experts to advise Local Safeguarding Children Boards (LSCBs) about the initiation and publication of SCRs. Final reports,

including the LSCB response are to be fully published. The revised guidance incorporates a more specific orientation towards learning and improvement; LSCBs are required to maintain a local learning and improvement framework and SCR outcomes will be linked to inspections. However whilst the guidance sets out some principles for undertaking SCRs – these include proportionality and independence – the model for undertaking them is not prescribed. Thus in future SCRs may be undertaken using a systems methodology recommended by the Munro review of child protection (Munro 2011; 2012; Department of Education 2011).

Learning from Serious Case Reviews

Serious Case Reviews provide a rich source of information about contemporary child protection and as such have been subject to a range of research reviews. These have largely focused upon what SCRs tell us about child deaths and serious incidents due to child maltreatment, and the lessons for improving child safeguarding at a policy and practice level. The biennial studies into SCRs have identified common errors in the collection, interpretation and sharing of information and shortcomings in decision making, interagency working and professional/family interaction (Sinclair & Bullock 2002; Rose & Barnes 2008; Brandon *et al.* 2008; 2009; 2010). Since 2008, Ofsted have produced overviews of SCRs; these highlight the features of cases and some recurring themes such as listening to the child/young person, and the vulnerabilities facing babies and older children (Ofsted 2008; 2009; 2010; 2011a; 2011b).

Despite this wealth of information about serious cases, it remains unclear whether SCRs contribute to learning and the avoidance of future errors (Fish *et al.* 2008; Rose &

Barnes 2008; Sidebotham 2012) or focus upon blame (Laming 2009; Munro 2010). Consequently work has been undertaken to improve recommendations and learning arising from SCRs (Sidebotham *et al.* 2010; Brandon *et al.* 2011a), as well as developing an alternative approach based upon systems analysis (Munro 2005; Fish *et al.* 2008). The latter, rather than a concern with individual error and blame seeks to identify underlying factors that either support good practice or create unsafe conditions within the work environment. One of the strengths of this model is its 'nearness to practice' (Fish *et al.* 2008, p. 127) and although recent piloting suggests it is more successful in engaging with front-line practitioners this approach is resource intensive (Fish *et al.* 2010, p. 17-18).

Given the time consuming and emotionally charged nature of SCR processes it is surprising little research has examined the perspective of those involved. Fish *et al.* (2008, p. 129-130), writing specifically about SCR methods, observed the dearth of published accounts of SCR processes from those involved. The exception is Brandon *et al.* (2009) who, in the biennial study of SCRs for 2005-2007 undertook telephone interviews with 17 LSCB members and 7 front line health and social care practitioners who had been involved in SCRs or with the child and/or family. While this largely provided details about the stages of the SCR process it did highlight the pressures facing those involved such as unrealistic timescales for completion and the emotional impact felt by practitioners (Brandon *et al.* 2009).

Thus while it is clear that SCRs are important drivers within English child protection and have been subject to critical debate, there has been little interest in examining their production from the perspective of those involved. This study is focused upon the

organisational context of the NHS, which provides a wide range of universal and specialist service for children and families, and examines the perspectives of health professionals with specialist Safeguarding Children roles (Named and Designated Doctors and Nurses for Safeguarding Children) about their involvement in SCR processes.

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Safeguarding Children in the NHS.

Within the NHS, specialist roles are undertaken by Named and Designated Safeguarding Children Doctors and Nurses. Designated professionals have a strategic lead for safeguarding children across the local health economy, while the role of Named professionals is to promote good practice and provide advice within their organisation (HM Government 2010). Named and Designated Nurse roles are usually a dedicated job; in contrast, Named and Designated Doctors usually continue in senior clinical roles with the specialist safeguarding remit undertaken as an additional role in protected time. The changing NHS landscape has seen a political emphasis on preserving these roles although the organisational arrangements are varied.

Although Named and Designated Safeguarding Children professional roles are long established within the NHS (HM Government 2010) little research has examined their work. Studies of the specialist safeguarding children nurse role have focused on child protection supervision and support (Lister & Crisp 2005; Rowse 2009) and their role in primary care reforms (Appleton 2012). The implementation of the Named Doctor role in a local context has been described by Polnay & Curnock (2003); they were also the subject of a research study reported by Power (2008), who used vignettes of a child protection scenario to compare the clinical judgements of specialist and non-specialist staff. More recently a survey

conducted by the Royal College of Paediatrics and Child Health found the majority of named and designated doctors who responded did not believe they have the time necessary to fulfil their functions effectively (RCPCH 2012, p. 4-5). There has also been a wider debate highlighting the challenges for doctors working in child protection, and their ongoing training needs (Bannon & Carter 2003; Carter *et al.* 2006; Skellern 2008) and this, rather than the specialist roles, appears to have been the focus of most discussion.

When a SCR is undertaken NHS Designated and Named Safeguarding Children professionals will be involved, although with different roles and responsibilities. Named staff are typically responsible for producing the Individual Management Reports (IMR) for their organisation, supporting staff and disseminating learning. Preparing an IMR involves gathering information and compiling a report which details their own organisation's involvement in the life of the child and family that is being reviewed. Designated professionals then produce a Health Overview Report which collates and analyses all the IMRs across the health economy from a commissioning perspective. These reports contribute to and inform the final SCR report, which is written by an independent author and overseen by an LSCB-appointed overview panel. No previous research has examined the work of NHS Named and Designated Safeguarding Children professionals in relation to SCR processes.

The Study

This study aimed to explore the views of NHS Named and Designated Safeguarding Children professionals in relation to the purpose and process of producing SCRs. The research questions were:

- What are the experiences of NHS Named and Designated Safeguarding Children professionals in relation to the SCR process?
- How do NHS Named and Designated Safeguarding Children professionals describe the organisational, professional and personal impact of producing SCRs?
- What do NHS Named and Designated Safeguarding Children professionals perceive to be the purpose of SCRs and the value of their outcomes at local and national level?

The study took place in a large metropolitan area in the north west of England during 2011. NHS ethics (IRAS) and Research and Development approval was gained for 20 sites within this geographical area; this included 10 Primary Care Trusts, 6 acute hospital Trusts and 3 mental health Trusts. Study information and an invitation to participate was sent to an executive lead for safeguarding with a request to circulate to all Named and Designated Safeguarding Children professionals within their organisation. Those who expressed an interest were asked to complete a consent form, and a time and date agreed for the telephone interview. In total 19 telephone interviews were undertaken with Named and Designated Safeguarding Children professionals.

The telephone interviews lasted approximately thirty minutes and followed a semi-structured interview schedule which asked respondents for their views and experiences of SCRs, their purpose, and the organisational, professional and personal impact of producing them. Telephone interviews were digitally recorded, transcribed verbatim and the data were analysed thematically (Braun & Clarke 2006). To strengthen rigour this was undertaken independently by two researchers, and involved repeatedly examining the data to identify patterns of meaning and themes. The research was undertaken according to established

ethical principles such as clearly explaining to participants the purpose of the research, establishing informed consent and ensuring anonymity.

The Participants

The study took place at a time of major organisational upheaval within the NHS and from April 2011 many staff previously employed by a PCT were transferred to other NHS organisations. This, together with some uncertainty about accurately directing the initial mailing impacted upon the recruitment challenges faced by this study.

The 19 NHS Named and Designated Safeguarding Children professionals who participated in this study included 5 Named Doctors, 10 Named Nurses, 1 Designated Doctor and 3 Designated Nurses for Safeguarding Children. They worked in acute, mental health and primary care settings, and thus were involved in safeguarding children in different contexts and roles. They also had varied experiences of involvement in SCRs with some reporting extensive experience and others relatively new to this work.

Findings

Doing the work

Doing SCRs are hard work and time consuming. The work involves information gathering, obtaining health care records, compiling chronologies of agency involvement, and speaking to and providing support for healthcare staff who worked with the child or family. The substantial work that SCRs require was reflected throughout the data as participants

described how doing SCRs impacts on their time and disrupts their routine work schedules. For example the following data extract lists the type of involvement associated with doing an SCR.

> *....when we have a Serious Case Review, you just know it's got to take priority over everything else. So we have spent an inordinate amount of time supporting the board, sitting on panels determining whether or not Serious Case Reviews are required, sitting on groups coming up with the terms of reference once that's determined, and then the amount of work you have got to put in attending the panels themselves which, you know, some days a full day, two days at a time. I would actually say that more of the work of reading and preparation for those meetings I end up doing in my own time (Interview 19).*

The time-consuming nature of doing SCRs which frequently involves out of hours or additional work, and taking work home in order to complete reports within tightly proscribed timescales was discussed by many participants. This was described by many as stressful and disruptive because it takes them away from routine work, physically as well as emotionally, and has to be fitted around existing work commitments. This was particularly problematic for doctors who identified difficulties in changing routine clinics and schedules.

> *Yes it's hugely stressful, everyone says that don't they, (laughter). I mean we are supposed to get protected time and be able to cancel other work. But in practice, particularly for a practising doctor it's really difficult to cancel work. So it's very difficult to cancel clinics and meetings and child development team and all the things*

that are booked in your diary. So it's very, very stressful, the sort of tight time scales. And I always end up doing a lot of it at home in my free time, and it has put a huge pressure on my home life (Interview 18).

There are also challenges in achieving organisational support and understanding about what undertaking a SCR involves; many participants suggested the time and work required was frequently under-estimated by senior managers

....the amount of work that's needed to actually undertake it and to do a really good piece of work and commit to it is massive. And I don't, I think, it's very under-estimated by senior managers in the organisation. I think it's recognised as being needed to be done. But there is, there isn't enough, I don't think, commitment in recognising that staff need to be released to do it, to actually do a good piece of work (Interview 12).

There were also considerable frustrations evident due to the rigid process associated with SCRs, in particular the requirement to produce reports within tight timescales (HM Government 2010 para. 8.23) which was a key source of stress.

And I think that timescales, they put the pressure on and you're very, very aware of them and you want to do the best job. But you're very aware that you're doing it in a very time limited way and that you need to. And it's all that commitment, but it's other things as well, because it affects everything, it affects your overall practice I think and what's going on in the office, because everything, you know, everything takes a

second, back step, but it's family life and everything gets completely affected and the timescales I think are very tight (Interview 12).

Other participants described the work of producing a SCR as long-winded and bureaucratic. It was considered that much effort was directed at refining the report, rather than focusing upon the lessons of the case which often emerged early in the process. Thus producing a SCR creates considerable pressure for those involved, and is frequently experienced as intensive and stressful.

Emotional Dimensions

SCRs are undertaken when a child has died or suffered a serious incident, so it is unsurprising some participants found their involvement emotionally difficult.

Yeah well I think you can't help become emotionally involved because you learn about a child's life from beginning to end. So even though you have not met that child it is like you have formed a relationship with them, through the notes, because you have seen how they have progressed and how they have been seen with their parents and things like that. So it does have an emotional impact and though the outcome isn't. Even though you know the outcome because that is why you do Serious Case Reviews. So it does have an emotional impact (Interview 14).

The following participant highlights another reason contributing to the emotional aspect of involvement in SCRs.

.... I think also on the emotional side is ensuring that you get it right, and I guess there might be some fear of, or stress, anxiety around what if my report is deemed to be a complete disaster by OFSTED. Because it's quite important, you know it does carry quite a bit of weight the rating (Interview 13).

The stresses associated with producing the report were described by most participants as the main source of emotional distress. As the above extract indicates 'getting it right' was a key concern. While there were a number of stakeholders whom participants felt they needed to 'get it right' for – this included the child and family, the NHS organisation, the SCR Overview author and panel and the LSCB – there was no doubt that, at the time the study took place, meeting Ofsted requirements was the primary concern. The workload and time commitments outlined earlier, also added an emotional dimensional to producing the report.

Other reasons contributing to the emotional impact included a perception that lessons had not been learnt and similar issues were recurring, and that the focus upon the child or young person who was the subject of the review was lost. Many participants suggested producing the SCR within the proscribed process, and in particular meeting Ofsted requirements, had taken the focus away from safeguarding children.

But I have to say when it comes to the Serious Case Review itself, I think the main agenda is the Ofsted. You wouldn't have thought so. But I think, you know, if you honestly ask people what drives the Serious Case Review you know after that initial

'oh a child's died and we've got to learn lessons'. It's the process, it's what are Ofsted are going to say? (Interview 4).

The emotional dimension of involvement in SCRs was a key theme, and although unsurprising, participants reported various experiences of support and preparation. While many reported attending recent training, this had not always been available and many recalled learning on the job, guided by more experienced colleagues. Participants also reported varied experiences of support from colleagues, with some receiving good support and supervision, and others feeling isolated and unsupported in the SCR process.

Learning or Being Judged?

Most participants considered the purpose of SCRs was to learn lessons and prevent similar events occurring in the future. This is illustrated in the following data extract.

I think the purpose is really to learn isn't it. To learn, how can I put it. It's a learning thing isn't it? Because something has gone wrong somewhere. The purpose is to find out what went wrong, make sure that it doesn't happen again, make sure that we're doing it better, we're supporting the families better, make sure that we are picking things, you know, better than before, so that the same issues or the same problem never happens again. I think it's a learning, it's learning from what happened and not, you know, repeating the same mistakes again (Interview 7).

This emphasis upon learning lessons from SCRs reflects the dominant discourse about their purpose (Brandon *et al.* 2009; 2010; HM Government 2010; Munro 2011), and was widely reiterated by participants in this study. Many were involved in disseminating the learning from SCRs within their organisation or professional group.

Some participants identified some positive outcomes from SCRs they had been involved; these included recommendations leading to practice improvements about issues such as working with fathers, parental alcohol use, and tighter case planning. SCRs were also used in supervision with staff . The time lag between preparing the case review and implementing the learning was identified as a tension as were the challenges of embedding learning and sustaining change. Concerns were expressed about the often local nature of learning from SCRs, with some suggesting the need for a national resource to facilitate wider sharing of learning.

Despite the learning discourse being the key rationale for conducting SCRs, there were also some concerns about their overall purpose.

> *.... in theory, I guess the purpose of them is to learn from things that have gone wrong, to make sure they don't go wrong again. In reality, at the moment, the purpose is to tick the boxes and for Ofsted to be able to mark your work as an academic reflection on how it's been written for your organisation. Not about the actual content of what you've analysed and what you've said about that child and the learning. It doesn't seem that the content is particularly relevant, it's more the way it's written and* how *it's been put together basically (Interview 9).*

The idea that Ofsted were marking reports like an academic piece of work, was echoed by many of the participants, suggesting fear of being judged or blamed centres more upon their performance in accomplishing the reports rather than any practice or organisational issues uncovered by the case review.

Discussion

SCRs are an important feature of the English child protection system, shaped by and contributing to policy and practice developments. As they have grown in importance SCRs have become the subject of research attention, although this has focused upon analysing the features of cases and the learning required to improve safeguarding practice (Brandon *et al.* 2009; 2010; 2011a; 2011b). Concerns about how these processes lead to professional blame and a defensive and risk oriented safeguarding culture have been widely debated (Rose & Barnes 2008; Laming 2009; Munro 2010; Sidebotham 2012). As a result there is a shift towards adopting a systems-based approach to learning from serious cases (Munro 2005; 2011; Fish *et al.* 2008).

Undertaking SCRs are substantial exercises, but little research has examined the everyday work processes associated with their production (Brandon *et al* 2009). This study explored the views of NHS Named and Designated Safeguarding Children professionals about their involvement. A key finding has been the additional workload required to produce a SCR; this has temporal, organisational and emotional elements, and suggests staff could be more fully supported and prepared for undertaking this work. There are also tensions as to whether SCRs promote learning or blame. This is a well-rehearsed theme, but in this study

concerns about blame focused upon producing the report rather than the case itself. Fears of being judged on the report contributed to emotional stress and detracted from the child safeguarding focus that many felt should underpin this work. The ending of Ofsted evaluation of SCRs and revised guidance introduced since the fieldwork was completed (HM Government 2013; Loughton 2012) may address some of these concerns about being blamed, but the study also found that doing SCRs is experienced as a rigid and bureaucratic process. While the discourse of learning was evident, the study also found mixed views about the value of SCRs.

The research examined an organisationally sensitive topic at a time of rapidly evolving policy reforms. This included developments about conducting SCRs which included full publication, the debate generated by the Munro review and interest in the systems approach (Munro 2011; Fish *et al* 2008). There were also significant organisational changes within the NHS at the time of the study; in particular from April 2011 many staff previously employed by a PCT were transferred to other NHS organisations, and this may have impacted upon study recruitment.

Conclusion

SCRs are important artefacts of the English child protection system. They are produced in line with institutional requirements and as such display a scientific-bureaucratic rationality (Lam 2000). Their production involves multi-agency and multi-professional contributions, which combine to establish a 'master narrative' of the case. The processes for undertaking this are laid down in statutory guidance (HM Government 2013), but

nevertheless this involves a social process to which safeguarding professionals contribute and are accountable.

This study has drawn attention to underlying social processes in the production of SCRs. In particular it highlights the efforts in accomplishing the SCR reports - clearly this is not simply a case of gathering and compiling information, but a multi-layered task which requires the collation and sense making of multiple agency accounts of organisational and professional involvement in the case. This aspect of the work has been largely invisible in recent debates about SCRs. Fish *et al* (2008, p129-130) point out the paucity of discussion about methods used for SCRs.

> *'The community of people involved in both commissioning and conducting case reviews is large and contains a wealth of experience ....we would like to urge all those involved to talk and write about their experiences and reflections on the methodologies that they have used and the kinds of learning achieved thereby* (Fish *et al* 2008, p.130).

This study focuses upon the views and experiences of NHS Named and Designated Safeguarding Children professionals involved in SCR processes, rather than the methods of undertaking the reviews. Nonetheless it is hoped the findings contribute to enhancing the overall understanding of how such processes are undertaken, and helps to open up to scrutiny the work required and the challenges generated for those involved in these important processes (Fish *et al* 2008).

References

Appleton J.V. 2012. Delivering safeguarding children services in primary care: responding to national child protection policy. *Primary Health Care Research and Development* **13**: 60-71. DOI:10.1017/S1463423611000375

Bannon M. J. & Carter Y.H. 2003. Paediatricians and child protection: the need for effective education and training. *Archives of Disease in Childhood* **88:** 560–562.

Brandon M., Bailey S., Belderson P., Gardner R., Sidebotham P., Dodsworth J., Warren C. & Black J. 2009. *Understanding Serious Case Reviews and their Impact: A biennial analysis of serious case reviews 2005-07.* Department for Children, Schools and Families: London.

Brandon M., Bailey S., Belderson P. 2010. *Building on the Learning from Serious Case Reviews: a two year analysis of child protection database notifications 2007-2009.* Department for Education: London.

Brandon M., Sidebotham P., Bailey S & Belderson P. 2011a. *A study of recommendations arising from serious case reviews 2009-2010.* Department for Education: London.

Brandon M., Sidebotham P., Ellis C., Bailey S. & Belderson P. 2011b. *Child and family practitioners' understanding of child development: Lessons learnt from a small sample of serious case reviews.* Department for Education. Available https://www.education.gov.uk/publications

Brandon M., Belderson P., Warren C., Howe D., Gardner R., Dodsworth J. & Black J. 2008. *Analysing child deaths and serious injury through abuse and neglect: what can we*

learn? A biennial analysis of serious case reviews 2003-05. Department for Children, Schools and Families: London.

Braun V. & Clarke V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**: 77-101.

Carter Y.H., Bannon M.J., Limbert C., Docherty A. & Barlow J. 2006. Improving child protection: a systematic review of training and procedural interventions. *Arcives of Disease in Childhood* **91**:740-743.

Crisp B.R. & Lister P.G. 2004. Child protection and public health nurses' responsibilities. *Journal of Advanced Nursing* **47**: 656-63.

Dale P., Green R. & Fellows R. 2005. *Child Protection Assessment Following Serious Injuries to Infants: Fine Judgments*. John Wiley & Sons: Chichester.

Department for Education and Skills 2003. *Every Child Matters: Change for Children*. The Stationery Office: London.

Department of Health 1991. *Working Together Under the Children Act 1989: a guide to arrangements for inter-agency co-operation for the protection of children from abuse.* Department of Health & Home Office, HMSO: London.

Department of Health 1999. *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children.* Department of Health, Home Office, Department for Education and Employment: London.

Department for Education 2011. *A child-centred system. The Government's response to the Munro review of child protection.* Department for Education: London. Available https://www.education.gov.uk/publications

Devaney J.,Lazenbatt A. & Bunting L. 2011. Inquiring into Non-Accidental Child Deaths: Reviewing the Review Process. *British Journal of Social Work* **41**: 242-260.

Fish S., Munro E. & Bairstow S. 2008. *Learning together to safeguard children: developing a multi-agency systems approach for case reviews.* SCIE Report 19. Social Care Institute for Excellence: London. Available www.scie.org.uk

Fish S., Munro E. & Bairstow S. 2010. *Piloting the SCIE 'systems' model for case reviews: learning from the North West.* SCIE: London. Available www.scie.org.uk

HM Government 2006. *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children.* The Stationery Office: London.

HM Government 2010. *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children.* Department for Children, Schools and Families: London.

H.M. Government 2013. *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. Department of Education, London.

Lam A., 2000 Tacit knowledge, organisational learning and societal institutions: An integrated framework *Organisational Studies* 21: 487 - 518

Lord Laming 2009. *The Protection of Children in England: A Progress Report*. The Stationery Office: London.

Lord Laming (2003). *The Victoria Climbie Inquiry: Report of an Inquiry by Lord Laming.* Command 5730. Norwich: Stationery Office.

Loughton T. (2010). *Letter to LSCB chairs, Directors of children's services: publication of serious case review overview reports.* Tim Loughton, Parliamentary Under-Secretary of State for Children and Families. 10 June 2010. London, Department of Education.

Loughton T. (2012). *Letter to LSCB chairs, Directors of children's services: evaluation of serious case review overview reports.* Tim Loughton, Parliamentary Under-Secretary of State for Children and Families. 5 July 2012. London, Department of Education.

Munro E. 2005. A systems approach to investigating child abuse deaths. *British Journal of Social Work* 35: 531-546.

Munro E. 2004. 'The impact of child abuse inquiries since 1990'. In Stanley, N. and Manthorpe J. (eds). *The Age of the Inquiry: Learning and Blaming in Health and Social Care*. Routledge: London.

Munro E. 2010. *The Munro Review of Child Protection 1st Report - Child Protection: A Systems.* The Stationery Office: London.

Munro E. 2011. *The Munro Review of Child Protection Final Report: A child centred system*. The Stationery Office: London.

Munro E. 2012. *The Munro Review of Child Protection. Progress Report: Moving towards a child centred system*. The Stationery Office: London.

Munro E. 1999. Common errors of reasoning in child protection work. *Child Abuse and Neglect* **23**: 745-758.

Munro E. 2010. Learning to reduce risk in child protection. *British Journal of Social Work* **40**: 1135-1151.

Ofsted 2008. *Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008*, Ofsted: London.

Ofsted 2009. *Learning lessons from serious case reviews: year 2 (2008-09). Ofsted:* London.

Ofsted 2010. *Learning lessons from serious case reviews (2009-10).* London: Ofsted.

Ofsted 2011a. *The voice of the child: learning lessons from serious case reviews. A thematic report of Ofsted's evaluation of serious case reviews from 1 April to 30 September 2010.* Available http://www.ofsted.gov.uk

Ofsted 2011b. *Ages of concern: learning lessons from serious case reviews. A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011.* Available http://www.ofsted.gov.uk

Ofsted 2011c. *Letter from John Goldup to Directors of Children's Services and Chairs of Local Safeguarding Children's Boards.* 14/12/11. Available http://www.ofsted.gov.uk/resources/serious-case-review-evaluations-april-2007-onwards

Parton N. 2004. From Maria Colwell to Victoria Climbie: Reflections on public inquiries into child abuse a generation apart. *Child Abuse Review* **13**: 80–94.

Parton N. 2006. *Safeguarding Childhood in a Late Modern Society*. Palgrave: London.

Parton, N. 2011. *The increasing length and complexity of central government guidance about child abuse in England: 1974-2010*. Discussion Paper. University of Huddersfield, Huddersfield. (Unpublished). Available at http://eprints.hud.ac.uk/9906/

Polnay J. & Curnock D.A. 2003. What's in a Name? Named Doctor in Child Protection Interpretation and Implementation of the Role. *Child Abuse Review* **12**: 335-346.

Power S. 2008. Named/designated doctor status and judgement in child protection scenarios. *Archives of Diseases in Childhood.* **93**:612-613.

Reder P. & Duncan S. 2004. 'From Colwell to Climbie: Inquiring into fatal child abuse,' in Stanley, N. and Manthorpe, J. (eds). *The Age of the Inquiry: Learning and Blaming in Health and Social Care.* London: Routledge.

Robson C. 2002. *Real World Research: A Resource for Social Scientists and Practitioner-Researchers.* Blackwell: Oxford.

Rose W. & Barnes J. 2008. *Improving Safeguarding Practice. Study of Serious Case Reviews 2001-2003.* Department for Children, Schools and Families: London.

Rowse V. 2009. Children's nurses' experience of child protection – what helps? *Child Abuse Review* 18: 168-180.

Royal College of Paediatrics and Child Health 2010. *Safeguarding Children and Young People: Roles and Competences for Health Care Staff.* Intercollegiate document.

Royal College of Paediatrics and Child Health 2012. *Safeguarding in 2012: views from the frontline.* RCPCH: London. Available http://www.rcpch.ac.uk

Sidebotham P. 2012 What do serious case reviews achieve? *Archives of Disease in Childhood* 97:189-192

Sidebotham P., Brandon M., Powell C., Solebo C., Koistenen J., Ellis C. 2010. *Learning from Serious Case Reviews: Report of a research study of learning lessons nationally from serious case reviews*. Department for Education: London.

Sinclair R. & Bullock R. 2002. *Learning from Past Experience: A Review of Serious Case Reviews.* Department of Health: London.

Skellern C. 2008. Medical experts and the law: Safeguarding children, the public and the profession. *Journal of Paediatrics and Child Health* **44**: 736–742.

Stanley N. & Manthorpe J. 2004. *The Age of the Inquiry: Learning and Blaming in Health and Social Care.* Routledge: London.

Vincent S. 2009. *Child death and serious case review processes in the UK.* CLiCP Briefing 5. University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection: Edinburgh.