MPHIL

Learning from disasters

Professional decision-making at the frontline of child welfare practice

Gallagher, Stuart

Award date:
2015

Awarding institution:
University of Bath

LEARNING FROM DISASTERS

Professional decision-making at the frontline of child welfare practice

VOLUME 1 OF 1

STUART BERNARD GALLAGHER

A thesis submitted for the degree of Master of Philosophy (MPhil)

University of Bath

Department of Education

February 2015

COPYRIGHT

CONTENTS

ABSTRACT

This thesis examines the concept of learning as it is presented in the context of serious case reviews (SCRs) and discussions regarding their purpose in preventing the maltreatment of children. The examination uses Toulmin's (2003 [1958]) model of argument to consider the extent to which learning, as it is presented in the current statutory guidance on safeguarding children, warrants the claim that SCRs, using any learning model, can prevent child maltreatment. It is proposed that the current conceptualisation of a learning model is poor and fails to address the crucial issue of learning transfer. The thesis reviews a wide range of perspectives on learning and their respective ways of dealing with learning transfer. A number of learning models relating to current child welfare and child protection practice are examined in light of this review and it is argued that none of the models adequately addresses the critical issue of learning transferring beyond the frontline of child welfare practice to the private lives of children. The thesis proposes that a fuller account of learning may, however, warrant the guidance's claim when learning transfer is considered from the Goodwin's (1994) anthropological study of professional vision. Goodwin's theory is adopted to engage critically with a purposive sample of SCR executive summaries (published between 2008 and 2011) in order to understand how coding schemes and highlighting used in the sample enable a relation to be drawn between what is *learned about* serious cases, what can be *learned from* them, and how learning *can prevent* child maltreatment. The thesis concludes that the use of public sense-making protocols and imagery may yet be necessary to enable an effective learning model to be constructed, one which would warrant the statutory guidance's claim.

CHAPTER ONE

INTRODUCTION

In general terms, this thesis is about serious case reviews (SCRs), independent reviews of significant or fatal maltreatment of children which are published by local safeguarding children's boards (LSCBs) in England with the purpose of supporting child welfare professionals and professional organisations to learn from the published findings in order to prevent further children suffering significant or fatal maltreatment. More specifically, though, this thesis is about that claim to *learning* and especially the claim to *learn from*. Currently, findings and recommendations (that is, lessons) from SCRs are expected to be disseminated and transformed into action plans for implementation by a range of individuals and organisations. This model of learning is a highly restricted representation of learning. In other words, the specific focus of this thesis is to understand better the contribution a fuller account of learning can make to the rationale of SCRs by drawing current debates concerning the meaning of learning and the mobility of knowledge, or transfer of learning, into a relation with published examples of SCRs.

More specifically still, this thesis addresses these concerns to a particular phrase in a single sentence in the current edition of the statutory guidance document *Working Together to Safeguard Children* (HM Government, 2013):

> LSCBs may use *any learning model* which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro. (HM Government, 2013, p 67, para 11)

It is interesting that such scope of learning is permitted, given the specific findings/dissemination/action/implement model embedded within current SCR processes. A fuller account of learning and learning transfer may require crucial choices and trade-offs to be made for the development of *any* such model and the statutory guidance does not offer guidance regarding the principles of learning upon which *good*

choices, which will develop an effective learning model, can be made. This needs to be explored further, especially since learning is so explicitly associated with SCRs and learning from them with the lived experiences of this country's most vulnerable children. Given this oversight of learning, it cannot be said with certainty that effective learning models, drawing on explanations of learning other than dissemination of findings, will align quietly with the principles of the statutory guidance. These principles include: the development of "a culture of continuous *learning and improvement*" within child welfare services; the independence of SCR authors and chairs; the full involvement of professionals who had contributed in some way to the case being reviewed; the involvement of the child's or children's family; the publication of transparent findings in SCRs; and the regular monitoring of service improvement (HM Government, 2013, pp 66-67, para 9, emphasis in original). One principle states that "the approach taken to reviews should be *proportionate* according to the scale and level of complexity of the issues being examined" (HM Government, 2013, p 66, para 9). This thesis argues that problematizing learning and learning transfer and evaluating their contribution to SCRs only increases the complexity of examining such issues. By restricting learning to a dissemination model, SCRs in no way currently approach the issue of *learning from* children's experience of serious maltreatment for the purpose of preventing child maltreatment in proportion to the complexity of that process.

It is not clear why the statutory guidance (HM Government, 2013) does not specify that LSCBs can adopt only *effective* learning models, appropriate to the task at hand, rather than *any* learning model. With a fuller understanding of learning, the guidance may be in a position to suggest the adoption of learning models that *effectively prevent* children suffering harm due, in part, to professionals and organisations learning from SCRs, rather than any model which adheres to pre-determined principles, which are as yet unconnected to any evidence that they actually, effectively serve the ultimate purpose of reviewing serious cases.

This thesis explores a wide range of perspectives on *learning*, each of which attempts to explain what learning actually is, and what it implies for human knowing and acting. It also explores what each perspective has to say about how its concept of learning is capable of becoming mobile, of transferring across people, places, activities and even

time, in order to develop a fuller account of what is implied by *learning from*, in this specific case, learning from SCRs in order to prevent children suffering significant harm.

There are good reasons for undertaking this study. For example, Munro (2010, p 9) argues that, "Serious Case Reviews (SCRs) have not fostered a learning culture which supports improved practice". Also, having undertaken a Delphi study in order to understand better the factors that practitioners claimed would help them learn from SCRs nationally and locally, Sidebotham et al (2010, p 47) concluded that "the potential learning opportunities provided by Serious Case Reviews are not being fully realised either at a local or a national level". Similarly, the national panel of independent experts on serious case reviews (DfE, 2014) recently emphasised that

> an investigation, regardless of title, should seek to establish the cause of an incident and attempt to prevent its recurrence. […] The panel's view is that far too many SCRs fail to do this effectively. (DfE, 2014, p 6, para 18 and p 7, para 26)

One dimension of this thesis argues that a possible explanation for such ineffectiveness is the dangerous assumption of social policy that *learning* and *learning transfer* are unproblematic concepts to adopt. This thesis problematizes learning and learning transfer and attempts to understand what contribution this troubling and unpacking of *learning* and *learning from* SCRs could make to 'any learning model'. For example, in its current form, serious case reviewing helps us to learn *about* historical cases of child welfare disasters. In them are published details of serious cases, presented as the case unfolded chronologically. The challenge is to articulate how these details become resources *to learn from*. In other words, reviewing serious cases implies the mobility of findings from one case or more than one (extremely acute) case of child welfare practice to another case, in which the professional(s) and organisation(s) prevent a child or children suffering significant harm in part due to what they successfully learned from previous case or cases. This requires an articulation, not only of learning, but of its transfer across different children's lived lives, for example, and the transfer of learning from professional interactions with children, families and other professionals to children's private lives. Reviewing serious cases implies that learning is transferred across space, from place to place, and across time in order to allow specific child welfare

structures to learn from the work of dissimilar child welfare structures. Learning from past interactions is expected to inform present or future interactions, without any certainty that the interactions share features other than a child welfare concern.

The thesis reviews theories of learning and learning transfer currently valid in the educational, psychological, sociological, ethnographic and anthropological fields in order to address its concerns regarding the adoption of 'any learning model' (see Chapter Three). It evaluates their contribution to our understanding of current articulations of learning in child welfare professional practice, strategy and systems (Chapter Four). The thesis then draws on 13 previously published 'special cases' of SCRs in which the independent authors make a claim that the serious case was, to a greater or lesser extent in my interpretation, *preventable*. (Not all cases studied claim the cases were literally preventable, and the choice of cases as 'special' depends on my own interpretation of the SCR authors' claims that the cases were 'not inevitable', to give but one example.) It does this to understand better the cases' arguments that individuals and organisations other than those involved in the original case can learn from such special cases so that children's suffering of significant maltreatment is prevented. The thesis draws on work undertaken in the field of anthropology to provide structure to this analysis. It adopts the concept of professional vision (Goodwin, 1994) to articulate how SCRs expect to support professionals to look backwards at previous serious cases so that they can subsequently look at present and future working cases in order to identify opportunities to learn from them (Chapter Five). This re-orientation of professionals currently working in acute child welfare cases is overlooked in the statutory guidance (HM Government, 2013). For example, SCRs should seek "to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight" (HM Government, 2013, p 67, para 10), but guidance that informs the viewpoint of professionals involved in the here-and-now unfolding situations of current case work is overlooked. Such guidance is necessary to support professionals' ability to recognise opportunities in that here-and-now to take sufficiently robust action that prevents child maltreatment. This thesis presents the 13 serious cases in a way that is sufficient *to learn about* each one. It then highlights and examines each review author's claim that a case was (in a wide sense) preventable. The thesis then collates the cases'

recommendations in order to evaluate how professionals could be expected *to learn from* such cases in order to prevent children who have not yet suffered significant harm from suffering harm (Chapter Six).

Another dimension of this thesis argues that, ultimately, any *effective* learning model will support child welfare professionals and organisations to understand the contribution of serious case reviews to an emerging professional field of *serious case previews*, where the potential for *learning* and *learning from* are embedded in a model that enables professionals and organises to orientate themselves to a number of orders of time and place simultaneously, from retrospective analysis to present and prospective preventative action. This model, which this thesis claims does not yet exist, is likely to take the form of a graphic representation, such as an image, rather than a series of procedures (Chapter Seven). This claim is based on the social constitution of professional vision, which Goodwin (1994) argues comprises the practices of coding phenomena, highlighting aspects of the phenomena salient to particular professional interests, and graphic representations that embody solutions to past problems which also enable professionals engage with problems at hand, and to ensure relevance of professional development across time.

So, SCRs are undertaken in order that professionals learn from them. The intended consequence of their professional learning is that the professionals produce new actions and decisions that prevent children suffering serious maltreatment. Therefore, the intervention of *learning* transforms serious case reviewing into frontline serious case *previewing*. Professionals are expected to make decisions and undertake actions, learnt from serious case reviews, on behalf of children's welfare which has *not yet* suffered significant harm. In this sense, serious case reviewing demands the prospective education of child welfare professionals. Kozulin (1998) proposes that such a positioning of learning makes a special demand on previously held assumptions about the place of knowledge in solving familiar, predictable problems.

> Prospective education implies that students should be capable of approaching problems that do not yet exist. (Kozulin, 1998, p 154)

Kozulin (1998) might claim, then, that any effective learning model would embody and support professional prospectivity in addition to the retrospective, historical character of published SCRs.

This thesis examines these concepts of learning and learning transfer in relation to a concrete issue. A significant proportion of children whose experience of significant or fatal maltreatment are subject to review are not known to child protection services at the time that they suffered the critical episode of maltreatment, such as children's social care services, the police or the National Society for the Prevention of Cruelty to Children (NSPCC). Some have been known previously; however, at the time that the children suffer the maltreatment that is to be reviewed, they are either not assessed as being at risk of suffering such harm, or the children do not present to child welfare professional vision as being at such risk. This presents a serious dilemma of learning transfer: is learning from this identified 'group' of cases expected to transfer to child welfare professionals and organisations that serve children whose needs are not assessed or considered to be sufficiently complex or acute to warrant a referral to adequately protective services, such as those identified above? Or is learning expected to transfer to those same protective services that are not aware of the possibility of such cases developing, given that children's presenting needs are not assessed as sufficiently concerning to warrant being formally brought to their attention, for example through a referral to children's social care services? Perhaps any learning model is expected to manage both tasks of learning transfer simultaneously. What is being highlighted here are the problematics of transferring learning not only across individuals and organisations separated in time and space, but also across levels of children's welfare services that are organised according to current epistemologies of need and appropriately matching service intervention.

In summary, this thesis is an examination of the current claim that SCR learning and learning from SCRs is necessary and sufficient to prevent children not previously subject to SCR suffering significant maltreatment. The aim of this thesis is to engage critically with the statutory guidance (HM Government, 2013) regarding SCRs in order to trouble the assumptions regarding *learning* that are embedded within its approach to serious case reviewing. The guidance argues that the professional actions of 'individuals and

organisations' can support efforts to prevent the serious maltreatment of children when lessons formulated by serious case reviewing are learned. Further, the guidance argues that this is achieved by those individuals and organisations applying those lessons by means of 'any learning model' that aligns with the guidance's principles of learning and improvement.

Figure 1A (page 14) frames the argument within the structure of Toulmin's (2003 [1958]) model of argument. Toulmin suggested that this structure could be applied to most argument in order to support the analysis of what he claimed were the consistent constitutive elements of an argument and it serves as a useful means of presenting the specific aims of this thesis and the grounds upon which the thesis's evaluation will take place.

Using Toulmin's model, the argument of *Working Together to Safeguard Children* (HM Government, 2013) can be structured as follows: children's serious maltreatment can be prevented (*claim*) when individuals and organisations learn lessons from serious case reviews (*data*) through the use of any learning model consistent with the principles of the statutory guidance (*qualifier*) (see Figure 1A on page 14). Thus far, this argument (and the interdependence of its constitutive parts, data, claim and qualifier) has gone largely unchallenged. Critical perspectives regarding case reviews in other disciplines have been articulated in the literature, including a critique that positions such reviews as vehicles for the apportioning of blame within professional systems that were seen to have failed to fulfil their primary, statutory and legislative purpose as a result of professional investigation and review (see, for example, Reder et al, 1993; Stanley and Manthorpe, 2004).

This thesis's primary aim is to investigate the contribution made by *learning* in the dominant argument that *learning from* SCRs can *prevent* children suffering significant harm. The thesis is concerned with asking: to what extent might a fuller account and analysis of learning as an activity of individuals and organisations support or challenge the ambitions of the statutory guidance (HM Government, 2013)? Within Toulmin's (2003 [1958]) model, this critical approach to serious case reviewing would be framed as an investigation of the argument's warrant (see Figure 1A). The model indicates that only since the warrant is sound can the claim be good. In other words, the argument

that child abuse can be prevented when individuals and organisations learn lessons from SCRs by using any learning model consistent with the principles of learning and improvement of *Working Together to Safeguard Children* (HM Government, 2013) *since* learning is not a problematic concept in relation either to the prevention of children's significant harm, the activity of individuals and organisations, models of learning and SCRs and serious case reviewing. Should this be the case, then the argument is sound and the claim valid. It is the purpose of this thesis to evaluate the grounds of this warrant. It engages in research in order to examine the extent to which the contribution of learning to the purpose of SCRs can be seen as problematic or not problematic.

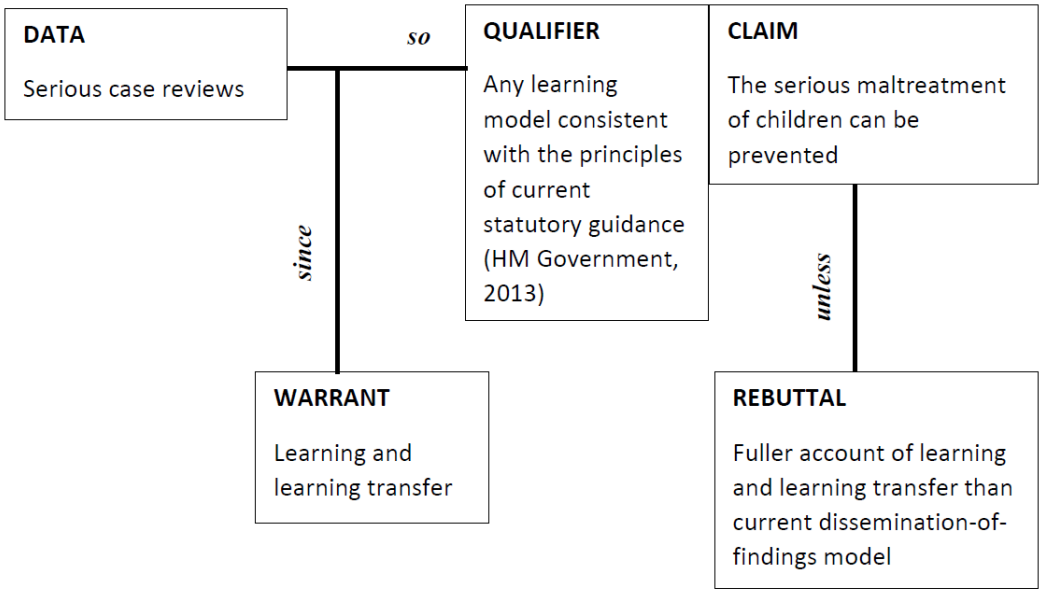

FIGURE 1A The thesis's purpose expressed in terms of Toulmin's structure of an argument (see Toulmin, 2003 [1958], p 94)

The aim of this thesis, concisely, is to examine whether or not a fuller understanding of learning *warrants* the claim of the statutory guidance. Its approach is to examine the purpose of SCRs and serious case reviewing by means of a focus on learning, and the assumptions regarding it that are embedded within the claim. Thus far, this approach is unique and requires approaching the data (SCRs) and social policy arguments (the claim of HM Government, 2013, regarding the review of serious cases) from the perspective of learning and the learning sciences.

Figure 1A illustrates that Toulmin's (2003 [1958]) model also accommodates an argument's *rebuttal*. It shows that unless evidence can be presented to rebut the argument's claim, then the argument must be sound (at least provisionally). Given that the aim of this thesis is to examine the quality of the argument's *warrant*, evaluation of the research presented within these chapters constitutes an evaluation of the strength of any such rebuttal in the case of learning from SCRs in the prevention of children's significant harm. In other words, depending on the investigation of learning that might determine the quality of warrant, this thesis's goal is to articulate the extent of one *rebuttal* to the statutory guidance's argument. The development of this rebuttal will be addressed within the respective summary paragraphs of each chapter.

CHAPTER TWO

SERIOUS CASE REVIEWS, LEARNING AND LEARNING FROM SERIOUS CASE REVIEWS

INTRODUCTION

The purpose of this chapter is to introduce and evaluate critically serious case reviewing and serious case reviews (SCRs) as a learning project in order to examine the validity of the claim that SCRs and *learning from* SCRs contribute to the prevention of significant child maltreatment, from a cross-disciplinary perspective on learning. The purpose of this evaluation is to situate the thesis's own social scientific rationale for professional learning from SCRs of child welfare disasters within the context of the implied but never stated goal of producing *serious case previews* – offering conditions under which professional action can prevent, rather than simply react to, child maltreatment.

Currently, this process comprises particular cases being identified as meeting prescribed criteria in order to qualify as 'serious', and which are then reviewed by relevant professionals. These professionals qualify on account of their being of sufficient stature and experience for the purpose of describing circumstances in which child welfare principles and practices became confused or distorted in often complex and unpredictable professional interactions with children, their families and carers, as well as other welfare practitioners, resulting in a child's wellbeing being seriously compromised, in many cases with fatal consequences. Sidebotham et al (2010) argue that the value of undertaking SCRs

> comes, at least in part, from the opportunity they provide to critically examine safeguarding practice within the context of an understanding of the circumstances of a child's world and his or her suffering. (Sidebotham et al, 2010, p 47)

Reviews are intended to help us to learn about individual children's specific circumstances that included critical events of maltreatment in order that subsequent practice learns from this context and prevents its recurrence.

SERIOUS CASE REVIEWS AND LEARNING TRANSFER

> All violence against children is preventable. (UN, 2006, p 5, para 1)

The primary purpose of reviewing serious cases is to produce knowledge that contributes to professional and societal efforts to prevent children suffering maltreatment. The Local Safeguarding Children Boards Regulations 2006 regulation 5.1 establishes the statutory duty on LCSBs in England to undertake reviews of serious cases. The same regulation points out that these boards are also responsible for "advising the authority and their Board partners on lessons to be learned" (The Local Safeguarding Children Boards Regulations 2006, regulation 5.1e). Regulation 5.2 then defines what makes a 'serious case':

> For the purposes of paragraph (1) (e) a Serious Case Review 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.

The national panel of independent experts of serious case reviews recently identified "a deep reluctance in some instances to conduct SCRs and the panel has on occasions found the logic tortuous and considerable intellectual effort expended on finding reasons why an SCR is not required" (DfE, 2014, p 5, para 16). Where SCRs have been undertaken, the panel concluded that "quality is disturbingly variable, with good reports being outnumbered by the number of reports still failing on key points" (DfE, 2014, p 7, para 25).

One implication of the duty to undertake SCRs is the implied understanding that (a) the State is insufficiently knowledgeable about those it wishes to protect; (b) it is engaged in an educational project aimed at developing or producing this knowledge of 'children's worlds', in Sidebotham et al's (2010) phrase; and (c) the content and nature of a significant amount of this knowledge of children's worlds is uncertain and, consequently, highly contested. Consequently, 'learning' must negotiate an ethical tightrope between respect for children's private lives (and the necessary ignorance of their lives that this entails) and the ability to intervene robustly, effectively and accountably based on 'sufficient knowledge' to account for that intervention, which is the public (State) intervening in the private (children's private lives). Learning from SCRs, then, implies a transfer of learning from professional interactions with children, families and other professional individuals and organisations to children's private worlds where maltreatment is prevented.

Burton (2009) writes about the acquisition of information about a child's private life in her study of "the oversight and review of cases in the light of challenging circumstances and new information":

> When we read [...] files or hear about these cases, do we get a clear picture of what daily life is like for that child, living in that household? […] Can you picture what life is like for this child? Does this case file give you a real sense of the day-to-day experiences of this child living with these parents? (Burton, 2009, pp 3 and 7, citing Hart and Powell, 2006, p 19)

In other words, an *effective* learning model would expect learning to transfer from public cases to *other* children's private lives. This expectation makes significant demands on the quality of learning, since a right to privacy is established in international human rights instruments. For example, article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms (Council of Europe, 1950/2010) states that "Everyone has the right to respect for his private and family life, his home and his correspondence". The article permits interference by a public body with this right only on the condition that it is "in the interests of […] public safety [and] for the protection of health or morals, or for the protection of the rights and freedoms of others". Learning from the past maltreatment of children must serve as a warrant to intervene protectively in the

current lives of other children, who may not be suffering significant harm, yet the United Nations (2006, p 11, para 33), for example, considers it "clear that stable family units can be a powerful source of protection from violence for children in all settings". Making robust preventative interventions in private children's and family lives requires of learning from SCRs that it qualifies as sufficiently and necessarily relevant to challenge the instability of family units. And yet, conversely, "Identifying cases of abuse and neglect is an uncertain process since much of the worrying behaviour (both actions and omissions) goes on in the privacy of the home" (Munro, 2010, p 20, para 1.41). One research participant in a recent NSPCC survey commented, "When the doors are closed, kids only know what goes on in their own family" ('Andy', 22, in Radford et al, 2011, p 3). In a prevalence study of child abuse and neglect, Cawson et al (2000, p 4) point out that family life "is one of the least studied areas of our society".

The process of serious case *reviewing* is necessarily retrospective. It has been accused of suffering a 'hindsight bias' (Munro, 2011, p 18, paras 1.14-15). The intention is that professionals learn from SCRs in order to *work currently* as well as *prospectively* for the purpose of preventing such serious cases from recurring. This move from looking backwards at an historical child welfare disaster to prospective accountable professional frontline *action* is currently expected to result from lessons being identified which are subsequently learned, thereby achieving the outcome of *other* children being protected. Consequently, learning from SCRs implies a transfer of learning across different orders of time (from past, to present and future), across different professional actions (from failed interventions to successfully protective interventions), and across different places (public to private, there to here).

Reviewing serious cases is about learning how SCR learning can contribute to the design of a complex intervention that can be applied successfully to a myriad of child welfare scenarios. This raises a number of issues for learning and learning transfer, such as the following examples.

Learning from one child's abuse in order to prevent the abuse of another child supposes that what different children have in common can be established in relation both to identification of abuse and the risks of that abuse. Learning from SCRs implies that

professionals learn from 'serious cases' (that is, cases where children have either died or been significantly harmed and where concerns exist regarding interactions with services) in order to act in cases with 'non-serious' cases. This requires learning to transfer across heterogenous cases; that is, different kinds of child welfare cases.

The extent to which commonalities extend to the alignment of child welfare institutional constellations (that is, the historical combination of family, health, educational, employment and accommodation factors in a child's day-to-day life) around each individual child at any point in any child's life is not clear. This raises the question of whether or not learning from one child's suffering must include learning about how one particular alignment of professionals to child's needs may correspond to another alignment of child welfare professionals to presenting child needs. In this sense, learning is expected to transfer from one organisation of resources and services to other possible but differently organised resources and services.

A second issue concerns the question of *when* sufficient learning has been learned. Is there a reasonable limit to the knowledge we expect to learn from reviews of child maltreatment or must child maltreatment continue so that we exhaust learning from such cases? A third issue is, what needs to be learned?

FAILURE TO TRANSFER LEARNING

Cartwright and Munro (2010) raise similar concerns with regard to predicting the effectiveness of randomised controlled trials (RCTs). They engage critically with a route of causal claims made on behalf of the external validity of RCTs. "It-works-somewhere claims" lead to "It-will-work-for-us claims" (Cartwright and Munro, 2010, p 262. See also Cartwright, 2011, and Cartwright et al, 2009). Similarly, in his study of lesson learning in healthcare scenarios, Rasmussen (2000) observes a selective approach to evidence:

> Whenever we conclude that someone has made an error, and we search backward for the root cause of the error, we discover that there is no objective stop rule to terminate the causal back-tracking. Instead, we as analysts tend to stop whenever we find an event that we know how to cure. (Rasmussen, 2000, p 32)

Weick (2002) warns that this poses a serious threat to the validity of learning from historical cases:

> Most outcomes induce selective hindsight. If hindsight produces severe editing of the causal chain that led up to the outcome, then the lessons we feel we learned probably never happened. (Weick, 2002, s 13)

FAILURE TO TRANSFER LEARNING

On 14 July 2008 and 14 July 2011, respectively, the print edition of *Community Care* carried two news stories, entitled "Little-known facts" (Stephenson, 2008) and "Let's stop repeating the same mistakes" (Raynes, 2011). By the time each article reached the online edition, however, their titles had been edited: "Serious case reviews: why aren't lessons being learnt?" (Stephenson, 2008) and "Why do we not learn from serious case reviews?" (Raynes, 2011). On each occasion, Community Care's sub-editors understood how both articles' contents could be made more eye-catching: serious case reviewing as a process of failed learning transfer is a concern to frontline professional social care staff, among others working in children and adult services. Despite the resource investment regarding statutory serious case reviewing, these professionals are at risk of being accused at any moment of having failed to learn rudimentary lessons identified by previous reviews of serious cases of child maltreatment. What is at issue here is learning transfer and an assumption that is is not problematic.

Stephenson's (2008) article begins:

> Last month, the mother of Victoria Climbié, the eight-year-old girl who was killed in 2000, said she was shocked that lessons from the case had still not been learned. [...] The death of Khyra Ishaq [...] who was allegedly starved to death, and the case of Child B in Westminster, whose parents were jailed for torturing their four-year-old daughter who has cerebral palsy, are examples of the suffering children continue to experience.

Raynes's (2011) article, on the other hand, begins:

> Since 2007, our consultancy, Reconstruct, has undertaken serious case reviews involving 32 children in England and Wales. Not surprisingly, we found that the same errors and omissions were contributing time and again to agency failures to recognise and react adequately to the risks posed to a child.

Stephenson argues that, so long as children continue to suffer serious maltreatment, serious case reviewing will struggle to demonstrate its effectiveness. Michael Gove MP, in his previous role as education minister, published the full transcript of a serious case review, rather than an executive summary, and indicated when doing so that he approached SCRs as abstracted knowledge that could be put into service without problem in other cases:

> The circumstances of this case and others involving serious problems with child protection prompted this Government's commitment to make information available so that everyone can understand and learn from what happened. (Gove, 2012, p 1)

A significant proportion of children subject to SCR were not professionally assessed as being at risk of harm at the time that they suffered the critical episode of fatal or significant maltreatment. Even fewer children subject to SCR were subject to a Child Protection Plan at the time that they suffered harm. This chapter discusses the implications of this statistic for the character of a learning project from SCRs, since this statistical data indicates that a particular challenge for serious case reviewing is to transfer learning across child welfare service intervention thresholds, priorities and professional vision.

Following the publication of the 1999 edition of the statutory guidance, *Working Together to Safeguard Children*, biennial analyses of English SCRs (via child protection database notifications) were commissioned in order to identify recurrent themes and trends. The purpose of the analyses is to inform policy as well as practice. The analyses have been conducted by Sinclair and Bullock (2002) for the Department of Health, Rose and Barnes (2008) and Brandon et al (2008, 2009) for the former Department of Children, Schools and Families, and Brandon et al (2010, 2011) for the current Department for Education.

Sinclair and Bullock (2002, p 27) reported that, “Twelve of the 40 children were completely unknown to their local social services department at the time of the incident.” Rose and Barnes (2008), on the other hand, do not report any finding regarding the proportion of children subject to serious case reviewing and who were either known or unknown to children’s social care at the time of their harm, other than to observe that, “an extensive range of statutory services, in addition to health, education and children’s social care, had been involved with the children and their families at one time or another, including youth justice, housing, and adult services in health and social care” (Rose and Barnes, 2008, p 10). In 2008, Brandon et al reported that, “55% of children were known to children’s social care at the time of the incident” (Brandon et al, 2008, p 7) and in 2009 that, “Just over half of the children were known to children’s social care at the time of the incident” (Brandon et al, 2009, p 2).

Ofsted, in its role as independent inspector of statutory social care quality, also undertook serious case review analysis. In 2008, it reported a ‘key finding’ that:

> Most but not all the children (35 out of 50) whose tragic circumstances were subject to a serious case review in the sample analysed were known to social care agencies. All were known to universal services, usually education and/or health. (Ofsted, 2008, p 6)

Its 2009 evaluation of SCRs reported that, “Of the 219 children, 149 (68%) were known to children’s social care services at the time of the incident” (Ofsted, 2009, p 19). The next reported that, “At the time of the incident, 119 of the [194] children were known to children’s social care services” (Ofsted, 2010b, p 5). A year later, “Of the 93 children, 70 were known to children’s social care at the time of the incident” (Ofsted, 2011b, p 21). In a more recent evaluation, Ofsted reported that 39 of the 150 children in its sample were known to be ‘children in need’ (including children subject to a child protection plan) at the time of the incident (Ofsted, 2011c, p 31).

How do the samples compare? Sinclair and Bullock (2002) report that their analysis is based upon a random sample of 40 SCRs (20 completed in 1998-99 and 20 completed in 2000-01). However, “the researchers had some difficulty in compiling the necessary information” (Sinclair and Bullock, 2002, p 9), since reporting of SCRs was not mandatory

at the time that they undertook their evaluation. Nonetheless, by stratifying the reviews available to them, Sinclair and Bullock (2002, p 10) claim "some confidence that the sample adequately represents the range of cases subject to Serious Case Reviews". Rose and Barnes (2008) likewise experienced difficulties in accessing a soundly comparable sample of SCRs: "Whilst an estimated number of 180 reports were expected, only 45 were received and some reports contained no action plans" (Rose and Barnes, 2008, p 4). They do not claim that their sample of 40 is representative but rather is, "the best available in the circumstances" (2008, p 4).

For their analyses of their 2003-05 sample, Brandon et al studied 161 reviews notified during the period April 2003-March 2005 (Brandon et al, 2008, p 7). For the 2005-07 sample, Brandon et al could examine, "all available serious case reviews [189]" (Brandon et al, 2009, p 11). Similarly, the 2007-09 sample included "268 serious case reviews undertaken in England relating to incidents which occurred during the period 1st April 2007 – 31st March 2009" (Brandon et al, 2010, p 1). In each of their first two analyses, Brandon et al found that a little less than half (45% in each case) of their samples of children subject to SCR were *not known* to children's social care at the time of the critical incident of the children's serious harm. The sample findings are presented in tabular form in Figure 2A.

YEAR	SAMPLE		CHILDREN		SOURCE
	SCRs (n=)	*Children (n=)*	*Known to children's social care at time of incident (%)*	***NOT** known to children's social care at time of incident (%)*	
1998-99	20	20	65	25[a]	Sinclair and Bullock (2002, p 85, 'old guidance')
2000-01	20	20	65	35	Sinclair and Bullock (2002, p 85, 'new guidance')
2001-03	40	45	N/A	N/A	Rose and Barnes (2008)
2003-05	161	161	53	45	Brandon et al (2008, p 51, table 18)
2005-07	40[b]	40	55	45	Brandon et al (2009, p 61)
2007-09	268	268	N/A	N/A	Brandon et al (2010)
2008	50	50	70	30	Ofsted (2008, p 6)
2009	173	219	68	32	Ofsted (2009, p 19)
2009-10	6	6	100	0	Brandon et al (2011)
2010(a)	147	194	61	39	Ofsted (2010b, p 5)
2011(b)	67	93	75	25	Ofsted (2011b, p 21)
2011	113	150	26	74	Ofsted (2011c, p 31)

Notes: [a] Two out of 20 cases (10%) in Sinclair and Bullocks's 1998-1999 sample are 'not recorded'. [b] This number represents Brandon et al's 'intensive sample' as opposed to their full sample of 189 cases.

FIGURE 2A Children subject to serious case review and either known or unknown to children's social care services at the time of the critical incident of significant harm

Unlike the earlier analyses of complete samples, Brandon et al (2011) purposely draw upon only six cases from a 2010 sample. Their aim was to conduct an "in depth exploration of a small number of SCRs to consider how the knowledge that practitioners, and especially social workers, have on child development might have had an impact on the case and on outcomes for the children" (Brandon et al, 2011, p 3). The sample, then, includes only children who "have a greater degree of social care involvement than is known to be found in serious case reviews as a whole" (Brandon et al, 2011, p 3). Therefore, no claim is made that these six cases are representative of all other SCRs conducted in the period 2009-10.

This discussion of the SCR evaluations and analyses shows that there appear to be at least three kinds of SCR samples available: full cohort studies, purposive samples, and samples drawn from acknowledged 'dubious sources' which may be 'the best that can be collected under the circumstances'. Consequently, evaluations and analyses of themes and trends concerning SCRs may not transfer across samples, since they are comprised of heterogenous inclusion criteria.

This thesis takes as its concrete focus the ability of SCR learning and learning from SCRs to enable professionals and organisations working with children not currently known to children's social care, the police or NSPCC, to prevent those children, who do not currently present to professional assessment as at risk of suffering serious harm, from suffering significant or fatal harm. It does so in order to study the dynamics of learning transfer across humans, time and place, serious and non-serious cases, child welfare disasters to preventative actions, organisational structures and resources, service levels and assessment priorities. I return to the following quotation as an illustrative example.

> Most but not all the children (35 out of 50) whose tragic circumstances were subject to a serious case review in the sample analysed were known to social care agencies. All were known to universal services, usually education and/or health. (Ofsted, 2008, p 6)

Depictions of child welfare provision often comprise successive levels of professional intervention in children's lives on behalf of their welfare. Sometimes, four levels are depicted (universal, additional, complex and acute), sometimes more, depending on the distinctions made between children, their needs, and the ability of local authority children's services departments to tailor provision according to priorities in children's needs. Importantly, the distinctions account for the State's interest in securing children's wellbeing by collaborating with children and their parents and carers.

Level One represents universal children's needs, such as health, safety, education and wellbeing generally. Concrete services provided to satisfy these needs include general medical practice, pre-schools and schools, community policing and so on. The services are often referred to as 'universal services' since they are provided on behalf of the entire children's population. The value of universal service's contribution to children's

wellbeing is measured by certain outcomes enjoyed by children and prescribed by predominant theories of child development: meeting developmental milestones, regular and punctual school attendance with a view to progressing positively beyond compulsory education, secure attachments to parents and carers, and so on. Assessment of these needs is routine, for example routine school assessment, routine health checks and routine community police patrols.

Level Two represents those children's needs which are not sufficiently satisfied by the provision of universal services. These needs are represented as being 'in addition' to children's universal needs, for example, children's difficulties with understanding and learning, children's physical or sensory impairment, children's emotional and behavioural difficulties, and an inability to relate to others in groups or individually. Consequently, the second 'level' of child welfare work is often described as 'additional support' for children with 'additional needs'. Without this additional support, the children are expected to suffer poor outcomes despite the provision of universal services. Assessment of these needs is intended to be sufficiently 'early' and holistic (Allen, 2011; Field, 2010; Marmot, 2010; Tickell, 2011) in order to provide children with additional and early intervention services that will enable them to enjoy those same outcomes as children who do not have 'additional' needs and to prevent problems from escalating or becoming entrenched. Currently, the co-ordination of needs assessment and service provision is provided by the Common Assessment Framework (CAF) in its diverse local forms.

Level Three represents complex needs. Complexity in children's needs means that the relationships between factors which support a particular child's wellbeing and factors which undermine a particular child's wellbeing are not so easily assessed and understood (Stevens and Cox, 2008). Consequently, co-ordination of the services provided to the child is also complex. The presence of complexity in children's lives triggers statutory assessment. In other words, the State's interest in securing children's wellbeing is articulated in relation to *individual* children's particular circumstances, rather than so-called cohorts of children. That the State should take this interest is not a spontaneous compassionate event; rather, legislation imposes a duty on the State to act, for example section 17 of the 1989 Children Act.

In order to enjoy similar outcomes to those children whose needs are satisfied by the provision of universal services alone, children whose needs are considered 'complex' require the provision of services that can acknowledge this complexity when making interventions to secure their wellbeing and co-ordinate subsequent work on behalf of the child with authority. These include children with disabilities, special education needs, children demonstrating poor development, children seeking asylum and children whose lives include offending behaviour. Accounting for the complexity of these children's lives and co-ordinating a response which seeks through some intervention to achieve outcomes similar to those enjoyed by children requiring the provision of universal services only is a considerable task.

Level Four represents interventions which acknowledge a clear and relatively unambiguous risk to the child's wellbeing: abuse and witnessing abuse, sexual exploitation, self-harm and suicidal threats, possible custodial sentencing. The State's role in relation to these children is described as 'protective': the children are in need of protection from risk and harm. Again, the State's protective role is not spontaneous, compassionate and voluntary but, rather, is expressed as a legislative duty. Social care interventions are intended to co-ordinate professional welfare responses in circumstances where children's lives appear as either particularly complex (and consequently where their needs are not so easily identified) or harmful or at risk of being harmful.

What we learn from the Ofsted example above is that, much as children's needs may operate on a continuum, professional assessment of those needs can represent that continuum with varying degrees of accuracy. Fifteen of the children in Ofsted's 2008 sample of 50 were receiving services proportionate to universal (and perhaps additional). The remaining 35 children were identified as experiencing complex and risky lives and were receiving services proportionate to that assessment. *All* of the children either suffered or were at risk of suffering significant harm.

In her review of the child protection system, Munro (2010, p 21) points out that, "we can have only fallible [assessment] measures". Consequently, the inaccurate alignment of children's need and provision of sufficiently preventative service response would

result in a scatter of cases (see Figure 2B). The challenge then becomes identifying the threshold for provision of services in an inaccurate field:

> A low threshold for intervention produces a high rate of false positives (Figure III) while, conversely, a high threshold leads to a high number of false negatives, missed cases of serious abuse (Figure IV). […] given the same level of accuracy in the diagnostic process, moving the threshold to reduce one type of error automatically increases the other type (Munro, 2010, pp 22 and 23, paras 1.48 and 1.49)

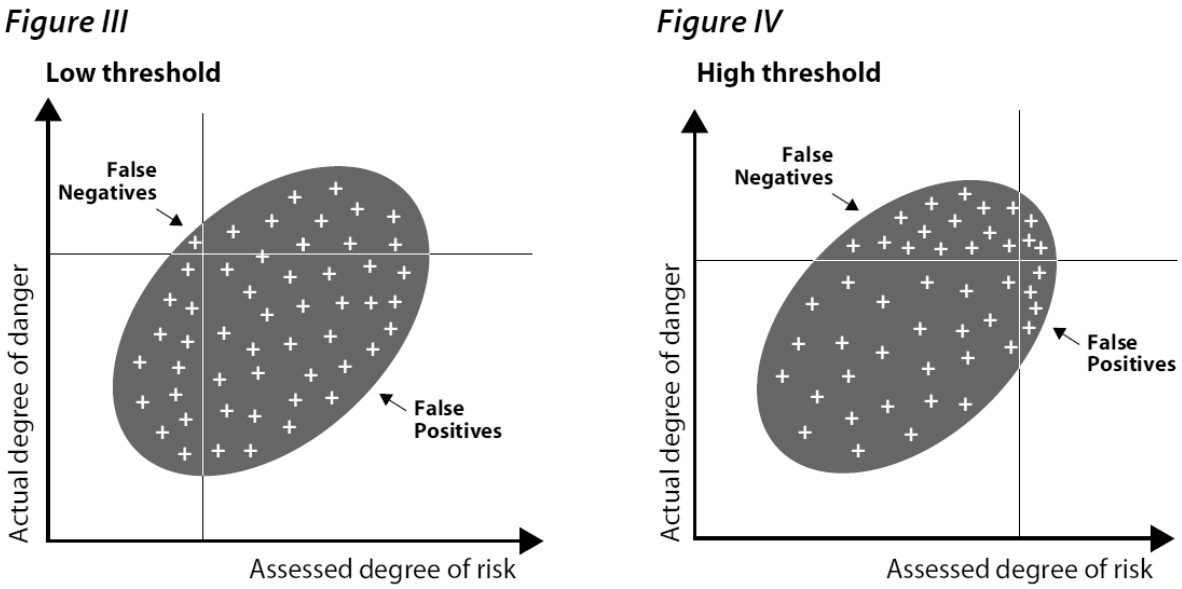

FIGURE 2B Taylor-Russell diagrams illustrating the consequences of raising or lowering thresholds for social care services in imperfectly assessed cases (from Munro, 2010, p 22)

Given the consequences of attempting to align service provision to need, learning from SCRs is unlikely to be an exact science: "Child protection work involves working with uncertainty: we cannot know for sure what is going on in families" (Munro, 2010, p 6). Rather, the fallible measures of child welfare assessments that may have contributed to SCRs remain the same measures in operation with professionals expected to transfer learning from previous cases to current casework in order to prevent the future significant harm of children.

Figure 2C is a basic illustration of the epistemology of children's welfare service arrangements. Ideal, accurate correspondence between assessed need and service provision is highlighted between service provision and assessed need. In other words, assessment of greater need should allow access increasingly specialised services. Figure 2D illustrates the position in this model of the children in the earlier Ofsted (2008) evaluation example. It shows that 35 of the children were receiving reasonably proportionate services. Fifteen others, on the other hand, remain some distance away receiving universal and perhaps additional support services, despite being exposed to a similar degree of risk.

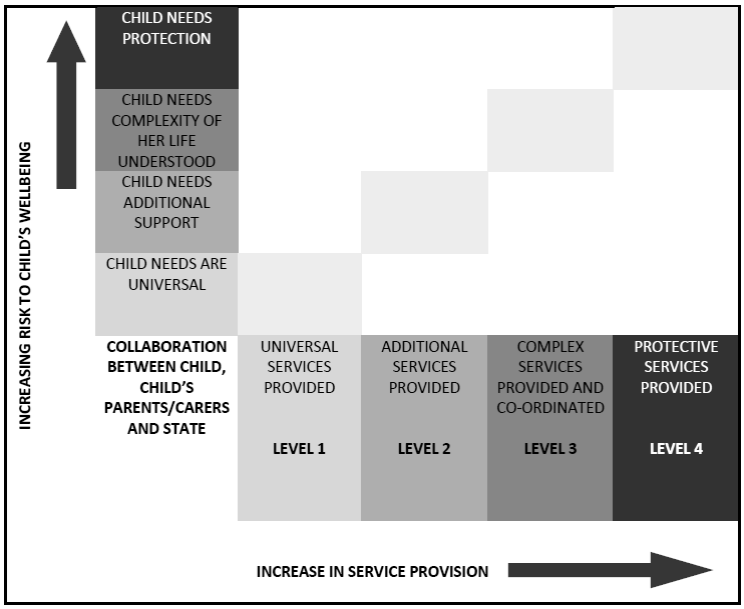

FIGURE 2C Provision of appropriate services to assessed need

Put another way, children are exposed to harm; despite structural and legislative provision to mitigate this exposure and protect them from harm, many children's exposure to harm may go unrecognised and they receive inadequate and disproportionate services. Some of these children suffer significant harm. These are the 15 children of Ofsted's (2008) evaluation. Children are exposed to harm. Due to structural and legislative provision to mitigate this exposure and protect them from harm, many children's risk of harm is recognised and they receive proportionate protective services. Some of these children suffer significant harm. These are the 35 children of Ofsted's (2008) evaluation.

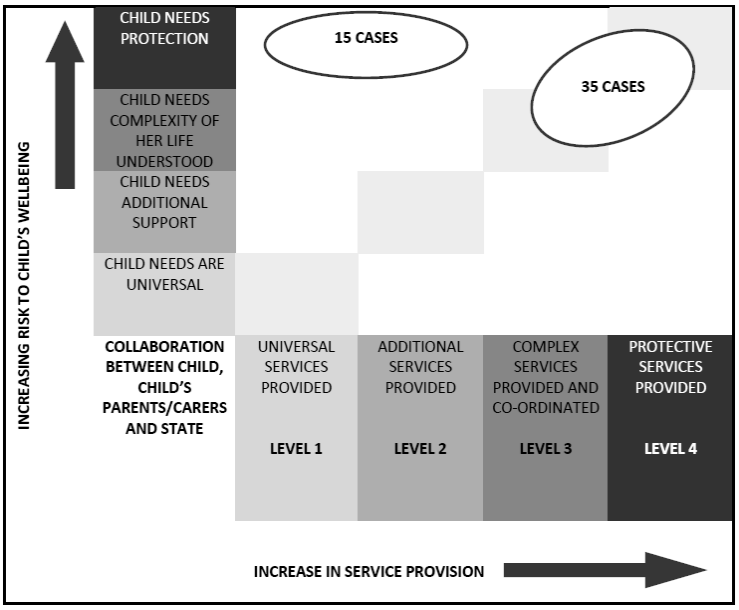

FIGURE 2D Provision of services to 35 of the 50 children subject to serious case review in Ofsted's evaluation (2008)

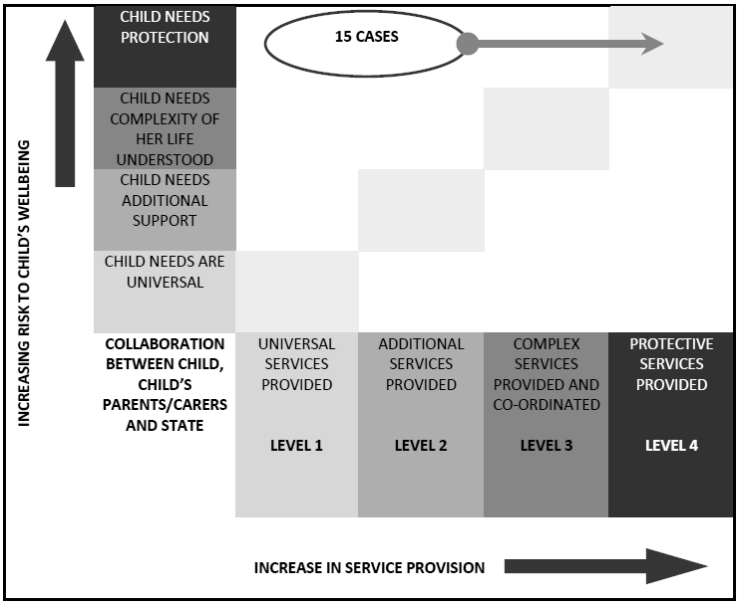

FIGURE 2E Green arrow indicates one possible understanding of 'what needs to be learned' from this SCR evaluation: how to ensure children suffering or at risk of suffering significant harm are assessed by appropriately protective services

Figure 2E illustrates one possible object of learning on behalf of the 15 children not in receipt of services proportionate to their needs. The arrow indicates that, learning from this evaluation of SCRs suggests new practices that incorporate these cases into a different case category that qualifies the children for protective services.

In order to protect the 15 from harm, professional learning must focus on recognition of risk of harm in assessments undertaken at lower levels of children's service structures so that the children can receive protective services. In order to protect the 35 from harm, on the other hand, professional learning must focus on making protective services adequately protective. Undertaking this work will benefit the work undertaken with the first group. However, both aspects of SCR learning imply dissimilar demands on learning transfer across statutory duties. For example, section 47 of the 1989 Children Act states that

> Where a local authority [...] have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare. (1989 Children Act, s47.1.b)

These enquiries are normally allocated by local authorities to children's social care services. However, section 11 of the 2004 Children Act placed a statutory duty to safeguard the welfare of children on a range of services other than children's social care, which operate within the roughly drawn four levels of service provision indicated earlier:

> (2) Each person and body to whom this section applies must make arrangements for ensuring that
>
> (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and
>
> (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need. (2004 Children Act, s11.2)

The discussion thus far suggests that the complex nature of children's lives and their interactions with families and welfare institutions means that their exposure to harm sometimes evades current methods of formal professional assessment. Professionals have a statutory duty to protect children primarily; adherence to formal assessment and historical structural arrangements is secondary. One consistent key finding from various samples of SCRs is that a significant proportion of children at risk of serious maltreatment and therefore in need of protection are seen by professionals working in universal services rather than protective, investigative social care services. These professionals also have a duty to protect children, even if the primary purpose of their professional role is the promotion of children's wellbeing through routine and universal health, education and policing interventions. Therefore, this thesis argues that learning from cases where children suffered serious maltreatment but were not assessed as at risk of such may require transfer to professionals working *outside of* social care settings as much if not more than to professional children's social care services.

Figure 2F records the percentage of children within each of the samples of SCR evaluation discussed earlier whose names were either placed on their local authority's child protection register or who were subject to a child protection plan at the time of the critical incident.

	SAMPLE		CHILDREN		
YEAR	SCRs (n=)	Children (n=)	On CPR or with CPP at time of incident (%)	**NOT** on CPR or CPP at time of incident (%)	SOURCE
1998-99	20	20	15	85	Sinclair and Bullock (2002, p 86, 'old guidance')
2000-01	20	20	15	85	Sinclair and Bullock (2002, p 86, 'new guidance')
2001-03	40	45	18	80[a]	Rose and Barnes (2008, p 79, table 8)
2003-05	161	161	12	88	Brandon et al (2008, pp 53-54, table 20)
2005-07	175[b]	175	17	83	Brandon et al (2009, p 24, table 7)
2007-09	264[c]	264	16	84	Brandon et al (2010, p 18, table 3.8)
2008	50	50	26	74	Ofsted (2008, p 17, para 34)
2009	173	219	19	81	Ofsted (2009, p 19, para 26)
2009-10	6	6	33	66	Brandon et al (2011, p 3)
2010(a)	147	194	25	75	Ofsted (2010, p 10, para 17)
2010(b)	67	93	13	87	Ofsted (2011b, p 21)
2011	113	150	10	90	Ofsted (2011c, p 31)

Notes

[a] One out of Rose and Barnes's sample of 45 children (2%) was not recorded as being either on or not on a child protection register. [b] This represents Brandon et al's full sample (n=189) as opposed to their 'intensive sample' (n=40) but where some cases have been removed where it is unclear whether the child protection plan was prior to or post incident. [c] Brandon et al removed a small number of cases from their overall sample of 268 SCRs where the child protection plan appeared highly likely to be post incident.

FIGURE 2F SCR samples: number of children subject to Child Protection Plans or on Child Protection Registers at the time of the critical event of the child's maltreatment

The purpose of this diagram is to demonstrate the scale of learning transfer across serious to non-serious cases, where the current service epistemology and assessment measures indicate that children's complex lives often evade the expectations of

statutory duty. In this case, each child subject to SCR either suffered or else was likely to suffer significant harm; second, where each local authority has a 'reasonable cause to suspect' children are suffering or likely to suffer significant harm, the 1989 Children Act expects it to "make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare" (1989 Children Act, section 47.1.b). Learning comprises the formation of reasonable suspicion at the level of universal services.

CURRENT SCR LEARNING MODEL

Despite the scale and complexity, the learning itself remains enigmatic. In its recent publication, *Good Practice by Local Safeguarding Children Boards* (Ofsted, 2011), Ofsted (2011, p 32) point out what 'learning' from SCRs is expected to be:

> LSCBs demonstrate good practice by:
>
> - Being proactive in ensuring that lessons are learned from SCRs and in disseminating information from SCR findings
> - Ensuring that recommendations are implemented, holding agencies to account for progressing their individual action plans
> - Using SCR findings to drive improvement and to influence future plans
> - Learning from the process of carrying out SCRs
> - Understanding how implementing the findings of SCRs makes a difference to children, young people and their families
> - Learning from 'near misses' and serious incidents that do not meet the criteria for SCR. (Ofsted, 2011, p 32)

'Learning' here is a matter of lessons and recommendations, dissemination of information and implementation of recommendations. It drives improvement and holds professionals accountable for their actions. Learning is also evaluating the implementation of learning. Ofsted's description of SCR learning comprises a series of bureaucratic exercises which fail to articulate the relation between retrospective accounting and the production of new professional actions and decision-making protocols. This failure undermines the development of actions that will prevent harm

suffered by specific children living in specific local authorities. In other words, it fails to articulate a coherent explanation regarding the transfer, or mobility, of learning across crucial social-cultural domains of people, places, time, service epistemology, statutory duty, and so on. By adopting a dissemination model, SCR learning as currently envisaged sidesteps engaging with precisely this crucial dilemma. The crucial stumbling block is mistaking *learning about* serious cases for *learning from* them. The following SCR evaluation provides an illustrative example.

In *Child and Family Practitioners' Understanding of Child Development* (Brandon et al, 2011), Brandon and her colleagues determined "to provide an in depth exploration of a small number of SCRs to consider how the knowledge that practitioners, and especially social workers, have on child development might have had an impact on the case and on outcomes for the children" (Brandon et al, 2011, p 3). The team used a transactional ecological perspective to analyse each case so that "the complex interaction of both parental and child vulnerability factors" (Brandon et al, 2011, pp 3-4) could be recognised and the distribution of professionals' child development knowledge analysed accordingly. Key themes from the analysis included, "agencies' faltering responses to potential warning signs of abuse and neglect that could be seen to link to the child's development, or to an understanding of the child's likely developmental capacity" (Brandon et al, 2011, p 4). Brandon et al (2011) are concerned to *learn about* the role played by professionals' knowledge of child development in the resolution of child welfare concerns. The analysis helps us to learn about, "The need for heightened concern about any bruising in any pre-mobile baby" (Brandon et al, 2011, p 5), for example. We learn that, "Good relationships with health visitors and paediatricians will enable social workers to check out concerns" (Brandon et al, 2011, p 7). The analysis does not help us to explain how learning from these SCRs and SCR evaluations can be made mobile across complex social domains in order to effectively prevent the maltreatment of children currently being served by professionals working beneath the thresholds for children's social care statutory intervention.

Figure 2G is a basic illustration of the character of interventions available to child welfare professionals when acting on behalf of a child's welfare. It represents these interventions according to a scale of parental risk to children's welfare. Where parents present to child welfare professionals as 'low risk', the professional interventions are more universal in character. The interventions are designed to be deliverable consistently to a population of children. At the other end of the scale, where parents are assessed as posing a high risk to their children's welfare, the emergency protection order represents the ultimate professional intervention in the private home of the child. Since the child's home is no longer professionally assessed as a place of safety, the order is sought to remove the child to a place of safety. In between lie a range of increasingly 'strong' professional interventions on behalf of a child, ranging from early interventions to investigations of child maltreatment (section 47 inquiries).

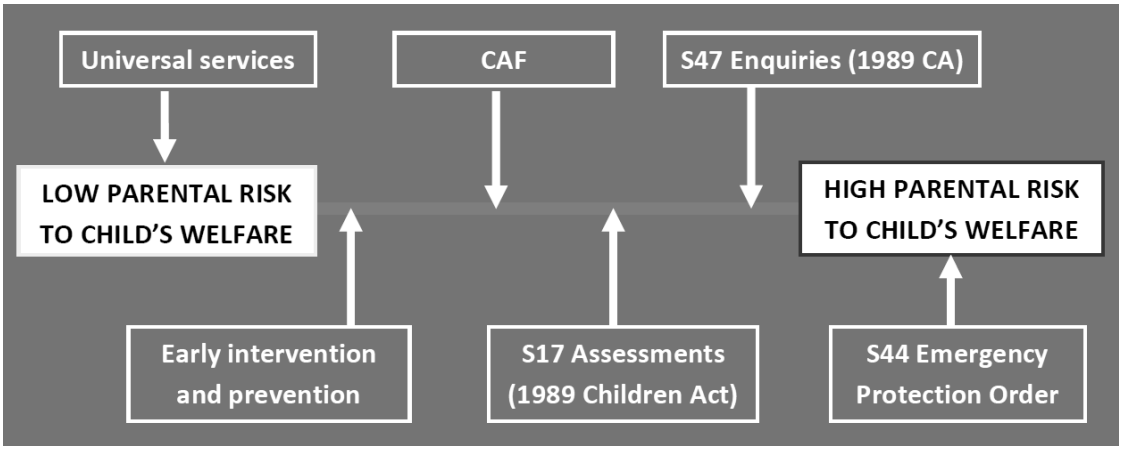

FIGURE 2G Range of professional interventions according to perceived threat of parental care to child's welfare

It demonstrates the scale of transfer necessary to enable professionals and organisations working with different approaches and under different intervention rationales to learn from SCRs. At the far left-hand side of the scale are interventions such as GP surgeries, routine health visiting, school curricula, for example. These are universal services delivered consistently and tailored to individual children only at the point of delivery (GP examination, health visitor guidance, lesson planning and classroom management, for example). Further to the right and 'early interventions' are

designed to target specific populations of children and families in order to make a professional intervention that is sufficiently early and effective to prevent any presenting child welfare concern becoming complex. Parents present as relatively low risk. However, the risk is that, without professional intervention, the presenting child welfare concern will remain unresolved and will require substantially more complex intervention at a later date. There are ethical and financial rationales for these kinds of intervention. By intervening sufficiently early, children suffer less and the cost of delivering services to them and their families is considerably less than co-ordinating a complex professional response to problems which may have become 'entrenched'. Early intervention across a wide range of child welfare fields has recently attracted significant treatment in the literature (Allen, 2011; C4EO, n.d.; Field, 2010; Marmot, 2010; Tickell, 2011). Since children suffering significant harm engage with universal services, and their families may present as suitable sites for early professional intervention, this thesis focuses on learning from serious cases that is relevant to professionals operating at the universal and early intervention levels, including the Common Assessment Framework (CAF), who may respond to such children being assessed under those specific processes. Figure 2G positions the CAF between early interventions and social care section 17 assessments of child needs. This distinction, which does not always occur in practice, is made purely to illustrate the role of the CAF in providing professionals with a system to resolve child welfare concerns at the level of an individual child (unlike broader early interventions) but without requiring a referral to children's social care in order that a section 17 assessment be undertaken.

This chapter now focuses on the CAF given its position between universal and single-service responses to assessed need and more statutory safeguarding welfare and protective responses. It may be here that the implications of learning from SCRs can be most vividly understood in the context of this thesis, since it is at this level of non-statutory service co-ordination that the mobility of learning from cases where children suffered maltreatment but had not been assessed as such that learning can be expected to have particular importance. The CAF was introduced to complement the government's *Every Child Matters: Change for children* agenda (DfES, 2004). This agenda oriented professional interventions in children's lives towards securing five particular

outcomes for the children: Safety; Health; Enjoyment and achievement; Economic wellbeing; Making a positive contribution. Central to the framework was the assessment itself. The assessment is non-statutory and instead is consent-based. This means that no assessment could proceed without the express consent of either the child or the child's carer's (as appropriate). This establishes a qualitatively different working dynamic between the child, the child's family and the children's workforce than a statutory intervention such as a section 47 investigation of child maltreatment. The assessment form synthesises a range of standalone, service-specific assessments so that it is 'common' to the diverse range of welfare professionals who may engage with a single child or family. The structure of the assessment form itself prompts the assessing professional, from any child welfare disciplinary background (education, health, youth justice, for example) to undertake an adequately 'holistic' assessment of a child's needs.

Interestingly, the CAF assessment's ecological/environmental focus on the child's 'holistic needs' is confined to the child's private home life, rather than prompting professionals to continually reflect upon the nature of their interactions with children, families and other professionals as SCRs envisage. The CAF was designed to overcome the obvious challenges of resolving problems that stretched across a number of institutional domains, not least by providing the children's workforce and the family the opportunity of a single, holistic assessment rather than a series of assessments undertaken with the child and family by professionals representing each distinct institutional priority. However, despite its design, the CAF encountered a number of challenges. Evaluating the pilot stage of CAF implementation in England, Brandon et al (2006) identified factors that either helped or hindered the children's workforce when implementing CAF, such as enthusiasm at grass roots and managerial level (helping) or lack of professional trust (hindering). White et al (2009) argued that the CAF disrupted frontline professionals' everyday moral judgements by exerting "its own 'descriptive demands', which are intended to help and inform professional sense-making, but which can feel tyrannical to the form completers" (White et al, 2009, p 1213).

The CAF's position on the intervention scale is represented in the following graphic (Figure 2H; HM Government, 2006), which presents CAF as a three-step process – preparation, discussion and delivery. When these steps are taken competently, the child

and family's needs are met. Once achieved, the goal is to 'close involvement' with the child and family.

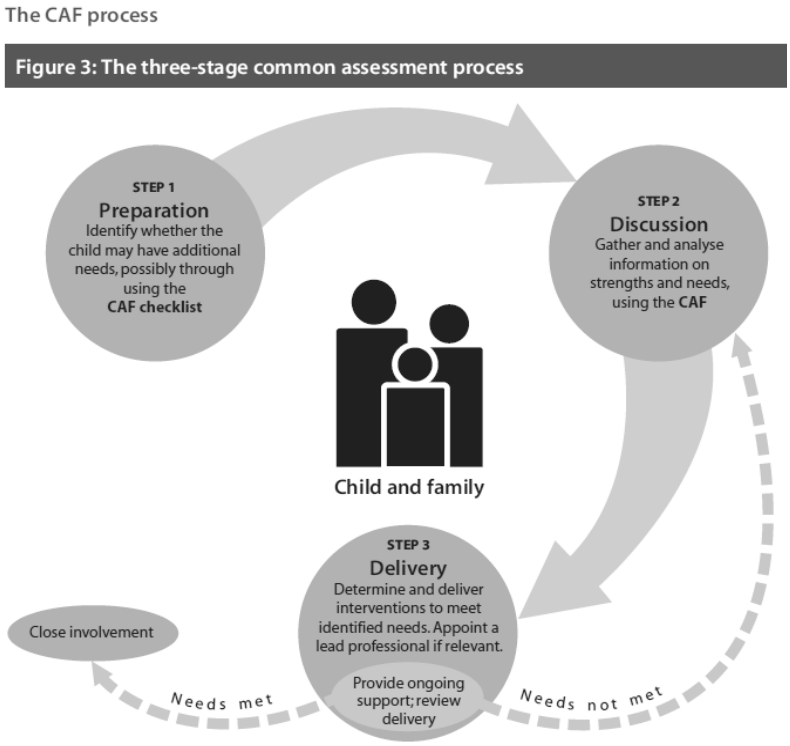

FIGURE 2H The CAF process (HM Government, 2006, p 13, fig 3)

Figure 2I, on the other hand, illustrates how an English local authority actually articulates the practical operation of this three-step process. Where previously the government envisaged a service to 'wraparound' children and families, the local authority operation is represented by a linear series of professional conditions and actions, of which the CAF assessment of a child is only one possible outcome. This flowchart from the frontline acknowledges that professionals working at the CAF level of professional child welfare intervention have to make decisions regarding ambiguous presenting children's needs. One such decision may be whether or not a child's need is one of protection from the child's parents (and requiring escalation of the case to children's social care) or one of seeking consent from the child's parents in order to design a professional intervention to meet the child's needs before 'closing involvement'. The flowchart clearly identifies 'exit' routes (highlighted in the original copies in red) from the CAF process to children's social care engagement with child

protection concerns. In practice, then, the flow chart serves as professionally embedded practical guidance to professionals to query what kind of child welfare concern they expect to assess under the CAF process. The frontline flowcharts accommodate the possibility that children suffering or at risk of suffering significant harm *may present* to professionals working within the CAF processes, rather than present spontaneously to children's social workers with obvious needs of protection. Conversely, in their study of referrals to Oldham Council's children's social services, Mason et al (n.d., p 13) found that, "almost half of the cases currently being referred to social services could be diverted via a common assessment of other forms of intervention". This indicates a grey area in which children suffering significant harm present at the CAF level and children appropriately served by the CAF process present at the level of children's social care intervention.

However, the primary purpose of discussing the CAF, in relation to Figure 2I's attempt to embody consistency in the choices and trade-offs made by professionals working with families, is to indicate that learning from SCRs may be evidenced not only in frontline protective professional action, but also in the material, graphic representation of professional practice guidance. In other words, learning must transfer from practice to imagery, which is intended to offer practical guidance to current and future professional practice at each level of service interaction with children and their families.

While Figure 2I illustrates the diversity of intervention strategies, Figure 2J presents instead the diversity of prevention strategies. What are presented here are at least four levels of prevention that differ significantly in kind. Universal primary prevention, at the far left of the diagram, addresses the entire population and aims to reduce the later incidence of problems. Selective primary prevention, on the other hand, focuses on those groups that are at higher than average risk of developing problems. Secondary prevention aims to provide an early response or intervention when low level problems arise in order to prevent them getting worse. Tertiary prevention involves responding when the problem has become serious, for example, child protection, hospital care, criminal justice. Finally, quaternary prevention includes the provision of therapy to victims so that they do not suffer long term harm, for example, therapy for victims of sexual abuse or therapeutic help for looked after children (Munro, 2011, p 79, para

5.30). In order to account for effective learning from SCRs in order to prevent children suffering maltreatment, an effective learning model needs to articulate how learning will transfer across this scale of prevention, and must avoid falling into the trap identified by Gough (1994) when 'prevention' "mostly concerns the avoidance of the initial occurrence of abuse" (1994, p 317).

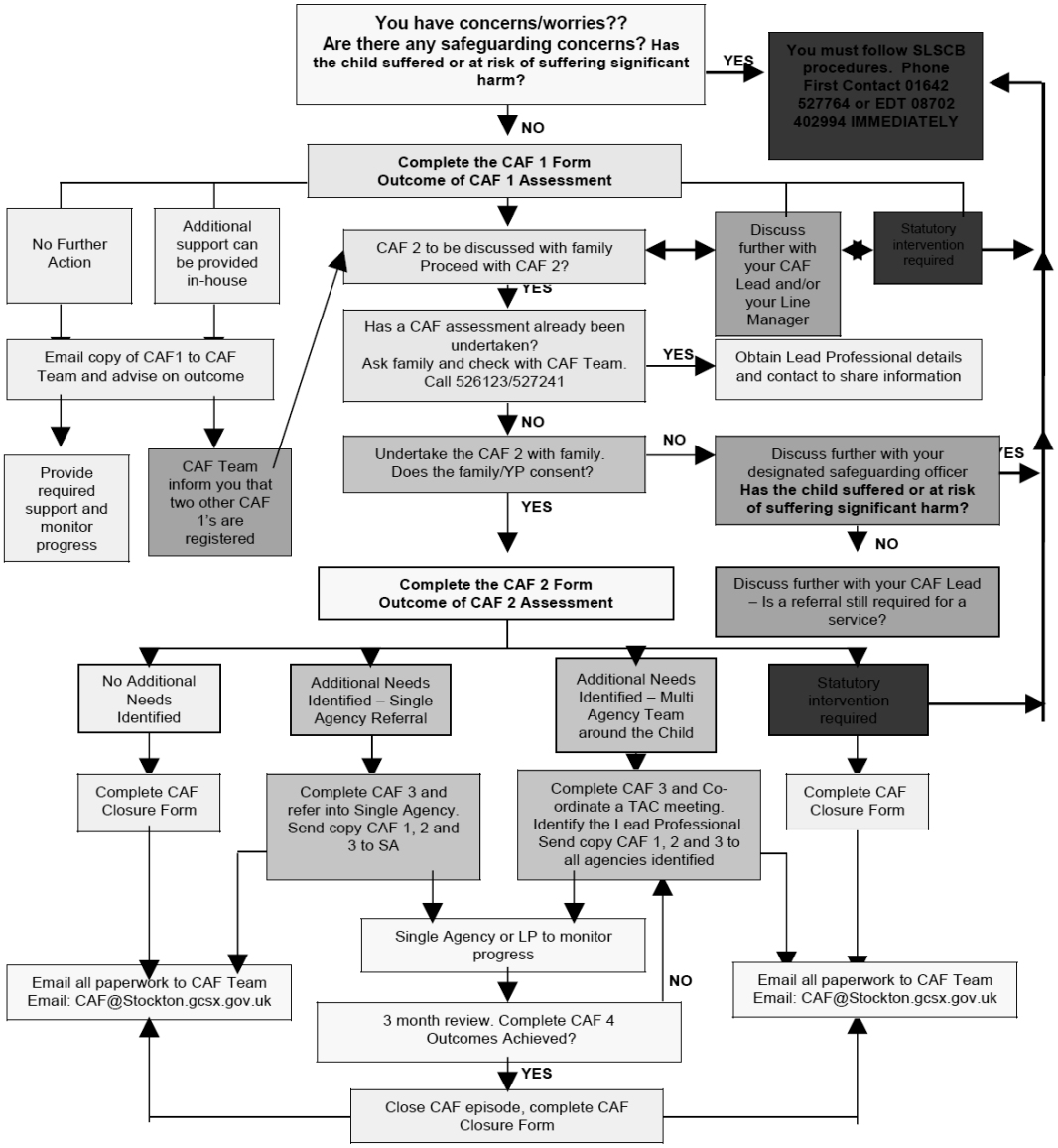

FIGURE 2I CAF flow chart (Stockton-on-Tees, 2010, p 3)

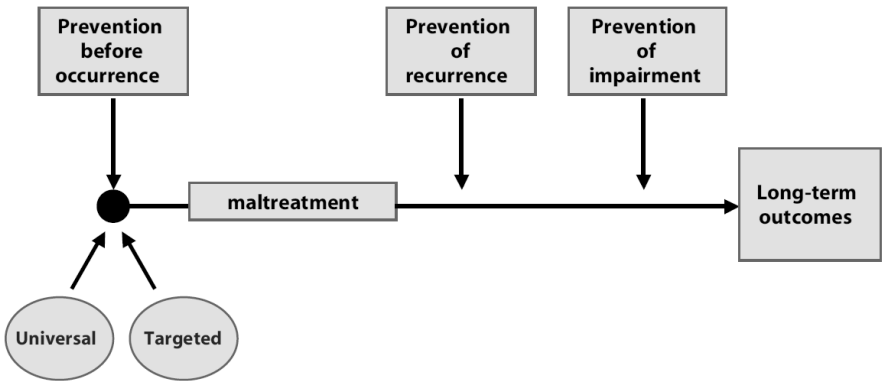

FIGURE 2J Levels of prevention strategies (Munro, 2010, p 25, adapted from J. Barlow and A. Schrader MacMillan [2010] *Safeguarding Children from Emotional Maltreatment: What works*, London: Jessica Kingsley Publishers)

Throughout this thesis, terms such as 'serious child maltreatment', 'significant harm', and 'child abuse' are often used interchangeably to refer to the acute, persistent and sometimes fatal experiences that children subject to SCR have suffered. However, it is important to unpack the load that these terms carry in order to understand better what exactly it is that SCRs are intended to prevent.

This chapter has already indicated the constitution of a 'serious case' according to the Local Safeguarding Children Boards Regulations 2006 (regulations 5.1e and 5.2). This included the formulation that categorised a serious case as one which includes knowledge of or suspicions of child abuse and neglect *and* the child has been seriously harmed. Current statutory guidance (HM Government, 2013) does not specify exactly what comprises 'serious harm'. However, the Department for Education (DfE, 2015) recently issued a consultation that included the possibility of including the following guidance to LSCBs:

> 'Seriously harmed' […] 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 impairment at the time of the incident, and/or long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development. (DfE, 2015, pp 10-11)

One cited purpose of the consultation was LSCBs' need for clarity regarding what exactly qualified a case as sufficiently 'serious' so that a SCR could be initiated. Already at this

early stage, the focus of SCRs is *learning about historically constituted cases* rather than learning how to prevent current cases from qualifying as serious.

In a legislative context, rather than SCR, determining whether or not a child's harm is considered significant is less a matter of it being long-term or life-threatening in itself, but rather of comparing the development of a 'significantly harmed' child with "with which could reasonably be expected of a similar child" (Children Act 1989, s31.10). This encompassed general categories of physical, emotional and sexual abuse (commission) and neglect (omission) (including the witnessing of significant harm) which themselves prove problematic when attempting to develop coherent research bases (see for example, Babatsikos, 2010; Glaser and Prior, 1997; Iwaniec, 1997; Johnson, 1994).

From this perspective, the seriousness and significance of children's maltreatment rests on the reasonable expectations we have of children's holistic welfare and development – however, the 'we' may become culturally and socially problematic. Following this, Cawson et al (2000) concede that "there can be no fixed and permanent definition of maltreatment, but only one which is acceptable in a particular culture at a particular time" (Cawson et al, 2000, p 3).

The World Health Organisation (Butchart et al, 2006) attempts to offer a global definition of child abuse in the 21st century as

> all forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. (Butchart et al, 2006)

This positions children's experiences of abuse always with regard to the child's relationship contexts, where they may not enjoy an equal share of values such as power. It also expands consideration of abuse to perpetration beyond private family life towards the relationships of commercial organisations to children's development. Harm is also considered as extended into the dignity of children within interpersonal contexts. Further, Cawson et al (2000, p 2) note that in such contexts, children are

> especially vulnerable in many dangerous situations which might also affect adults, such as exploitative labour conditions or polluted environments. (Cawson et al, 2000, p 2)

Given the absence of a single, uniform definition and understanding of child abuse and significant harm, being able to measure and compare the prevalence and incidence of what qualifies as serious maltreatment is very difficult. In order to conduct a large-scale survey of the prevalence of child abuse in the UK, Radford et al (2011) defined severe maltreatment according to their own inclusion criteria, which indicated an interest in defining the terms of significant harm in more concrete than generalised terms. These included the following examples:

> there was rape or attempted rape, or forced sexual contact, by an adult or child […];there was contact sexual abuse by an adult to a person under 13; […] the maltreatment resulted in physical harm or injury […]; the maltreatment happened six or more times; […] (Radford et al, 2011, p 6)

One measurement of their study, having used these concrete criteria to define what the research team took to be severe maltreatment, concluded that "almost 1 million secondary school children have been seriously physically or sexually abused or neglected at some point in their childhood" (Radford et al, 2011, p 4). However, this raises the tricky issue of the contribution of time to such measures, with inevitable consequences for cross-sample comparisons, for example. At what point in their childhood did children experience severe maltreatment? Do they continue to be exposed to that maltreatment or have their living conditions changed? In other words, it is difficult to know exactly what kind of evidence Radford et al's (2011) provides for professional planning. Indeed, Jütte et al (2014) observe that

> It is often difficult to synthesise different research studies which may use different definitions and methodology in researching risk factors. (Jütte et al, 2014, p 10)

Similarly, it is difficult to understand exactly how to act preventatively on reading claims such as that from UNICEF (2003) that "two children die from abuse and neglect every week […] in the United Kingdom", and DfE (2010) statistics that "Nearly half of the

46,700 children currently subject to a Child Protection Plan are recorded under the category of neglect" (DfE, 2010, cited in Munro et al, 2014, p 63). There is no formal mechanism available to transform these numbers in to identifiably responsive actions, other than a general but acute sense of urgency that actions must be taken. However, another consequence of imprecise measurement tools is that "child maltreatment is known to be both under-reported and under-recorded" (Munro et al, 2014, p 63).

It is becoming apparent that childhood experiences of maltreatment evidence as chronic or severe ailments in adulthood. The Adverse Childhood Experiences (ACE) Study (Anda and Fellitti, 2010), which is a longitudinal study including about 18,000 participants, each of whom is followed for no less than ten years, indicates that ACE are strongly relates to health and social wellbeing throughout the lifespan. Anda and Fellitti (2010) include childhood maltreatment among adverse experiences (cited in Munro et al, 2014).

One response to the inability to rely on precise definitions and clear-cut categories of serious maltreatment and comparable measures of its prevalence and incidence across populations and over time, is to seek clarity in causal links between identifiable social phenomena (risk factors) and instances of child maltreatment in the expectation that the strength of the causal link will enable the identification of abuse and maltreatment and consequent effective preventative intervention. Some examples of risk factors that have been the subject of research include substance misuse generally (Scaife et al, 2009) and parental substance misuse specifically (Nagle and Watson, 2008), parents' own experiences of maltreatment in childhood (Haapasalo and Aaltonen, 1999), parental mental ill health (Laulik et al, 2014), intimate partner violence (Goddard and Bedi, 2010) and youth prostitution (Cusick, 2002).

Jütte et al (2014) present general categories of environmental risk factors in children's lives that correlate statistically with incidences of child abuse. At the level of society, the risk factors identified include ethnicity, social inequality and neighbourhood deprivation. Community-level factors include social isolation and the quality of the children's care system. Finally, at the family level, correlates include the child's physical or learning disability, low parental capacity, domestic violence, poverty and parental learning difficulty (Jütte et al, 2014, p 11). In an evaluation of a SCR sample, Brandon et al (2010,

p 33) identified the high incidence of what is identified as a 'toxic trio' of domestic abuse, substance misuse and parental mental ill-health together in families receiving child protection services and subject to serious case review (cite Brandon et al 2009).

At the level of the child, the concept of resilience has been explored to understand why children's responses to adversity including maltreatment are not uniform. Bifulco (2013) argues that resilience is "best seen as normal child development under difficult conditions"; this property of children means that efforts to establish clear causal links between risk factors and our ability to predict children's experiences of maltreatment will be distorted in individual cases in practice.

Statistical correlation between child abuse and risk factors depends only on known cases. Consequently, reading these risk factors on to the general population is fraught with difficulty since it is not known how representative known cases are of the general population (Munro et al, 2014). Furthermore, the inconsistency of risk factor recognition tools undermines coherent efforts to understand the relation between such factors and the prevalence and incidence of serious child maltreatment. Daniel et al (2009) distinguished 74 separate tools in only 63 studies. (Examples include the Child Abuse Potential Inventory, the Child Well-Being Scales and the Child Behavior Checklist). Despite extensive research efforts to establish causal links between social phenomena and child maltreatment, Munro et al (2014) concede that

> the truth of the matter is that largely we do not know why some people hurt children, when others in similar circumstances do not. (Munro et al, 2014, p 66)

For Munro et al (2014) the critical issue is professionals' ability to weigh multiple adversities against individual risk factors facing individual children in the here and now. Compared with efforts to articulate relations between risk factors and outcomes, this professional judgement "is much trickier" (Munro et al, 2014, p 65).

It is to be expected, then, that efforts to formulate preventative strategies must do so in the absence of consistent definitions, measurements of scale, prevalence and incidence and causal links between risk factors and predictable outcome of maltreatment. Nevertheless, a number of researchers have attempted to design such strategies at a

number of levels of society, for example, family-based, population-level intervention approaches to promote effective parenting (Sanders et al, 2003), partnership with parents (Wurtele and Kenny, 2010), parenting programmes for the prevention of child sexual abuse (Babatsikos, 2010), work to strengthen parent–child relationships (Wolfe, 1993), community-based projects (Cox, 1998; Jack, 2004), school-based primary prevention projects (Johnson, 1994), the involvement of fathers in primary prevention programmes (Smith et al, 2012) and community networks of protective adults (Davies, 2004).

Recently, Munro et al (2014) drew on the philosophy of Mackie (1965) to argue that what are often misread as causal factors are in fact 'INUS conditions' (where INUS stands for 'an insufficient but non-redundant part of a condition that is itself unnecessary but sufficient for the result'). The benefit of this philosophical approach to the development of prevention strategies is that

> the concept of the INUS condition offers a conceptual framework that links both the protective and risk factors identified by research on maltreatment. (Munro et al, 2014, p 62)

For example, this framework enables researchers not only to see a risk factor, such as parental mental ill health, for example, as an indispensable part of a current, complex assessment of child maltreatment, but to recognise it as only part and not the only (sufficient) part of the assessment. The incidence of parental ill health in any given case, conversely, is also part of what Munro et al (2014) formulate as "a complex sufficient (but not necessary) condition" of a child's serious maltreatment. However, since the whole sufficient condition of parental mental ill health is not necessary to predict the incidence of child abuse (as the incident of serious child maltreatment could have occurred under other conditions), parental mental ill health can no longer be justifiably identified as a cause of child abuse but, following Mackie's (1965) work, is better understood as an INUS condition (Munro et al, 2014, p 67).

In summary, serious child maltreatment is an undeniable reality and challenge that faces child welfare professionals and services. However, the difficulties experienced in generating sufficiently concrete definitions that would enable professionals to identify

its risk or occurrence in the midst of unfolding, rapidly shifting case work and understanding the practical benefits of statistical data regarding the prevalence and incidence of maltreatment has prompted varied searches for identifiable causal links between risk factors and predictable outcomes.

The absence of such causal links critically undermines efforts to predict maltreatment based on analysis of known cases (which may themselves not represent the general population). Munro et al's (2014) recent research indicates that, although any particular risk factor or combination of factors may be sufficient to explain or predict cases of serious child maltreatment, at the same time those factors or combinations of factors may not be necessary in the creation of conditions in which children actually suffer acute maltreatment.

It is in this context that this thesis attempts to understand better the contribution that learning is assumed to play in the development of preventative professional actions and strategies in light of SCRs. Its focus on learning and learning transfer engages with the practical difficulties of establishing comparability and consistency across diverse spaces, orders of time, service types and levels of intervention, levels of prevention, and so on. Its focus is an evaluation of whether or not learning is a sufficiently coherent concept to overcome the critical difficulties apparent in establishing cross-case comparison and transfer of learning.

SUMMARY

This chapter has articulated the thesis's concern with SCR learning and learning transfer. The current model of dissemination, implementation and evaluation effectively sidesteps the thorny issues implied by learning transfer. Some of these issues have been presented in this chapter and each one represents a considerable challenge to child welfare professionals and organisations. They include the assumption that learning about serious cases is sufficient to prevent children suffering further maltreatment. This completely ignores the need to account for the possible mobility of learning from past cases of maltreatment to current and future cases of maltreatment prevention, which by implication is concerned with aspects of time, place, differing levels of service provision

and prevention, children's service structures and intervention types, and so on. Primarily, it fails to account for the practical accomplishment of SCR learning, such as the prevention of child maltreatment in their private homes.

The chapter argues that 'any learning model' recommended by statutory guidance needs to account for this transfer of learning in order to demonstrate its effectiveness. It suggests that the model may need to be embedded in current graphic representations of practice in order to serve as a mediating artefact of learning transfer.

Chapter One articulated the aim and ultimate goal of this thesis with reference to Toulmin's model of arguments (Toulmin, 2003 [1958]). It demonstrated that the legislative duty placed upon LSCBs to undertake SCRs is based upon the argument that children's significant harm can be prevented when individuals and organisations use any learning model to learn lessons from published SCRs (HM Government, 2013). The model expressed this argument as a *qualified claim* based on *data* (see Figure 1A on page 14). The aim of this thesis is to examine whether or not this claim is warranted, given a close study of learning and its possible contribution to SCRs, models of learning and the prevention of children's significant harm.

This chapter has engaged primarily with two aspects of this model. First, it presented a study of the argument's primary data, serious case reviews (SCRs); and second, it presented professional preventative strategies as diverse rather than uniform. Serious case reviews can be seen as comprising a consistent category of data primarily on account of the equifinality of the grounds for the review: that the children subject to review either suffered fatal maltreatment and died or suffered significant harm and concerns were raised regarding the quality of professional interaction with the children and their families (HM Government, 2013). What SCRs do not necessarily share in common include particular characteristics of children and families, the individuals engaged with them in organised professional activity, the wider environmental contexts of the children's activities or those of their families and children's welfare services and so on. Furthermore, the chapter has indicated that the lessons drawn from analyses of SCRs relate to diverse samples of SCRs.

In relation to the aim of this thesis, as framed with reference to the Toulmin model of Figure 1A (see page 14), it can be said that Chapter Two indicates that 'any learning model' adopted by individuals and organisations to prevent the serious maltreatment of children based upon the data presented within published SCRs must be devised with consistent reference only to the very event (the equifinal maltreatment of children) that it must prevent. This is a significant demand on *any* learning model. The statutory guidance does not indicate how the model can address this expectation, only to demand that incorporates and abides by its own principles of learning and improvement (HM Government, 2013).

Chapter Two claims that the primary challenge of any such learning model is to respond to this expectation, and argues that this must account for the *transfer of learning* across a wide range of domains. Given that serious case reviewing necessarily is a retrospective activity, and one with expectations that its lessons, shaped by the past in cases of apparent prevention failure, can subsequently shape prospective professional action in cases of prevention success, the contributory role of learning and its transfer between the initial activity (the SCR) and its intended effects (a professional ability to formulate serious case *previews*) requires rigorous examination. The domains across which learning must be transferred include the following:

- *Time*, given that a retrospective review is intended to produce published documents (a LSCB's SCR and its executive summary) which is available over time to be put to use to inform prospective individual action and organisation that will make an effective contribution to the prevention of children's harm.

- *Places and people*, given that the intended prospective action and organisation is likely to occur with reference to other cases of child welfare concern in other parts of the local authority and other local authorities. Furthermore, each subsequent case of professional action and organisation will require the transfer of learning from professional domains of inter- and intra-professional collaboration to professional interactions with children's and families and further to the private homes and lives of children and their families.

- *Service interventions*, given that a significant proportion of children subject to SCR (and therefore who experienced, or were at risk of experiencing, significant harm) were either not known to or had not yet presented to services designed to pursue legislative and statutory duties to investigate and protect.

- *Prevention strategies*, given that *learning from* SCRs implies primary, secondary and tertiary prevention of children's maltreatment in all child welfare cases with which professional individuals and organisations are engaged.

This chapter has shown that current articulations of good practice (and therefore *learning transfer*) extend only so far as a model of dissemination and implementation, requiring only the planning of actions and their subsequent evaluation. In terms of Toulmin's (2003 [1958]) model, dissemination and implementation must be examined in terms of the necessary requirement to specific the dynamics of learning from SCRs and its transfer across the highly contestable domains of time, place, persons, interventions and strategies in order to evaluate the quality of warrant that would support the claim that any learning model can support individuals and organisations to learn lessons from SCRs in order to prevent children suffering significant harm. At best, the dissemination–implementation model might claim that *any action plan* is sufficient to meet the demands of learning and learning transfer. At worst, however, it sidesteps the fundamental question of what learning actually is in relation to the developing capacity of professionals to preview cases that might qualify as serious at a later date when sufficiently robust preventative actions are not formulated at a necessarily early point in time.

Chapters Three and Four present reviews of two bodies of literature. The first review examines perspectives on learning presented within the learning sciences literature; the second review examines models of learning that relate to current child welfare and child protection professional practices in England.

CHAPTER THREE

LITERATURE REVIEW 1

PROBLEMATISING 'LEARNING' AND CHALLENGES OF LEARNING TRANSFER

INTRODUCTION

Chapter One argued that, in its current organisation, serious case reviewing does not sufficiently problematize learning. This is important given its claim that learning about and learning from cases categorised as 'serious' can contribute to professional child welfare efforts to serious child maltreatment. Currently, serious case reviews (SCRs) produce findings and lessons to be disseminated and implemented. However, the purpose of SCRs implies that the retrospective process of learning about historical cases of child maltreatment enables prepares professionals to learn from those cases in order to see and even foresee unfolding cases that may become serious, and then to prevent the kinds of cases that might otherwise qualify as 'serious'. Learning, seen from this perspective, requires knowledge to be transferred across temporal and spatial boundaries, between past and present and orienting towards the future, learning from the there-and-then to transform practice in either the here-and-now or at some future there-and-then.

In order to respond to the claim that learning is insufficiently problematized at present, this chapter reviews the diverse ways that learning can be articulated. Part One presents learning either as monologic, dialogic or trialogic (following the distinctions of Paavola and Hakkarainen, 2005). Each of these theoretical articulations of learning makes unique demands of 'any learning model' that would claim to prevent children suffering maltreatment based on learning about and from serious cases. Part Two reviews the

manner in which each articulation of learning assumes transfer of learning and knowledge across people, places and time. Part Three presents a review of alternative explanations for the (re)production of knowledge and knowing across people, places and time that do not depend on the concept of transfer.

PART ONE

MONOLOGIC LEARNING

Paavola and Hakkarainen (2005) argue that a metaphor of acquisition

> is easily connected to a 'folk theory' of mind according to which the mind is a container of knowledge, and learning is a process that fills the container, implanting knowledge there. (Paavola and Hakkarainen (2005, p 537))

This knowledge is independent of the spatial and temporal conditions prevailing at the event of acquisition. Hence, its independence of the environment and invariance of meaning across places and time result in what is monologic learning, characterised by the acquisition of knowledge by an individual that has been transmitted by another. The ideal characteristic of knowledge is its generalizability. Since acquisition is the dominant metaphor, learning becomes the accumulation of "basic units of knowledge that can be […] gradually refined, and combined to form ever richer cognitive structures" (Sfard, 1998, p 5). For example, the purpose of formal education, from this perspective, is to support "the construction of information structures and procedures that support understanding and reasoning" in the individual mind (Greeno, 2006, p 81).

Sfard (1998, p 5) warns that the familiarity of this cognitive perspective on learning discourages us from ever challenging its presentation of human minds as 'empty vessels' that need to be filled with knowledge, which then becomes the property of the individual human. Learning, from this perspective, is quantifiable and enables those who can claim to have acquired or assimilated significant quantities of knowledge to make claims about knowledge in a similar way that one may make claims to material personal possessions. Sfard (1998) warns that monologic perspectives on learning

> may draw people apart rather than bring them together [as] the need to prove one's 'potential' sometimes overgrows his or her desire to be useful. (Sfard, 1998, p 8).

Lave (2012) warns that a monologic perspective reduces learning to "A concept of individual, internal mental exercise", produced through institutional arrangements such as teaching, which then becomes mistaken as "a prerequisite for learning" (Lave, 2012, p 161). Lave's (2012) concern is that the environmental and cultural contingency of schooling is overlooked when we grant authority of our learning and that of others to the formal teaching practices of qualified teachers only. Sfard (1998) approaches a further difficulty of monologic learning from the perspective of the acquisitive learner by identifying a paradox: "How can we want to acquire a knowledge of something that is not yet known to us?" (Sfard, 1998, p 7). Further,

> How do we account for the fact that learners are able to build for themselves concepts that seem fully congruent with those of others? Or, to put it differently, how do people bridge individual and public possessions? (Sfard, 1998, p 7)

This paradox points to a formulation of learning that must account for contingencies that extend beyond acquisitive individual minds towards cultural constructions of shared understanding and intersubjectivity.

Greeno (2006a) highlights methodological implications of a monologic, cognitivist, acquisitional approach to learning in educational research. Researchers adopting this approach would make a 'strategic, factoring assumption' that theories relating to learning activity can be supported by evidence gathered at the individual level:

> [T]o study individual learners, researchers [must] create a new kind of activity structure – a laboratory experiment – and because we do not yet know how the properties of individuals depend on the social context, we have to make a factoring assumption: that the principles that characterize behaviour of the individual research subject do not depend significantly on the rest of the activity system. (Greeno, 2006a, p 83)

Lave (2012) also argues that researchers adopting a monologic approach to learning research will produce third-person accounts of learning "as something done to others" (Lave, 2012, pp 161-62). Instead, Lave would urge researchers to put aside the assumptions of monologic learning in order to make it "possible to adopt a political stance that moves closer to historically specific analyses of persons in their practices" (Lave, 2012, p 162).

DIALOGIC LEARNING

What Lave (2012) points away from is a stress on individual minds and what it contains, and instead points towards a focus on the "evolving bonds between the individual and the others" (Sfard, 1998, p 6). Rather than knowledge being something an individual possesses or has, *knowing*, instead, emerges *dialogically* between individuals and others participating in activities that are of mutual interest in "the constant flux of *doing*" (Sfard, 1998, p 6, emphasis in original). Dialogic learning

> is seen as a process of becoming a member of a community and acquiring the skills to communicate and act according to its socially negotiated norms. (Paavola and Hakkarainen, 2005, p 538)

A dialogic perspective does not restrict learning to internal cognitive structures but instead can recognise understanding – *cognition* – only as distributed across and located within social networks of participation. Concepts related to this perspective of learning include 'everyday cognition' (Rogoff and Lave, 1984) and 'situated learning' through the practice of 'legitimate peripheral participation' (Lave and Wenger, 1991) in 'communities of practice' (Wenger, 1997). Greeno (2006a) argues that this shift in perspective has implications for researchers:

> The interactional approach focuses its study on the whole activity system, and it leads to conclusions about the principles of coordination of interactive systems. This means that the researcher has to analyse the whole activity system without yet having complete understanding of the individual components – particularly the human participants in the system. (Greeno, 2006, p 82)

One example of dialogic learning is Wenger's (2000) framework of social learning. It conceptualises learning as an interplay of historically and socially defined competence with personal experience. In one example:

> We join a new community [and] feel like a bumbling idiot among the sages. […] We feel an urgent need to align our experience with the competence 'they' define. Their competence pulls our experience. (Wenger, 2000, p 226)

In the second example,

> We have been with a community for a long time [but then] have an experience that opens our eyes to a new way of looking at the world. […] We now see limitations we were not aware of before. […] We are using our experience to pull our community's competence along. (Wenger, 2000, pp 226-27)

Wenger's (2000) social learning theory explains learning as that which happens when social competence and personal experience "are in close tension and either starts pulling the other" (Wenger, 2000, p 227). Here, our understanding of learning has escaped individual minds and begun to account for mutual development of individuals in communities. For humans,

> this perspective highlights the importance of finding the dynamic set of communities they should belong to – centrally and peripherally – and to fashion a meaningful trajectory through these communities over time. (Wenger, 2000, p 243)

Dialogic learning of this kind presents its own problems of analysis. Van Oers (2004), for example, argues that a dialogic perspective on learning such as that promoted by Wenger (2000) defines the context of learning rather than learning itself. Consequently it does "not give a clear theory of learning itself" (Van Oers, 2004, p 7) which would explain what new competences are yielded by participation in communities and what this means at the level of the individual that we would recognise as 'learning'. Furthermore, Paavola and Hakkarainen (2005, p 539) highlight that, "since the [participation] model focuses on adaptation to existing cultural practices, it does not prompt one to pay any special attention to creative changes in these practices". This

prevents analysis of individuals or communities learning something 'new', which cannot be reduced merely to a tension between social competence and individual experience.

Van Oers (2004) and Sfard (1998) both express concern that neither the acquisition metaphor nor the participation metaphor individually is sufficient to explain adequately the process of learning of individuals situated in environments and practices. However, Sfard (1998) recognises that "The relative advantages of each of the two metaphors make it difficult to give up either of them" (Sfard, 1998, p 10). Instead, Greeno (2006a) proposes a 'situative approach' that synthesis both metaphors. A situative approach emphasises neither individuals only nor situated contexts only. Instead,

> the main focus of analysis is on activity systems: complex social organizations containing learners, teachers, curriculum materials, software tools, and the physical environment. (Greeno, 2006a, p 79)

The purpose of focusing upon an activity system, rather than individual learning alone or cultural practices alone, is to evaluate knowledge within the activity and to account for the development of the activity. In other words,

> The study of learning activity requires us to develop concepts and principles that can explain how and why activities in a setting result in changes in what people can do. (Greeno, 2006a, p 80)

The task of drawing together a focus on individual sense-making and a focus on the situated aspects of evaluating sense and knowledge in order to account for learning as an activity system reveals a significant tension for the researcher: where the goal of a situative analysis is "to understand cognition as the interaction among participants and tools in the context of an activity" (Greeno, 2006a, pp 83-84), the challenge is deciding "whether to proceed by reduction to study of the components, or by holistic study of the entire system" (Greeno, 2006a, p 82). The danger of assuming a focus on individual cognition decontextualized from interaction with the learning environment as an activity system risks "conclusions that we think are about the individual, but in fact depend on broader features of the activity system" (Greeno, 2006a, p 83).

Pink and her colleagues (Pink, 2011; Fors et al, 2013) have proposed a synthesis of a different kind. Rather than position learning as either of the mind only or of the mind-in-environment only, they claim that an individual's learning is constituted by a full range of embodied senses within temporally and spatially constituted places, as mind–body–historically constituted environment. They call this 'multisensory emplaced learning'.

Pink (2011) draws from a number of sources, including the anthropologist Howes (2005), who had called for a move away from a concept of embodiment towards the "emergent paradigm of emplacement" (Howes, 2005, p 7), and the geographer Massey (2005), who has developed a concept of 'place-event' to explain the temporal and spatial constitution of space as perceived by humans. Rather than articulating a learning environment as an activity system, and critiquing situated cognition's difficulty with the situatedness of situated cognition (see Fors et al, 2013, p 173), the concept of multisensory emplaced learning instead aims to account for "the specificity and intensity of the place event and its contingencies, but also the historicity of processes and their entanglements" (Pink, 2011, p 354) in order that the researcher can "reformulate learning through a focus that engages with both the detail of how it happens and the shifting environments of which it is a part" (Fors et al, 2013, p 181). Emplacement is preferred to situatedness since it is characterised, according to Massey (2005), by its

> throwntogetherness, the unavoidable challenge of negotiating a here-and-now (itself drawing on a geography of thens and theres); and a negotiation which must take place within and between both human and nonhuman. (Massey, 2005, p 140)

Drawing on Massey's (2005) work, the concept of multisensory emplaced learning shares the situative approach's analysis of the individual's developmental relationship with environmental resources for the purposes of learning, but also locates (or situates) the nonhuman, rather than the human alone, as temporally and spatially constituted. Fors et al (2013) describe this negotiation as "our relationships with the technological architectures of learning", meaning discourses, ideologies and representations "that form part of learning processes" (Fors et al, 2013, pp 174-75). They present examples of initial analyses of this concept, such as an examination of how digital media teaches us

to learn through touching, learning to taste at organic food markets, and learning to listen in order to evaluate developing skateboarding ability (Fors et al, 2013).

TRIALOGIC LEARNING

This chapter earlier noted that Paavola and Hakkarainen's (2005, p 539) concern that dialogic learning from the perspective of situated learning did "not prompt one to pay any special attention to creative changes in these practices". Scardamalia and Bereiter (2006, p 97) observe that, "Ours is a knowledge-creating civilization", which cannot be explained by situated cognition alone:

> Sustained knowledge advancement is seen as essential for social progress of all kinds and for the solution of societal problems. (Scardamalia and Bereiter, 2006, p 97)

Paavola and Hakkarainen (2005) distinguish trialogic learning from monologic and dialogic learning approaches "because the emphasis is not only on individuals or on community, but on the way people collaboratively develop mediating artifacts" (2005, p 539), including the "deliberate advancement of knowledge rather than just production of material things" (2005, p 535). Bereiter (1997) argues that this advancement is human scientific endeavour, enabling humans

> to overcome the situatedness of cognition [by] creating a world of immaterial knowledge objects and acquiring expertise in working with them. (Bereiter, 1997, pp 284-85)

Scardamalia and Bereiter (2006, p 98) argue that the goal of this advancement is 'idea improvement', rather than 'truth' or warranted belief. However, although trialogic learning may appear to have returned to the human mind of monologic learning, 'idea improvement' is the work of communities and not individuals. Scardamalia and Bereiter (2006) emphasise the community's knowledge *of* rather than the community's knowledge *about*: ""Knowledge of is activated when a need for it is encountered in action" (Scardamalia and Bereiter, 2006, p 101). Here, knowledge is not seen as

something acquired or participated in, but rather created for the purpose of social progress.

PART TWO

CHALLENGES OF LEARNING TRANSFER

Serious case reviewing, as Chapter One indicated, implies the transfer of learning from an historical, 'serious' case of fatal or significant child maltreatment to the prevention of such a case. This implies transfer across time, from a retrospective analysis to the prospective organisation of professionals involved in current and future cases. Transfer may also take place across service levels of intervention and prevention, as indicated by the previous chapter's highlighting of children whose serious maltreatment was subject to review but whose assessed needs did not include protection from significant harm. Instead, these children's needs were served by child welfare organisations working to support the child and family in light of less acute presenting issues. There is also a spatial transfer, since learning identified in a SCR is not expected to take place in and only in the exact individual and organisational situations that were reviewed in the original case. Rather, it is the prevention of the maltreatment of other children, in some other place or places, that is a goal of serious case reviewing. Serious case reviews, then, not only help us to *learn about* particular cases but expect us to *learn from* them in order to prevent other, not-yet-serious cases from becoming serious.

The consequences for our understanding of learning's contribution to the prevention of fatal and significant child maltreatment in SCRs through 'transfer' are significant, since it might be argued that transfer of learning is distinct from learning itself:

> Transfer is distinguished from run-of-the-mill learning by virtue of its distinct tasks and situations […] it does not include the genesis of tasks and situations as a part of the process. (Beach, 1999, p 101).

This is important since, as Hatano and Greeno (1999, pp 647-48) observe, while "creative human minds often try to apply to a novel problem seemingly relevant knowledge from another domain, finding the really applicable knowledge in many other

domains remote from the novel situation can be very hard". Learning and its transfer is related to individual and organisational perception of the relevance of what was learned to the situation to which it may be transferred. These lines indicate that the unproblematic concept of transfer embodied in the dissemination–implementation model of SCRs seriously underestimates the possible complexity of learning transfer.

TRANSFER OF MONOLOGIC LEARNING

Monologic learning proposes a cognitivist perspective on the almost material acquisition of knowledge, organised within individuals' minds by information structures that help us to find meaning, make connections and understand. How this knowledge is acquired – transferred – supposes that knowledge be transmitted by the knower to the one who needs to know. Thus acquired, the knower is in a position to transmit their knowledge to another who does not yet know. It is this perspective which would appear to underpin the optimism of 'disseminating findings' from SCRs in the expectations that learning 'happens'. Published SCRs are expected 'to transmit' their lessons unequivocally to other child welfare professionals and local safeguarding children's boards (LSCBs) whose information structures are expected to enable them to understand what each lesson means for local child welfare practice.

Sfard (1998) suggests that a convincing model of learning "is probably bound to build on the notion of an acquired, situationally invariant property of the learner, which goes together with him or her from one situation to another" (1998, p 10). Greeno (2006a) argues in favour of invariant properties of different activities that engage individuals:

> Learning that occurs in one kind of activity system can influence what one does in a different kind of system, but explanations in terms of overlapping aspects of activities in practice are much more promising than explanations in terms of the transfer of knowledge structures that individuals have acquired. (Greeno, 2006a, p 80)

Hatano and Greeno (1999, p 650) warn of "fundamental limitations" in this idea. For example, failure to transfer "becomes a serious problem only when learners' independent problem solving is assessed, as in school". Similarly, LSCBs and other organisations are vulnerable to criticism when they are assessed as having failed to transfer the unproblematic, invariate meaning of SCR lessons. No allowance is made for the contingencies, conditions, interpretive challenges and dissimilar factors between SCR presentation of serious cases, and 'live', unfolding, ambiguous child welfare cases before professionals each day.

TRANSFER OF DIALOGIC LEARNING

Dialogic learning emphasises the locally situated, socially, physically and spatially constituted meaning of knowledge. The concept of learning transfer sits uneasily with such a perspective, since transfer assumes some equal relevance across situations, rather than within bounded situations. Bowker (n.d., p 3) has argued that, unlike optimistic accounts of monologic learning transfer, "Knowledge is always firmly tied to a locality". Sfard (1998) points out,

> Learning transfer means carrying knowledge across contextual boundaries; therefore, when one refuses to view knowledge as a stand-alone entity and rejects the idea of context as a delineated 'area', there is simply nothing to be carried over, and there are no definite boundaries to be crossed. (Sfard, 1998, p 9)

Hatano and Greeno (1999) similarly highlight the incompatibility of the concepts of learning transfer and communities of practice. They point out that, since the collaboration "is directed primarily to productive performance of the team as a whole […] a participant does not have to show her or his independent competencies" (Hatano and Greeno, 1999, p 650). Whatever an individual may take from one practice to another is lost in the activity production of the community.

Bereiter (1997) highlights a further difficulty with dialogic learning transfer. The typical course of situated learning is progress from incompetence to being competent and

smart, and that competence from a situative perspective, for example, involves being especially attuned to the human and non-human environment, then "the part that does not transfer is likely to include the being smart. […] In a new situation, you are liable to have to start over being stupid" (1997, pp 299-300).

Greeno (2006b) proposes that this overlap can be explained as the 'authoritative and accountable positioning' of individual learners across different situations. 'Authoritative' because, "transfer involves doing something that one has not been taught explicitly to do" (Greeno, 2006b, p 538) and 'accountable' because learners "use and comply with general concepts and principles of the domain" (2006b, p 545). The 'overlapping aspects' include treating a domain's resources as open to being "adapted, evaluated, questioned, and modified" (Greeno, 2006b, p 539). The 'positioning' aspect relates closely to Sfard's (1998) suggestion that an 'invariate property of the learner' transfers from situation to situation. Greeno (2006b) proposes that this property may be individuals' 'conceptual agency' (Pickering, 1995).

> For authoritative and accountable positioning [with conceptual agency] in learning to contribute to transfer, positioning must be included in what transfers between activity settings [which suggests] being entitled and expected to move about the environment freely, with access to resources throughout the environment and with the authority to use, adapt, and combine those resources in unconventional ways. (Greeno, 2006b, pp 539, 543)

As a precursor to Greeno's (2006b) suggestion of unconventional combinations of domain knowledge in response to localised activity, Hatano and Greeno (1999) had earlier proposed a situative alternative to the concept of transfer, 'productivity', which refers "to the extent to which learning in some activity has effects in subsequent activities of different kinds" (Hatano and Greeno, 1999, p 647). Rather than assuming that practice activity is characterised by static, fixed goals, where the product of the activity is accomplished through the increased efficiency and automaticity of the practice's community, Hatano and Greeno (1999) suggest that

> when successful participation in a practice requires flexibility and adaptiveness (e.g., making products meeting varied and changing demands), [practice

> participants] may learn to transform the concepts and methods of the practice. In other words, their learning is likely to be more productive. (Hatano and Greeno, 1999, p 650)

Greeno's (2006b) later concept of 'authoritative, accountable positioning' suggests that this productivity is a contribution of a practice participant to another domain activity that is evaluated by that domain as legitimate. There are echoes here of Wenger's (2000) 'social learning system' discussed above, where individuals' experience 'pulls' a community's competence.

TRANSFER OF TRIALOGIC LEARNING

Bereiter (1997) is not satisfied that either the positioning of an individual or the pulling of a community adequately captures the difficulty involved in offering a coherent explanation of learning transfer. He steps beyond both an isolated individual cognitivist explanation or a dialectic explanation to suggest a third factor. He cites space travel as "surely our most colossal example of transfer of learning":

> No amount of situated cognition or 'legitimate peripheral participation' would get people to the moon and back. It took something more to produce that kind of transfer, and we must try to pin down what that is. (Bereiter, 1997, p 300)

In an effort to pin down exactly 'what this is', Bereiter (1997, p 293) suggests that knowledge is produced (and not simply reproduced) in situated activities: "knowledge production, like any kind of human activity, takes place in some physical and social situation". Bereiter (1997) suggests that the production of knowledge in a socially, spatially and temporally constituted activity differs from the knowledge that is necessary to sustain the activity in itself. The transfer of this product does not become evident on its subsequent appearance in another activity, as either productive or authoritative knowing. Rather, Bereiter (1997) argues that this learning transfers *to the level of abstraction*, "overcoming the situatedness of cognition" (1997, p 285). Bereiter offers a concrete example (see Bereiter, 1997, p 291): having learned a way to beam an x-ray at a cancerous tumour, learners are then challenged with the task of devising a way for

Crusaders to attack a castle. According to Bereiter (1997), learners very rarely transfer learning from the x-ray activity to the Crusader activity when they are not prompted. When prompted, on the other hand, people make a connection. The abstract idea in the concrete example given above is 'focus' – the maximal effect when the convergent paths of things meet.

> Thus, transfer in such cases is anything but automatic. People have to be looking for a relationship. And what kind of relationship is it? The word that comes to mind is 'abstract.' It is a relationship based on formal, structural, or logical correspondences. (Bereiter, 1997, p 291)

Bereiter (1997) argues that this idea is a product of the situated learning activity. In order to solve the second problem by using the example of the first, "One has to create symbolic representations of situations and carry out operations on those symbols" (Bereiter, 1997, p 291). Learning, in this perspective, abstracts knowledge from its original temporal and spatial contexts in order to allow situated learners act upon it in order to learn how to transfer its relevance to one other concrete, situated activity. The transfer here is not universal, but from one concrete and distinct problem to another. The explanation is not that the activities 'overlap' in Greeno's (2006a) situative approach, but rather that the knowledge produced in one situation becomes a mediating object for other subsequent activities.

Bereiter (2014) has called this use of abstracted knowledge for the purpose of learning transfer 'principled practical knowledge' (PPK). He argues that it achieves concrete practical objectives but at the same time "can be communicated symbolically, argued about, combined with other propositions to form larger structures and so on" (Bereiter, 2014, p 5). The concrete example given above, concerning the prompt to use the learning from an x-ray activity to solve a castle attack activity, indicates that PPK's "main function is not explanation or prediction but practical guidance" (2014, p 4). In that example, problem-solving is the situated activity and PPK is the knowledge produced by coherent problem-solving activity. Bereiter (2014) highlights that the production and subsequent abstraction of knowledge from the problem-solving activity

> requires additional effort invested in producing knowledge that goes beyond what is required for the task at hand yet not so far beyond as to be unusable by practitioners […] PPK goes to a depth that is sufficient for a field of practice to advance. (Bereiter, 2014, pp 4, 6)

Bereiter (2014, p 5) defines PPK as "*know-how combined with 'know-why'* [or] more precisely characterized as *explanatorily coherent practical knowledge*" (emphasis in original). In this sense, 'solving the problem' of assessment of children's needs in order to prevent maltreatment requires professionals not only to learn *about* historical cases but, in order to learn *from* them, to know how to solve presenting complexities of the case by relating it symbolically and coherently to the principles of solved problems of the past, and acting upon this knowledge in order to prevent child maltreatment.

PART THREE

ALTERNATIVE TO TRANSFER 1: CONSEQUENTIAL TRANSITIONS

Beach (1999, p 107) argues that concept of learning transfer is "embedded within our folk notions of teaching, classroom learning, and the role of schooling in society" but is an acutely restrictive concept when people's practical learning is to be analysed. Beach offers five possible evaluations of situated learning transfer:

> An analysis of a person learning something on a second task (B) after having learned something during a prior task (A) contains five possible relations between the old and new learning. These possibilities are not mutually exclusive. Possibility 1: Some learning occurs prior to A and B but is excluded from learning on both because it is not seen as relevant. Possibility 2: Some learning occurs prior to A and B and is used in learning A and B because it is seen as relevant to both. Possibility 3: Some learning occurs prior to A and B but is used only in learning B because it is seen as relevant to B and not A. Possibility 4: Some learning occurs on A but is not used in learning B because it is seen as irrelevant to B. Possibility 5: Some learning that occurs only on A is used during learning B because it is seen as relevant to B. (Beach, 1999, p 107)

Beach (1997, p 108) argues that only Possibility 5 is what is commonly understood as learning transfer and, consequently, “An expanded definition of what counts as transfer in educational research is needed”. He observes that “Generalization at the intersection of persons and activities cannot happen without systems of artifacts, symbolic objects that are created with human intent” (1999, p 113). For Beach, however, by acting upon a new understanding of activity by means of such artifacts “the person experiences becoming someone or something new” (1999, p 113).

Bereiter (2014) earlier suggested that principled practical knowledge (PPK) emerged as a product of situated activity and cognition to become an immaterial knowledge object that offered practical guidance – know-how and know-why – that served to advance the knowledge of a community. The knowledge produced was, in Bereiter’s word, ‘abstract’. Rather than focusing on the characteristics of the knowledge produced, as in PPK, Beach (1999) instead focuses on the changed relation between a person and their contribution to an activity as a result of their interpretation of knowledge. Beach (1999) calls this change in relation a ‘consequential transition’:

> Transitions are consequential when they are consciously reflected on, often struggled with, and the eventual outcome changes one's sense of self and social positioning. (Beach, 1999, p 114)

Beach suggests four distinct but not mutually exclusive transitions:

- Lateral transitions occur when persons move in a single direction from one activity to another that are historically related, such as from school to work. Beach, (1999, p 114) explains that “the activity one is in lateral transition to is considered a developmental advance beyond the previous activity, which is seen as preparation for the new activity”.
- Collateral transitions, on the other hand, involve persons’ “simultaneous participation in two or more historically related activities” (Beach, 1999, p 115). A concrete example is the movement between home and school or between school and after-school employment. Beach (1999, p 115) warns that “they are more difficult to understand because of their multidirectionality”.

- Encompassing transitions refer to changes within an activity that is undergoing internal change, or when the rate of this change is experienced as rapid by the activity's participants. Beach (1999) offers the example of experienced teachers responding to new policy initiatives. Furthermore, in these transitions "Younger generations of participants often assist older generations in acquiring necessary knowledge and skills and are seen as more expert" (Beach, 1999, pp 117-18).
- Mediating transition refers to "a bridge between two other systems of activity and embodied a clear developmental agenda for its student" (Beach, 1999, p 119), such as a training event or training process since they "project or simulate involvement in an activity yet to be fully experienced" (Beach, 1999, pp 118-19).

Beach's (1999) proposed these transitions in order to broaden the analytical possibilities of researching and understanding the transfer of knowledge across activities. Analytically, Beach's initial concern to begin explaining such transitions is the relation between the person and the activity, which he refers to as 'developmental coupling':

> A developmental coupling encompasses aspects of both changing individuals and changing social activity. […] The coupling itself transforms or develops. Its directionality and causal relations are not efficient or antecedent/consequent; rather, they are correlational or relational in nature. (Beach, 1999, p 120)

This coupling refers not only to activity and situated persons, "but also to broader institutional, societal, and cultural forces" as well as artifacts, which necessarily "extend beyond a particular individual participating in a particular social organization at a particular time" (Beach, 1999, p 123). This focus on consequential transitions which are explained in part by the ongoing, ecological development of relations between individuals and activities cannot admit simplistic accounts of transfer that expect prior knowledge to appear effectively and spontaneously in new activities. Beach's concept of consequential transition may refer to the development of individuals as professionals capable of preventing the significant or fatal maltreatment of children, but learning from SCRs, either through encompassing or mediating transitions, can account for only one possible contribution to this developmental coupling of child welfare professional and improved child welfare practice.

ALTERNATIVE TO TRANSFER 2: CONTINUOUS PROGRESSIVE (RE)CONTEXTUALISATION

Van Oers (1998) proposes that learning transfer is better understood as continuous progressive recontextualising; that is, the "continuous process of embedding contexts in contexts" (Van Oers, 1998, p 135). Van Oers opposes notions of decontextualizing (for example, see Donaldson, 1978; Wertsch, 1985) as an explanation of meaningful abstract thinking, since "it is consistent to argue for the importance of context for all forms of meaningful concept formation (including abstract concepts)" (Van Oers, 1998, p 136). He argues that "where decontextualization is said to occur, actually a process of *recontextualization* is going on" (Van Oers, 1998, p 137, emphasis in original).

Van Oers (1998) distinguishes between horizontal and vertical recontextualisation. Horizontal recontextualisation occurs when "a new situation is recognized as an opportunity for an alternative realization of a well-known activity" (Van Oers, 1998, p 138) (similar to Greeno's, 2006, concept of authoritative, accountable positioning). However, as activities develop, new problems emerge that require new patterns of activity. Here, Van Oers, suggests, are the conditions for vertical recontextualisation: new patterns and contexts for action emerge in a well-known activity but which do not constitute "directly a new, alternative realization of that activity" (Van Oers, 1998, pp 138-39). Van Oers offers a concrete example of observing children playing 'shoe shop' at school:

> Within the context of the shoe-store play activity, attention was drawn to actions of measuring. During the play activity, measuring became a separate activity for the children, including forms of measuring and conversations about measuring that the children never could have heard in a real shoe store. Measuring as a new activity gradually emerged out of the shoe-store play activity, leading to a new, even more 'abstract' activity and context of acting. (Van Oers, 1998, p 138)

Figure 3A illustrates this process of continuous progressive (re)contextualisation (Van Oers, 1998).

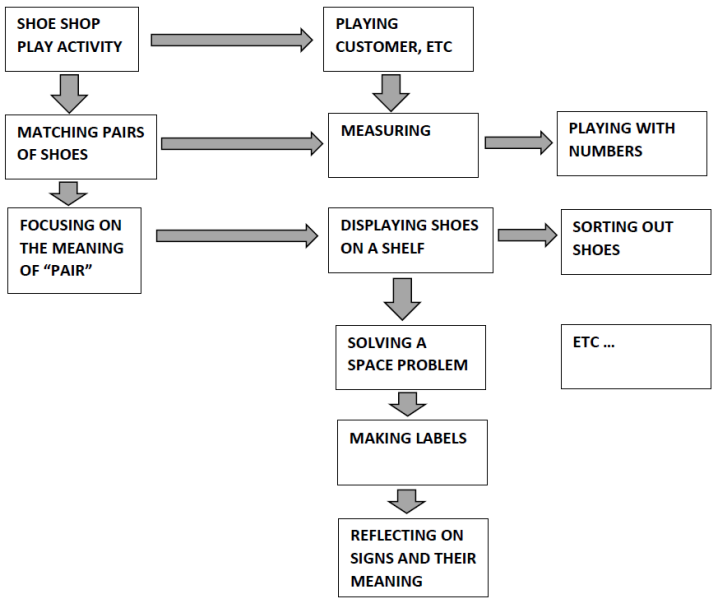

FIGURE 3A Example of continuous progressive (re)contextualisation in children's shoe store play activity (from Van Oers, 1998, p 140, fig 1)

ALTERNATIVE TO TRANSFER 3: MOBILE KNOWLEDGE IN MULTI-AGENCY WORK

Kanfer et al (n.d.) discuss the mobility of knowledge across multi-agency professional alliances. The researchers themselves (Kanfer et al) are distributed across a number of academic and professional sites. The purpose of their research is to understand how knowledge is constructed and shared among members of six multidisciplinary teams within the National Computational Science Alliance. Members include cosmologists, environmental hydrologists, molecular biologists, chemical engineers and other professionals. The teams are geographically dispersed. Their work is focused on "innovative and leading edge collaborations across disciplines, often across disciplines that have little history of working together" (Kanfer et al, n.d., p 3). Kanfer et al (n.d., p 2) began with the observation that such alliance organisations must depend on virtual collaboration, since, in addition to a distribution of financial and intellectual resources, alliances "require that certain degrees of knowledge be mobile in order for the alliance to be effective" (Kanfer et al, n.d., p 4) across geographic distributions and domain-specific knowledge. For example, the challenge facing scientists contributing to the alliance's teams was to communicate knowledge that is 'embedded' within specialist domains across several other domains.

> There are indications that this effort to make embedded knowledge mobile and shared across multidisciplinary scientific teams results in a complex series of trade-offs between communication efficiency and preserving context. (Kanfer et al, n.d., p 5)

Bowker (n.d., p 6) argues that, "in order to carry out effective communication, we need to be able to share units and shapes of time", so that knowledge can be shared across places, across service levels and degrees of intervention and across individuals and collectives/organisations. Context suffers. Since context may be a condition for knowledge evaluation, "*the nature of knowledge processes in groups and the goals of electronic infrastructures to support distributed knowledge processes may be in direct conflict with one another"* (Kanfer et al, n.d., pp 3, 4, emphasis in original).

Consequently, Kanfer et al's research team chose to distinguish 'mobile' from 'embedded' knowledge as follows:

> knowledge can be considered 'mobile' when it can be codified in a linguistic (written or oral) way and easily transferred or translated from one person or group to another. Knowledge is 'embedded' in a social system when it is bound up with a set of communications, practices, and tools that make linguistic codifications difficult. (Kanfer et al, n.d., p 4)

Figure 3B illustrates this explanation for the mobility of knowledge across people, professions, time and space. Each graphic represents two distributed, asynchronous multidisciplinary teams with diverse group contexts and history and the lines of communication between them, virtual or face-to-face. Graphic 3a represents 'imitative adoption', which aligns closely with monologic, non-interpretive learning. Graphic 3b indicates support for shared embedded knowledge, aligning with the dialogic perspectives discussed earlier. Graphic 3c, however, "depicts the sharing of representations of knowledge embedded in either team (or, again, between members of a multidisciplinary team)", codified in order to make it

> possible for teams with different social, organizational and disciplinary contexts, and teams whose members are from significantly different disciplines to effect

knowledge discovery by a synergistic pooling of their knowledge resources. (Kanfer et al, n.d., pp 11-12)

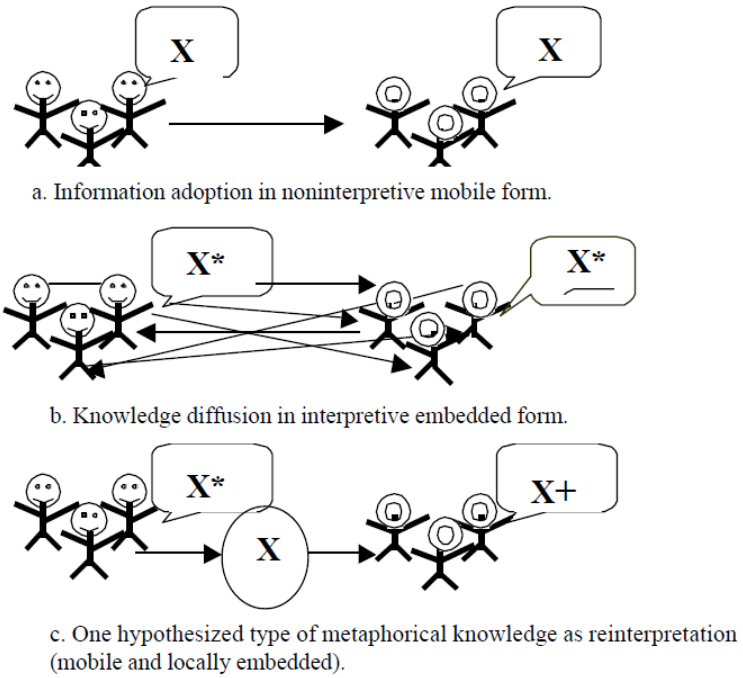

FIGURE 3B Possible modes of knowledge mobility (from Kanfer et al, n.d., p 10, fig 3)

Kanfer et al's (n.d.) focus is on multi-disciplinary, geographically distributed teams seeking to collaborate on shared projects and how knowledge is created in such alliances. They suggest that highly embedded knowledge becomes mobile when it is sufficiently codified (and compromised) to get the job done. Evaluative accuracy becomes less important than shared understanding that progress towards shared goals is being achieved.

SUMMARY

This thesis's primary goal is to examine the claim that learning contributes to the prevention of serious child maltreatment and that 'any learning model' is capable of this on the condition that particular principles of the statutory duty's framework are adhered to (HM Government, 2013). The purpose of this first literature review has been to scope the diversity of what 'learning' can mean. The division of learning into three categories

(monologic, dialogic and trialogic) is not intended to suggest that they are mutually exclusive, since they are not. Rather, the distinctions between them refer to the different relations they each emphasise in either the production or reproduction of knowledge. The shift from monologic learning to dialogic learning is a shift from focusing on cognitive structures inside humans' brains towards a relation between cognition and situated practice in environment and sociocultural activity and then towards the creation of new knowledge in communities.

Each perspective on learning also accounts for the transfer of learning, initially from the quite unproblematic transmission of monologic learning to the work undertaken on symbolic representations in trialogic learning. The chapter has also demonstrated that not all scholars consider the transfer metaphor particularly useful or analytical, and instead consider the movement of knowledge and learning to be evidence of consequential and recontextualising characteristics of social activity (see Beach, 1999; Van Oers, 1998).

The dissemination–implementation model adopted by serious case reviewing would appear to reflect a monologic perspective on learning. However, the statutory guidance includes a principle that an effective SCR

> seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight. (HM Government, 2013, p 67, para 10)

This principle indicates a situated perspective. This chapter has indicated that situated and situated perspectives on learning face considerable difficulty in articulating learning transfer, although situative accounts propose concepts such as productive knowledge (Greeno, 2006b). And finally, in order to prevent the serious maltreatment of children, professionals need to transfer learning from SCRs and interpret its meaning in relation to current cases in their work. This requires the production of new knowledge, since the complexity of individual children's lives means it would be inappropriate to assume that learning from a serious case is sufficient for understanding a current non-serious case. This would require a trialogic perspective.

Consequently, in order to develop a learning model that places the emphasis on *learning*, local safeguarding children's boards (LSCBs) are faced with a number of possibilities. The formulation of any model would necessarily require certain choices and trade-offs being made.

With reference to Figure 1A (see page 14) and Toulmin's model of argument (Toulmin, 2003 [1958]), the aim of this thesis is to examine more closely the extent to which a fuller account of learning can serve as a *warrant* for the *claim* that children's serious maltreatment can be prevented when individuals and organisations use any learning model consistent with the principles of learning and improvement of the current statutory guidance (HM Government, 2013) (*qualifier*) to learn lessons from published SCRs (*data*).

Chapter Two has already queried the adequacy that the current model of dissemination and implementation via action planning to account not only for the dynamics of learning from SCRs, given that only the equifinality of children's significant harm draws serious cases together as a coherent category of literature and professional review, but also for the transfer of learning across temporal, spatial, professional and social domains.

This chapter indicates that perspectives on learning and its transfer are heterogeneous and contested. Consequently, a claim that 'any learning model' will suffice to support both professional learning and the prevention of child abuse must engage critically with the diversity of perspectives and the goals of learning that each pursues. Currently, the principles of learning and improvement embedded within Working Together to Safeguard Children (HM Government, 2013) sidestep this critical engagement completely. This chapter has shown that a monologic model of learning and learning transfer would most likely resemble the dissemination–implementation model presented by Ofsted (2011) as good practice, relying on action plans being transmitted from the planning activity to the professional learning and prevention of harm activity.

This basic model does not acknowledge the dynamics of dialogic learning and the awkwardness with which accounts of learning transfer can be accommodated within them. Dialogic learning encompasses such conceptual possibilities as situated learning (for example, Lave and Wenger, 1991), situative approaches (Greeno, 2006a) and

multisensory emplaced learning (for example, Pink, 2011). 'Any learning model' cannot expect to ignore these possibilities, especially given that one principle of learning and improvement in the statutory guidance is "to understand practice from the viewpoint of the individuals and organisations involved at the time" (HM Government, 2013, p 67, para 10). More importantly for their ultimate purpose of preventing children's serious maltreatment, SCRs must support learning that enables individuals and organisations *at any time* to preview serious cases so that sufficiently robust early interventions and prevention strategies can be formulated *at any time* in the future.

This learning is likely to demand of individuals and organisations a significant degree of improvisation, since SCRs cannot prescribe exactly what specific individuals and organisations are capable of formulating such preventative interventions. The diverse characteristics of children and families alone will require an adaptive and interpretive approach to learning in order that such interventions are effective for specific and unique children. Consequently, any effective learning model that enables individuals and organisations to draw upon published SCRs to innovate preventative interventions would do well to engage with articulations of trialogic learning and its goal of articulating ways in which people can be prompted to work on abstract models so that the "situatedness of [their] cognition" (Bereiter, 1997, p 285) can be overcome.

This chapter has also presented alternatives to the concept of learning transfer that may also serve as useful models of learning. Consequential transitions (Beach, 1999) could account for professional learning that sees children at risk of significant harm enjoying conditions where such risk has been minimised or eliminated. Continuous progressive (re)contextualisation (Van Oers, 1998) may enable individuals and organisations to account for horizontal and vertical learning and therefore professional development and improvement as they examine current professional practice in light of lessons from SCRs. Finally, Kanfer et al's (n.d.) acknowledgement of mobile knowledge across domains of expertise, place and time is useful in articulating how diverse groups approach learning for a single common purpose.

In light of research presented in Chapters Two and Three, and with reference to the Toulmin model of Figure 1A (see page 14), it is reasonable to argue that *since* (a) the current dissemination–implementation model of SCRs engages so minimally with the

potential opportunities afforded by a wider range of learning concepts and the articulations of transfer that are fundamental to the effectiveness of SCRs, and *since* (b) the data are so diverse, the *qualified claim* that 'any learning model' can support individuals to learn lessons from SCRs in order to prevent children suffering serious maltreatment is only minimally warranted. Given that the resources for the development of an effective learning model may be available, it cannot yet be claimed that this diversity constitutes *a rebuttal* of the statutory guidance's claim that learning has a contribution to make to the minimisation of child maltreatment. The model as it is currently constituted, however, serves only as a minimal warrant for the claim.

CHAPTER FOUR

LITERATURE REVIEW 2

LEARNING IN HUMAN WELFARE SERVICES

INTRODUCTION

Chapter Three presented *learning* and *learning transfer* as a range of perspectives, some of which extend beyond the dissemination–implementation model proposed for serious case reviewing. It began by introducing the cognitive model of invariate information and knowledge acquisition. This model places learning inside people's heads, and the issue of transfer is resolved by identifying a conduit that can successfully transmit information, such as teaching or dissemination. The chapter concluded by presenting a research team's plans to understand how knowledge can be acquired, shared and combined within and between geographically and temporally distributed multi-agency alliances (Kanfer et al, n.d.). Each alliance comprises diverse scientific epistemologies, histories and dynamics, and the research team's goal is to understand better how the multi-agency alliance as a whole can produce innovations and new knowledge. The team proposed that a starting point would be to distinguish *mobile*, codified knowledge from *embedded* knowledge.

In other words, *learning*, when unpacked, demands attention not simply to individual humans, but at least to the mutually constituting (or constitutive) relations between humans and between humans and embedded, emplaced and/or abstracted knowledge, and also temporal and spatial factors and possible goals of knowledge production. Although Chapter Three demonstrated that the different perspectives are not mutually exclusive, there is no reason to assume that the statutory guidance's allowance that local children's safeguarding boards (LSCBs) can "use any learning model which is consistent with the principles in this guidance" (HM Government, 2013, p 67, para 11)

will not raise tensions regarding the necessary choices and trade-offs when designing such a model in light of the stated principles.

One possible tension is evident in the following line from *Working Together to Safeguard Children* (HM Government, 2013):

> [Current statutory guidance] focuses on core legal requirements and it makes clear what *individuals and organisations* should do to keep children safe. (HM Government, 2013, p 7, para 6, emphasis added)

There is a tension between the statutory framework's focus on only the professional individual and organisational factors in any model of learning and Chapter Three's presentation of learning as unlikely to be restricted only to the transmission and acquisition of invariate knowledge between human brains. For example, the statutory guidance

> seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight. (HM Government, 2013, p 67, para 10)

This implies situated learning, admitting that the knowledge of individuals and organisations was and is situated in time and place. The dissemination–implementation model of serious case reviewing assumes that it is possible to abstract this historically and spatially situated rationale for action and transfer it to current or future interactions between multi-agency professionals, children and families. What this assumption does not address is the constitution of situated action 'at the time', then and now. A number of possible situations can be proposed: active single agency or multi-agency interactions with children and families, active multi-agency working in children's welfare offices or distributed teams, and the children's and families' private lives.

This chapter examines work that has been undertaken in studies of learning in child welfare practice to understand better what situations are proposed as sites of learning. It begins with a review of Horwath's (2001) change model for practitioners learning to integrate new statutory assessment technology with existing practice priorities and procedures. Horwath (2001, p 29) argues, "Effective change is only likely to occur within

the organization if the external motivation to change can be transformed into internal motivation", pointing towards a relation or negotiation between individual and organisation as the focus for learning. Importantly, the chapter demonstrates that research extends beyond individuals and organisations to include attention to strategy (Morrison, 2000, 2010) and systems (Munro, 2010, 2011, 2012), for example.

PART ONE

OPERATION-LEVEL LEARNING

Horwath (2001, 2007) and Horwath and Morrison (2000) have examined the contribution of *training* to individual child welfare practitioners' positive adoption and integration of a new statutory assessment tool that shifts the focus of their operation-level work with vulnerable children and families. Their particular concern is understanding how a standard national strategy can be incorporated into and interpreted appropriately within the daily operation of individual assessments of children's welfare needs when other, preceding strategies are already 'in progress'. Horwath (2001) describe such dynamics as 'change' rather than learning. However, considering Van Oers's (2004) claim, cited earlier, that "learning is a process that describes the changes in both the structure of human actions and the meaning of human actions" (Van Oers, 2004, p 13), it is reasonable to proceed on the assumption that what Horwath is looking at here is the ability of professionals to learn how to assess children's needs differently, using a new tool, in a working situation which has previously been oriented to different historically constituted priorities of children's welfare.

In 2000, the Department of Health, Department for Education and Employment and the Home Office introduced the *Framework for the Assessment of Children in Need and their Families* (DoH, DfEE and HO, 2000). (It has since been replaced by HM Government, 2013; see especially HM Government, 2013, p 5, para 2). The new framework was intended to replace previous professional attention to assessment of risks in children's lives and the formulation of responses to acute and complex need embodied within

them. The new framework would instead enable practitioners to assess children and families holistically in order to understand their developmental needs as ecologically situated and for effective conditions for development to be safeguarded. The assessment framework was child-centred rather than risk assessment-focused, and provided an analytical scaffold to access three assessment domains:

- the individual child's developmental needs;
- the families' parenting capacity;
- wider family and environmental factors.

The implementation of this particular framework depended not only on professionals endorsing the expanded framework of assessment, but it also required of them

> an attitudinal shift away from a procedurally driven system to one based more on the use of professional judgement within a framework of procedures. (Horwath and Morrison, 2000, p 246)

In other words, the framework did not provide a readymade array of levers and buttons that practitioners would pull and push in order to achieve standard welfare outcomes, but instead expected assessing practitioners to interpret a wide range of evidence which would inform the formulation of ongoing and appropriate interventions and support.

Horwath (2007) argues that the scaffold overlooked a crucial fourth domain of assessment, which she calls 'the missing assessment domain' (Horwath, 2007). This domain constitutes assessing the practitioners' needs when undertaking an effectively holistic assessment, since this activity is likely to require the exercise of professional judgement regarding ambiguous evidence and ambivalence regarding appropriate action within shifting emphases of practice intervention. Interestingly, Horwath and Morrison (2000) superimpose this domain upon the existing domains of the new framework (see Figure 4A). While the assessment remains centred on individual children, each assessed child's developmental needs mirror the assessing practitioner's needs. For example, where the original assessment focused on the family's parenting capacity, Horwath and Morrison's (2000) model focuses upon the practitioner's agency capacity, which is "the capacity of the organization to meet the needs of the

practitioners" (Horwath and Morrison, 2000, p 249). The wider family and environmental factors of the child and family mirror the practitioner's and organisation's "external relationships with other agencies and community networks which are required by the practitioners" (Horwath and Morrison, 2000, p 249).

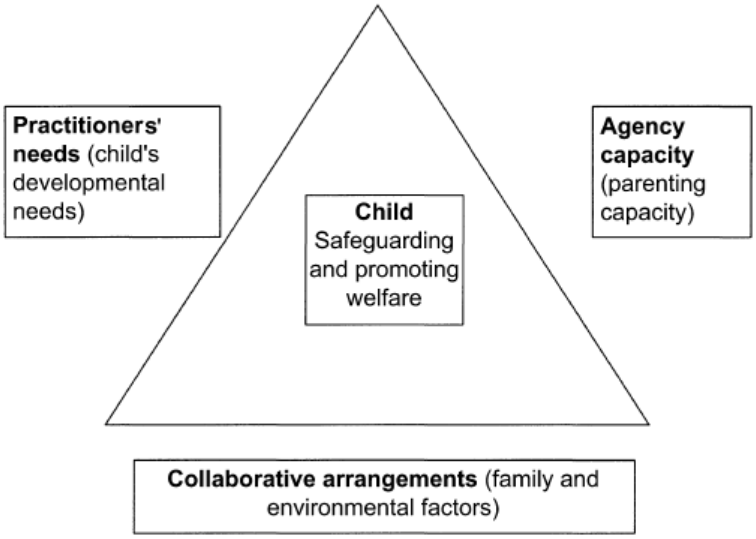

Figure 2 Triangle for auditing organizational readiness for change.

FIGURE 4A The 'missing assessment domain' (from Horwath and Morrison, 2000, p 250, fig 2)

Horwath and Morrison (2000) present examples of practitioners' needs and the agency capacity and collaborative arrangements necessary to meet them. For example, where they argue that practitioners need "clarity of values, and understanding the core business underpinning the service", the agency capacity should include a "mission statement that reflects agency values and is user-centred". Similarly, where practitioners need organised collaborative arrangements, including "constructive working arrangements with other professionals", the collaborative arrangements should include "Structures and systems for shared training and networking [and] systems for conflict management" (Horwath and Morrison, 2000, pp 251-52, tables 1 and 2).

Horwath (2001) suggests that learning to undertake the new assessment from the perspective of the four domains, rather than the original three, requires distinctive training interventions that enable practitioners to experience and embody this change at the operational level. In order to prepare individual practitioners for such learning,

Horwath (2001) adopts Protchaska and di Clementi's (1982) model of change. This is a professional tool more often used with clients, rather than the practitioners, of a particular social service intervention. The model comprises five stages: contemplation; determination; action; maintenance; and lapse. Horwath and Morrison (2000) explain that the model constructs a concept of change that "occurs when there are more motivational forces in favour of change than in favour of the status quo" (Horwath and Morrison, 2000, p 246). Individuals adopt and integrate change when their environment enables, permits and encourages them to do so, since these 'motivational forces' are "seen to reside not in individuals per se but in the interaction between the person and their environment, or in an organizational context, the worker and their agency" (Horwath and Morrison, 2000, p 246). External motivation, here, resides in the practitioners' organisational context and not in the needs of the assessed children families.

Horwath (2001) adapted the model "to provide a framework for the analysis of training needs and the development of training strategies to accompany innovations" (2001, p 20). Figure 4B illustrates Horwath's (2001) adapted model, which highlights the trainer's role as facilitator but also responsible for orienting operational practitioners towards a rationale for effective and durable change.

This model indicates that, at the first four of the model's five stages, managers and practitioners are situated only within a local professional community that is contemplating and committing to learning new assessment tools and policy through attendance at specific training events. Only at the fifth stage – maintenance/lapse in the model – does this situated learning encompass face-to-face situations with children and families under assessment. Horwath (2001, p 22, fig 2) describes this as implementation "in complex situations". This is the transfer of acquired knowledge (described in terms of equipment at stage 4 of the model) from trainer to practitioner, first, and from situated training event to professional practice in situated operation with children. Chapter Three noted that transfer of monologic learning uses transmission as a metaphor; dialogic, situated learning, however, has a problem with transfer, since the situated constitution of knowledge implies that such knowledge cannot be transferred. Horwath's (2001) adapted model explains this tension between consistency of observed transfer and

instability of situatedness by the metaphors of maintenance and lapse. Where the transmission and therefore transfer of knowledge is consistent,

> this stage should be a period of consolidation. The learner begins to feel confident in terms of transferring learning from training into practice. (Horwath, 2001, p 26)

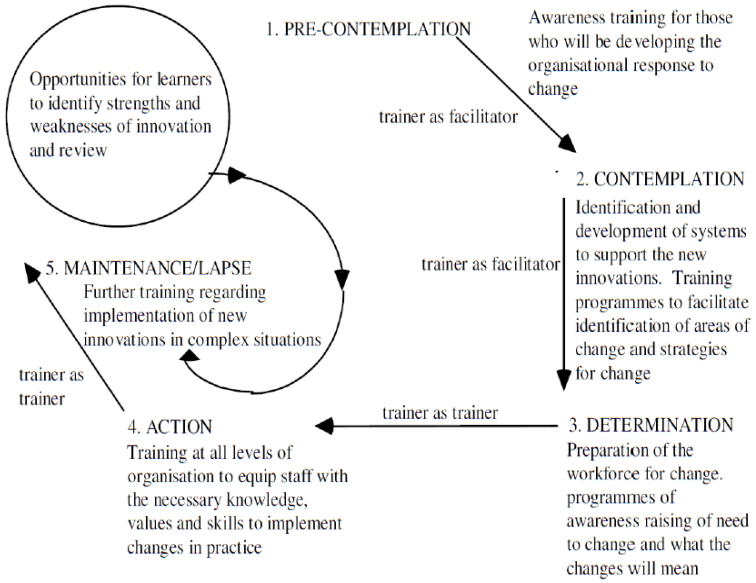

Figure 2. A training strategy based on a model of change.

FIGURE 4B Horwath's (2001) adaption of Protchaska and di Clementi's (1982) model of change to organise practitioners training (from Horwath, 2001, p 22, fig 2)

Failure of learning transfer in complex situations is described as "a tendency to lapse to tried-and-tested assessment methods" because operational-level professionals do not feel sufficiently supported to risk using the new assessment tool. Horwath (2001) suggests that the necessary condition for successful transfer of learning from training to complex, face-to-face interactions with children and families is "further learning opportunities" so that professionals can

> reflect on their experiences, consolidate and sustain learning and acquire new knowledge and skills to manage more complex assessment situations. (Horwath, 2001, p 32)

Learning, articulated here as 'training', is restricted either to a monologic model of knowledge and skill acquisition or a dialogic, highly situated model, either in training or

occasioning lapses in complex assessment situations. In neither case is the issue of 'learning lapse' or failure to transfer learning resolved by monologic or dialogic models of learning transfer. In her collaboration with Charles, Howarth recently expressed doubt regarding the ability of training to foster learning (Charles and Howarth, 2009). One difficulty identified is that is that investment in training takes place despite little evidence of its contribution to learning transfer:

> Developing clearly articulated, measurable outcomes that isolate the impact of training from other factors contributing to better outcomes for children is difficult. (Charles and Horwath, 2009, p 365)

Horwath's (2001) identification of the 'missing assessment domain' – that is, the situated conditions of learning at the level of the individual operator that are concurrent with the conditions of effective assessment of children's needs embedded within wider human and non-human environments – points to a number of levels of situated learning. In order for practitioners to learn of children's and families' holistic needs through an assessment procedure and loosen the grip on previously acquired risk assessment tools and priorities, the practitioner must learn how to incorporate the new framework into already-existing working practices, while the professional situation must also learn how to support each practitioner to do this to a collectively consistent standard, both within and across established inter-professional collaborations. It may be that expecting training events to adequately prepare professionals to transfer monologic learning to complex situations is overly ambitious, since the scale of the task facing the practitioners in Horwath's (2001) study requires orientation to all three models of learning simultaneously:

1. *acquisition of new knowledge* of professional assessment tools (monologic);
2. *development of a new community* of holistic needs assessment practice, including children, families and professionals within organisations (dialogic);
3. *production of knowledge* ('assessments') regarding individual children and individualised intervention within existing collaborative resources available in their working environment (trialogic).

'Any learning model', as proposed by the statutory guidance (HM Government, 2013) may likewise require attention to the principles of learning and learning transfer in three models simultaneously, which may inevitably contain within it important tensions and contradictions.

INTEGRATED TEAM-LEVEL LEARNING

Anning et al's (2010) Multi-Agency Teamwork for Children's Services (MATCh) project focuses on the constitution of intra- and inter-agency working in children's services. Starting with Øvreitveit's (1993) study of multi-disciplinary teams working in adult mental health, they propose at least five possible organisational team types: the fully managed team; the co-ordinated team; the core and extended team; the joint accountability team; and the network association (see Anning et al, 2010, pp 27-29).

Furthermore, they build upon Frost's (2005) four levels of partnership: cooperation, collaboration, coordination and merger/integration, where the continuum moves from working together while maintaining service independence (Level One) to a point where independent services become a single organisation in order to enhance service delivery (Level Four) (Anning et al, 2010, p 8). Their empirical work examines how diverse team type and degrees of partnership embody concrete examples of child welfare teams in the UK. Anning et al (2010) claim that each team studied is characterised by a particular dominant model of child welfare practice (see Figure 4C) based on each teams' understanding of childhood issues. For example, the child development and head injury teams studied each drew upon medical constructs to articulate the purpose of their engagement with children and families, whereas a nursery team articulated the character of their work in relation to children's individual needs. Anning et al (2010) develop this observation to include the complementary outcome model operating within each team. In order to meet children's individual needs, the nursery team, for example, approaches assessment of individual children's needs from a holistic approach.

TEAM	**DOMINANT MODEL**	**COMPLEMENTARY MODEL**

Young people's team	Family/systemic	Social deprivation
Child development team	Medical	Social/psychological support
Youth offending team	Social structural	Individual impact
Nursery team	Individual needs	Holistic approach
Head injury team	Medical	Social/psychological support

FIGURE 4C MATCh project's presentation of individual multi-agency teams' explanatory models (from Anning et al, 2010, p 52, table 4.1)

Child welfare teams, presented from this perspective, comprise at least three dimensions: team type, degree of inter- and intra-organisation co-ordination with children and families, and dominant/complementary explanatory model. Furthermore, Anning et al (2010) claim that the different 'explanations' available to different teams "can exist in the same team at different times and with a differing emphasis" (2010, p 59). The MATCh project's research highlights the challenge not only of co-ordinating intra- and inter-agency work; rather, it also highlights possible difficulties regarding individual learning within teams (adopting dominant explanatory models) and learning transfer across teams, since situated knowledge is evaluated by the dimensions of team type, partnership level and explanatory model, which may not transfer to alternative team types, levels of partnership with children and families, and dominant models of explanation of childhood issues.

Anning et al's (2010) work highlights the diverse possible routes of learning transfer. The MATCh project's presentation of dimensions of team activity explain how knowledge is created and evaluated within situated practice. It suggests that learning from historical practice, such as SCRs, will need to be understood, integrated and re-interpreted within diverse team types, at varying levels of inter-agency and intra-agency partnership with children and families and with different explanatory models of practice that articulate the purpose of working with a range of children simultaneously. Anning et al (2010) suggest that, in order for each team type to achieve improved outcomes for individual children served by multi-agency teams operating on a continuum of inter- and intra-

agency partnership, services will depend on “flexible and responsive modes of explanation” (2010, p 59).

Therefore, ‘any learning model’, as suggested by current statutory guidance (HM Government, 2013’), and its goal of promoting good practice and *learning from* historical welfare disasters, may need to recognise that the situated constitution of coherent team knowledge and purpose poses important issues regarding learning transfer and challenges the guidance’s focus on individuals and organisations only. Chapter Three indicated that a number of scholars (such as Beach, 1999, Bereiter, 1997 and 2014, Greeno, 2006a and 2006b, van Oers, 1998, and Hatano and Greeno, 1999) have suggested concepts and models that enable learning to exceed its embeddedness, such as knowledge building, productive knowledge, continuous progressive recontextualisation, consequential transitions and principled practical knowledge.

STRATEGY-LEVEL LEARNING

Morrison’s (2000, 2010) studies of learning focus more directly on situations of complex child welfare assessment practice rather than on training events. Morrison’s (2000) original study of strategy-level learning was produced in light of rapid changes to evidence-based practice guidance, such as the publication of revised statutory guidance for safeguarding children (the 1999 edition of *Working Together to Safeguard Children*) in addition to *Child Protection and Child Abuse: Messages from research* (DoH, 1995), the *Framework for the Assessment of Children in Need and their Families* (DoH, DfEE and HO, 2000), *Quality Protects* (DoH, 1998) and the then government’s ‘social inclusion’ agenda. He analyses learning at the level of ‘strategic leadership’, concerning the intra- and inter-organisational co-ordination of child protection practice and argues that analysing strategy-level learning is important because it is always

> situated within competing forces of continuity (staying the same) versus change, which is reflected in a dynamic interaction between power relations, communication and emotion. (Morrison, 2010, p 321)

Given shifts on a national scale, how might organisations develop a strategy that supports the consistency of effective practice across diverse team and partnership types and with vulnerable children so that these children experience beneficial outcomes? Morrison's (2010) concern is to support strategy-level organisations such as LSCBs "to develop more collective forms of knowing" (2010, p 313) so that strategy would not lose sight of frontline practice amidst such significant changes, and could learn from practice and improve strategy as a result. Morrison (2000) identifies the risk that, in strategy's haste to co-ordinate adequate multi-disciplinary and inter-agency intervention responses to the new policy framework, many important contingent factors supporting beneficial children's outcomes (such as protection from serious harm) would be overlooked.

> Simply stated, the argument is that effective inter-agency processes are highly dependent on the quality of collaboration *within* agencies and disciplines, and that together it is these processes that impact on the effectiveness of partnership with service users (Morrison, 2000, p 368, emphasis in original)

This points to the issue of learning transfer, from changes within and between teams to changes in the effectiveness of situated assessment practice with children and families, something described in Morrison's work as 'impact'. By adapting Howe's (1992) 'matrix of partnership', Morrison (2000) highlights that decisions taken at the strategy level could produce at least four types of partnership with service users at the frontline. Framing these partnerships along the dimensions of 'voluntary or involuntary engagement with process' and 'degree of participation', Morrison (2000, p 369, fig 2) proposes that partnership with children and families could be characterised either as paternalistic, adversarial, play fair or therapeutic, and it is only the therapeutic model of partnership between children, families and professionals that can be considered effective. This is so, since it comprises not only co-ordination of the goals of intra-agency working and inter-agency working, but sees co-ordination of resources with children and families as a partnership that is characterised by "working/learning together" (Morrison, 2000, p 369, fig 2):

> It is only through engagement at this level that many of the deeper level inter- and intra-personal changes in families can be made which are essential in the

> recovery from abusive experiences and the reduction of future risk. (Morrison, 2000, p 371)

Morrison (2000) is indicating that effective learning at the strategy level of children's welfare services 'impacts on' (that is, transfers to) the private lives of vulnerable families as prevention of maltreatment. Whether or not this is the effective partnership that strategy-level learning constructs depends its ability to learn from practice outcomes. Morrison (2010) distinguishes four learning responses available to strategic organisations, such as LSCBs, following child welfare outcomes (Figure 4D), defined by two continuums, one from "engaged, reflective and practice-orientated learning" to learning which focuses on "the avoidance of 'risk', through the auditing and control of compliance", and the other from system-level learning to individual-level learning (Morrison, 2010, pp 316-17).

In the lower half of Figure 4D, Morrison (2010) argues that strategic responses can become preoccupied with procedural compliance and a dynamic of blame. When strategy responds to child welfare outcomes in this manner, the "'learning of lessons' [such as from case reviews] becomes procedural and training is reduced to information briefings" (Morrison, 2010, p 318). In the upper half, when strategy responds to child welfare outcomes by reflective-engaged learning, "There is a coherent relationship between professional knowledge, values and procedural rules" (Morrison, 2010, p 319).

At the individual level, Morrison (2010) argues that reflective-engaged learning is characterised by authoritative reflective practice and at the system level by collective reflection and change (see Morrison, 2010, p 319, fig 3). One outcome of such individual and system-level learning is the therapeutic model of partnership that Morrison (2000) indicated earlier provided the conditions for learning to impact on inter-family dynamics and see children enjoy beneficial outcomes. Figure 4D, though, fails to address how 'authoritative, reflective practitioners', contributing to collective reflection and systems change, work and learn together with vulnerable children and families. To borrow Horwath's (2007) phrase, Morrison's (2010) model of strategy-level learning has a 'missing assessment' domain of its own. It does not account for absence of working and learning together in a therapeutic partnership with children and families, since it does

not include this collaboration within either the individual- or system-level learning of the child welfare strategy. This model explains learning within strategy but fails to offer an explanation regarding the relationship between reflective-engaged strategy learning and the therapeutic relationship in which child welfare professionals work and learn together with children and their families.

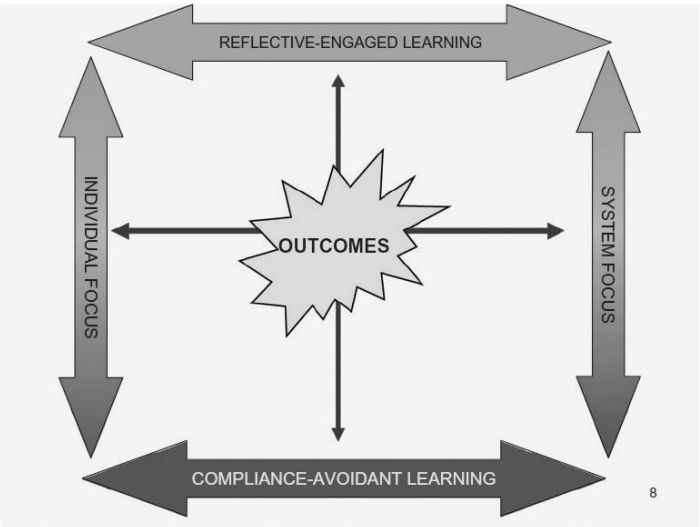

Figure 1. The learning response. This figure is available in colour online at www.interscience.wiley.com/journal/car

FIGURE 4D Four quadrants of possible learning responses by strategic bodies in child welfare practice (from Morrison, 2010, p 317, fig 1)

SYSTEM-LEVEL LEARNING

Munro's recent review of the child protection system (Munro, 2010, 2011, 2012) chose to focus attention on what Munro (2010) calls the 'frontline', the situated interaction between practitioners and children and families and of partnership co-ordination. Munro (2010) argues that it is there where policies, current and new, recommendations, and the diverse elements that constitute the different forms of partnership (Morrison, 2000, 2010 and Frost, 2005) converge and which are currently "creating an imbalance and distortion of practice priorities" (Munro, 2010, p 5). By highlighting the frontline as a place where practice activity embodies both past and present emphases and where confusion reigns, Munro (2010) echoes Massey's (2005) research focus on 'place':

> What is special about place is precisely that throwntogetherness, the unavoidable challenge of negotiating a here-and-now (itself drawing on a geography of thens and theres); and a negotiation which must take place within and between both human and nonhuman. (Massey, 2005, p 140)

Massey's description of place suggests that the so-called frontline of child welfare practice is a site of active negotiation between people, places and simultaneous orientation to different orders of time. It may the place where *learning from* can be drawn upon to articulate future action.

Earlier, Horwath (2001, 2007) described current assessment practices that expect professional assessment of children's needs to articulate children's needs holistically in order to co-ordinate effective professional partnership and had identified that individual endorsement of such change depended in part on practitioners' working organisational context. Munro (2010, p 6) recognises that, "For some [practitioners], following rules and being compliant can appear less risky than carrying the personal responsibility for exercising judgment [in assessment practice]". One possible explanation for such compliance, Munro (2011) suggests, is the standardisation of services in contrast to the uniqueness and individualisation of assessed children's needs:

> Services have become so standardized that they do not provide the required range of responses to the variety of need that is presented. […] Child protection work involves working with uncertainty: we cannot know for sure what is going on in families (Munro, 2011, p 6)

Morrison (2000), above, offered a number of possible models of partnership with children and families. A characteristic of the 'therapeutic model' was that services, professionals, families and children 'learn and work together'. However, as the review demonstrated, Morrison's (2010) model of reflective-engaged learning at the system and individual level did not articulate how such learning could transfer effectively from 'authoritative reflective practitioners' to children experiencing changes in the quality of their treatment in their private lives. Munro (2010) sketches out the difficulty that this poses for any definitive learning model that is evaluated on the basis of its contribution

to preventative professional action. Learning and working in therapeutic partnerships at the frontline must still transfer beyond the frontline to children's private lives:

> Identifying cases of abuse and neglect is an uncertain process since much of the worrying behavior (both actions and omissions) goes on in the privacy of the home. (Munro, 2010, p 20, para 1.41)

Munro's 'frontline', then, may be the site of negotiation for practitioners, children and families, policy agenda, assessment tools, partnerships and co-ordination amongst professional teams and services and learning from, all 'throwntogether' in a place, to use Massey's (2005) phrase, in order to prevent children suffering maltreatment in another 'throwntogether' place – the privacy of children's lives and homes.

Munro (2010) proposed a holistic rather than 'atomistic' approach to child protection, which is characterised by "long chains of causality, ripple effects, unintended consequences [and] feedback effects" (Munro, 2010, p 13, table 13). This introduction of 'feedback' into the frontline of child welfare practice is intended to serve as a device that enables professionals to overcome the challenge of situated, emplaced practice, and enable learning either to transfer or be recontextualised in children's private lives.

> Feedback arises when a system is monitored to check whether it is behaving as required and corrective action is used as necessary. (Munro, 2010, p 14, para 1.14)

Feedback helps practitioners perceive whether or not the child's situation is better served by practitioners "following rules and being compliant" or "carrying the personal responsibility for exercising judgment" (Munro, 2010, p 6). One use of feedback is 'single-loop learning' (Figure 4E), which helps systems learn whether or not practitioners are doing what they are specified to do:

> With single loop learning, targets are set for the child protection system and its performance is monitored to check (='learn') whether the performance matches the targets. If not, then action is taken to change what is going on in the system and put things right i.e. to hit the target. In feedback terms there is a balancing loop – B1 in the diagram – which acts to steer the performance measures closer and closer to the specific target. (Munro, 2010, p 14, para 1.17)

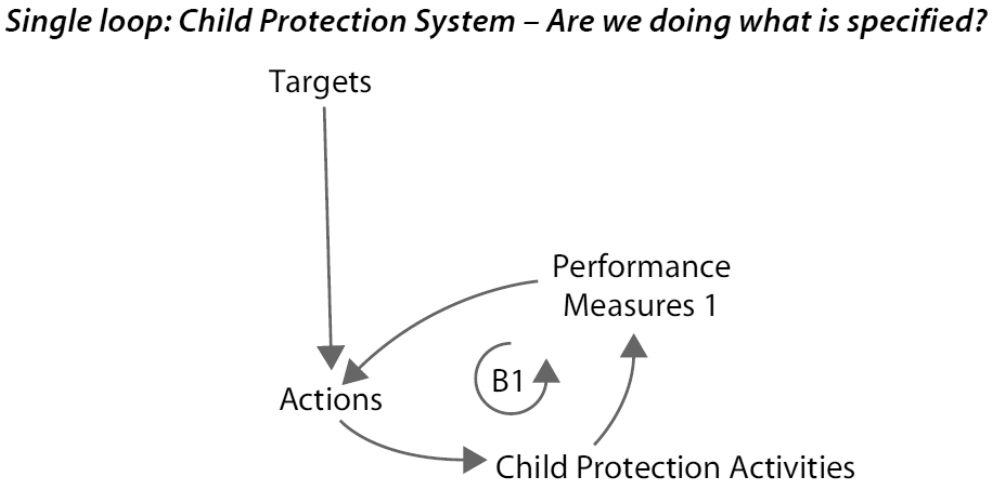

FIGURE 4E Use of feedback in single-loop learning to reach predetermined service targets (from Munro, 2010, p 15, para 1.17)

At the frontline, children experience this learning as partnership with practitioners and services that prefer to develop a recognisably standardised interaction, one characterised by a system that is preoccupied with finding answers to questions such as "has the set form on this case been completed and has this been done within the set deadline?" (Munro, 2010, p 14, para 1.16), rather than whether or not initial plans for appropriate pathways are enabling children to experience beneficial outcomes such as prevention of significant harm. Such questions may preoccupy practitioners concerned with developing a uniquely holistic, individually negotiated 'therapeutic relationship' (after Morrison, 2000) with children, which Morrison (2000) characterised as one in which children, families, practitioners and services learn and work together.

Such a relationship is indeed possible, Munro (2010) argues, when negotiation with feedback serves children's needs rather than the system's needs. Munro calls this alternative negotiation with feedback 'double-loop learning' (see Figure 4F), which helps systems learn whether or not the system has specified the right targets:

> With double loop learning a second loop uses the value of the performance measure to reflect on whether the correct target for the child protection system has been set. This new balancing loop – B2 – allows the target itself to be

changed, or updated as the system 'learns' more about what a sensible target might be. (Munro, 2010, p 15, para 1.19)

Munro (2010) argues that double-loop learning supports personal responsibility for exercising professional judgement and challenging targets that no longer seem reasonable in light of learning at the frontline.

Double loop: Reflective Child Protection System – have we specified the right thing to do?

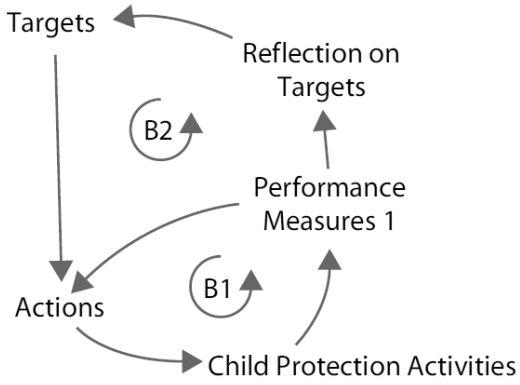

FIGURE 4F Use of feedback in double-loop learning to reach individualised targets for children in child protection system (from Munro, 2010, p 15, para 1.17)

Munro (2010, p 14, para 1.15) summarises the distinction between each learning model as follows: single-loop learning is "concern with doing things right" whereas double-loop learning is "concern for doing the right thing". Put another way, single-loop learning enables the child protection system to protect itself; on the other, through double-loop learning, the child protection system becomes capable of protecting children through balancing recognised professional actions with ongoing feedback from interactive work in uncertain situations.

Munro (2011) described the rejection of single-loop learning in favour of double-loop learning as a move from a compliance culture to a 'learning culture', in which social care professionals could enjoy "more freedom to use their expertise in assessing need and providing the right help" (Munro, 2011, pp 6-7). The organisational aspect of this culture is a consequence of feedback travelling from the frontline to the most senior managers

(Munro, 2011, p 62, para 4.31) in order that the organisation itself becomes capable of "making adjustments to facilitate its practice effectiveness with families and improve outcomes for children" (Munro, 2011, p 108).

More interesting would be to understand how learning at the frontline transfers, not only 'back' to the professional organisation's hierarchy but instead to each assessed child's lived experience. In this sense, while Greeno's (2006b) situative concept of 'authoritative, accountable positioning' is one explanation of people's ability to transfer knowing and knowledge from one situated activity to another, no empirical research has been conducted to help us understand how children might transfer the authority and accountability they share at the 'frontline' to that private, lived life beyond the frontline.

Previous to undertaking her review of the child protection system, Munro had contributed to the Social Care Institute of Excellence's (SCIE) development of a 'learning together' approach to SCRs (see, for example, Fish, 2009, especially p 6, table 2). In the final report of her review of the child protection system, Munro (2011) highlighted that the goal of this particular approach is "to move beyond the specifics of the particular case – what happened and why – to identify the 'deeper', underlying issues that are influencing practice more generally" (Munro, 2011, p 64, para 4.39). Importantly, the SCIE model would appear at first sight to include the possibility that children's, families' and practitioners' mutually emplaced, situated learning at the frontline enjoys its own unique underlying issues. However, Munro (2011) then clarifies that "the focus of a case review using a systems approach is on multi-agency professional practice, not the particular child(ren) and family" (Munro, 2011, p 64, para 4.39). Consequently, this model omits the contribution children and their families (and of course all of the environmental factors constituting their private lives and interactions with services) to studies of professional learning at the frontline. It also undermines efforts to formulate a learning model that can envisage learning being transferred either from the frontline to children's private lives, or from children's private lives to the frontline (and beyond to senior managers, and so on).

This chapter has identified that the statutory guidance's focus on "individuals and organisations" (HM Government, p 7, para 6) insufficiently addresses the possible levels at which professional learning takes place in child welfare systems. In addition to Horwath's (2001, 2007) focus on operation-level individual professionals, this chapter has noted team-level learning (Anning et al, 2010), strategy-level learning (Morrison, 2000, 2010) and learning at the level of the child protection system (Munro, 2010, 2011, 2012). The place (almost literally) of children in learning remains an inconsistent feature of the studies. Part Two examines another dimension of learning by focusing on constructs that mediate between individuals and organisations. The constructs examined are organisational climate and archives and learning digests.

ORGANISATIONAL CLIMATE

Glisson and Hemmelgarn's (1998) study of multi-agency, inter-disciplinary team working on behalf of children in state custody in the state of Alabama argues that successful child welfare practice is achieving beneficial outcomes for children's welfare. In order to achieve such success, children and families must experience practitioners as

> both available and responsive [and professional interactions with children and families] must be predictable, appropriate, and welcomed over an extended period of time. (Glisson and Hemmelgarn, 1998, p 404)

Furthermore, since effective professional partnership with children and their families individualises services to the unique holistic needs of children, "decisions that are in the best interests of a particular child may not fit predetermined criteria for service system quality" (Glisson and Hemmelgarn, 1998, p 416). In other words, achieving positive outcomes for vulnerable children may evidence the 'place' or situatedness of children and practitioners 'learning and working together' (following Morrison, 2010) rather than the bounded domains of practice governed by professional and organisational rules, routines and standard procedures.

Glisson and Hemmelgarn's study (1998) concludes that

> improvements in [children's] psychosocial functioning are significantly greater for children serviced by offices with more positive climates [where] positive climates reflect work environments that complement and encourage the type of service provider activities that lead to success. (Glisson and Hemmelgarn, 1998, p 416)

An office's climate refers here to organisational climate, which exists when perceptions of the psychologic climate of working environments "are shared among workers within a particular work unit" (Hemmelgarn et al, 2006, p 78). Psychologic climate is a concept that refers to individual employee's perception of the detrimental or beneficial impact of the work environment on his or her own psychologic well-being. It was measured in Glisson and Hemmelgarn's (1998) study using a Psychological Climate Questionnaire, which incorpated scales "measuring fairness, role clarity, role overload, role conflict, cooperation, growth and advancement, job satisfaction, emotional exhaustion, personal accomplishment, and depersonalization" (Glisson and Hemmelgarn, 1998, p 411). Where individual team members agree on the impact of such models on their own wellbeing, for example, "their shared perceptions can be aggregated to describe organizational climate" (Hemmelgarn et al, 2006, p 77).

Glisson and Hemmelgarn's (1998) finding moves us beyond the statutory guidance's concern with individuals and organisations, and strongly suggests that a critical and effective site of learning is a statistically aggregated perception amongst workers sharing the same working space. This aggregated perception, they argue, is the critical factor that supports practitioners to be

> responsive to unexpected problems and individualized needs, tenacious in navigating the complex bureaucratic maze of state and federal regulations, and able to form personal relationships that win the trust and confidence of a variety of children and families. (Glisson and Hemmelgarn, 1998, p 404)

The child welfare literature includes a number of references to organizational culture. For example, the following is a 'headline message' from a seminar on learning in child protection (CLiCP, 2009):

> A focus on changing and creating a more positive work place culture may be important in preventing child deaths. […] Staff working in a supportive, dynamic environment, may be best placed to be able to pool collective knowledge and use it to best protect children. (CLiCP, 2009, p 3)

Brandon et al (2010) identify the contribution of "sustained and dogged *professional challenge* – the ability to question, with confidence and authority, professional colleagues both within one's own agency and in other sectors" to securing positive child welfare outcomes (Brandon et al, 2010, p 54). Supervision (for example, Barlow with Scott, 2010; Gordon and Hendry, 2010) is also regularly cited as having the potential to make a substantial contribution towards children subsequently enjoying positive welfare outcomes.

In order to arrive at their conclusion, Glisson and Hemmelgarn (1998) piloted a quasi-experimental, longitudinal design in order to study 600 children entering state custody in 24 counties which were served by 32 public children's services. The children entered custody following court proceedings that were concerned with issues of neglect, abuse, status offences, or delinquent behaviour. The study's analysis was based upon a cohort of 250 children who remained in state custody for one year and whose psychosocial functioning was assessed as having improved in those 12 months. Data to support this claim for improvements

> were obtained from parents, parent surrogates, and teachers to describe the children's psychosocial functioning when they entered custody and 1 year after entering custody [and] from caseworkers and case files. (Glisson and Hemmelgarn, 1998, p 408)

Data were not obtained from the children themselves. No indication is given of the possible transfer of success from organisational climate to everyday lived experience of children exiting state custody. Consequently, the study's claims raise new issues that concern the contribution of learning to the achievement of positive outcomes for children. For example, Glisson and Hemmelgarn (1998) do not say whether or not any of the offices studied were also responsible for the casework that initially failed to prevent the children entering state custody and court proceedings (unless the claim would be

that securing custody for these children was a positive result secured by the same organisational climate that promoted improvements in the children's psychosocial wellbeing while in custody). Similarly, the study does not evaluate the same children's psychosocial wellbeing on their return to their private homes, where that was the case.

What is at issue here is the situatedness of improvements in children's wellbeing. Glisson and Hemmelgarn's (1998) study concerns children's psychosocial wellbeing and claims that a statistical aggregate of practitioners perceptions of particular office's respective climates, and neither professional service quality nor service co-ordination, explains the critical improvement in children's psychosocial wellbeing while they remained in state custody. Children's own perceptions of the partnership do not appear to be included for aggregation, nor are the children's home environments, the original material and inter-relationship conditions of abuse and neglect, considered as potential sites of situated learning. In other words, the study's finding that "improvements in [children's] psychosocial functioning are significantly greater for children serviced by offices with more positive climates" (Glisson and Hemmelgarn, 1998, p 415) does not address the possible difficulty that the outcome of the activities shared by children in state custody, their families and professionals working in the successful offices relies on situated, local knowledge. The ability to make claims that these same activities can lay claim to being able to prevent children suffering harm on their return to their homes or to recover from traumatic experiences in those places relies on assumption rather than relies on the articulation of learning transfer.

DECONTEXTUALISED ARCHIVES AND DIGESTS

In her review of the child protection system, Munro (2011) identifies that the goal of the SCIE model of serious case reviewing is "to identify the 'deeper', underlying issues that are influencing practice more generally", which she claims are "generic patterns" and which could "count as 'findings' or 'lessons' from a case" (Munro, p 64, para 4.39). Munro argues that by changing these generic patterns, we might anticipate wide-ranging practice improvement (see Munro, 2011, p 64, para 4.39). This suggests a model that assumes a particularly situated activity which is not located in a singular place, but

instead is practiced *widely*. The argument runs that learning to identify instances of its pattern types and effecting change in those instances can then account for the transfer of learning across people, places, time and place. A crucial pivot in this model's construct of learning and learning transfer appears to be a generalizable typology, decontextualized from individual, particularly situated events of child welfare work, characterised by the kind of individualised 'therapeutic partnership' advised by Morrison (2000). Indeed, Munro argues that

> Such learning will provide the basis for developing a common typology of factors influencing practice in helpful or unhelpful ways, to support national learning of trends and themes. (Munro, 2011, pp 63-64, para 4.32)

This typology reduces individual children's needs, as identified in professional assessment and ongoing feedback from the frontline, to typologies of practice trends and themes. Individual children's contribution to learning and learning from historical reviews of practice in order to inform future-oriented preventative practice is forgotten.

Munro is not alone is promoting the idea of a decontextualized body of 'lessons learned' from SCRs. In his review of the so-called Edlington Case (Doncaster, SCB, 2010), Carlile (2012) recommends that SCR findings "should form part of a gathering body of knowledge and guidance for practitioners and, where they become necessary, for other SCRs" (p 25, para 79).

Carlile (2012) compares such learning from serious cases of child maltreatment to the precedent of Court decisions with respect to retail labelling of goods. Apparently, these "have changed the practice of retailers" since "cases affecting retailers are reported formally and contained in digests of cases" (Carlile, p 25, para 79). Carlile (2012) uses this analogy to express his concern that "there is no efficient digesting, let alone digestion, of SCRs" (2012, p 25, para 79). Consequently, the ninth recommendation in Carlile's review (2012) reads:

> I recommend that under the guidance of the relevant Minister there should be established a Digest of open versions of SCRs. This is likely to lead to […] significantly increased capacity for lessons from one SCR to be learned and

> applied by the material statutory services in other locations. (Carlile, 2012, p 60, recommendation 9)

Carlile has faith that such a digest of historical cases would produce a practice scenario in which "examples of good practice in one area would be more likely to be replicated elsewhere" (Carlile, 2012, p 25, para 80). Carlile (2012) does not explain how, or where, or when, or why this might occur in practice. His recommendation neglects both to problematize learning itself and to offer an articulation of the *learning from*.

The statutory guidance for safeguarding and promoting the wellbeing of children (HM Government, 2013) promotes the idea of a decontextualized body of 'findings' that serves as a latent resource for learning transfer:

> SCRs and other case reviews should be conducted in a way which […] makes use of relevant research and *case evidence* to inform the findings. (HM Government, 2013, p 67, para 10, emphasis added)

More recently still, the national panel of independent experts on SCRs (DfE, 2014) recommended that

> DfE should take responsibility for considering how a repository of past reports could become a more active resource for learning, and what role it might play in ensuring the existence of such a centralised resource. (DfE, 2014, p 9, para 29)

This recommendation assumes that a body (or repository) of knowledge can be decontextualized and separated from practice to become an 'active learning resource', presumably when drawn upon by practitioners working with children and families to prevent significant harm. The panel does not indicate how, why or when professionals would access such a 'centralised resource' and how its content can be searched so that professionals could select appropriate lessons to their current work. It may be that its purpose is simply to serve as a warning to professionals to avoid succumbing to 'start again syndrome', in which "knowledge of the past is put aside with a focus on the present and on short term thinking" (Brandon et al, 2010, p 54; see also Brandon et al, 2008, ch 5)

Thus far, the argument in favour of decontextualized trends, typologies, lessons and conclusions appears to have erased the contribution of children to knowing in situated activity and the contribution of learning and learning transfer as an explanatory model for learning from SCRs.

Bowker's (n.d.) research includes a focus on the contribution of such 'digests' and typologies to knowing. In short, he asks: "What gets stocked in our memory as a society? [W]hat is in our Archive?" (Bowker, n.d., p 4). Bowker (n.d.) argues that digests' claims to hold 'universal' knowledge cannot hold. Following the work of Bruno Latour and Harry Collins, for example, such 'universal' knowledge is in fact restricted to highly localized space and time, that of a laboratory:

> When a science test starts with the phrase: "All things being equal …", asking then how fast a falling body will take to light, it points in the direction of all the work that is done in making other things equal – excluding vibrations, foreign products invisible to the naked eye, weather conditions so that in this very small, highly localized place, the laboratory, universal knowledge can be produced. (Bowker, n.d., p 2)

Bowker (n.d.) concludes that, to fall for the temptation of archiving universal accumulated knowledge that can be applied universally, knowledge "in order to be made storable, […] would have to lose its setting" (Bowker, n.d., p 10). Furthermore, decisions regarding what knowledge gets stored and what knowledge gets forgotten are rarely taken by those embedded within the original situations (see Bowker, n.d., p 5). Where SCRs are directly concerned with understanding of the interaction between vulnerable children and professional child welfare practitioners and services, Bowker's argument suggests that the situated knowing of professional assessment of children's needs and children's engagement with protective services is not as important as the situated knowing of the creators of any digest of SCR lessons and conclusions. Children's knowing and learning is disposable. Drawing on an analogy of scientific interest in recording the use of plants' medicinal properties within indigenous cultures, Bowker (n.d.) argues that such archiving implies that "current generations of plants and people can happily die without leaving any other trace, knowing that they are safely stored away in our databases" (Bowker, n.d., p 6).

Decontextualisation of learning as the crucial pivot to enable learning from SCRs to produce preventative professional action at the frontline of interaction with children and families is less an interest in learning and instead a demonstration of power and priorities. Bowker (n.d.) cites Derrida's (1996) work on 'arkhe' to suggest that

> [Arkhe] apparently coordinates two principles in one: the principle according to nature or history, there where things commence […] but also the principle according to the law, there where men and gods command, there where authority, social order are exercised, in this place from which order is given. (Derrida, 1996, p 1)

Derrida's (1996) articulation of 'arkhe' indicates that archives not only have a sequential character, but also a jussive character. A digest or typology offers the illusion that it represents an "inaugural act" (Bowker, n.d., p 6); but since it represents an artificial commencement of memory, the archive stands for "what can and cannot be remembered" (Bowker, n.d., p 8).

> The archive, by remembering all and only a certain set of facts/discoveries/observations consistently and actively engages in the forgetting of other sets. This exclusionary principle is […] the source of the archive's jussive power. (Bowker, n.d., p 8)

Assuming that children and their families are constituent elements of situative learning (Greeno, 2006a), alongside assessment tools, organisational strategy and the diverse explanatory models of multi-disciplinary teams, it would seem a grave threat to any learning model to draw upon SCRs as a source of archive material which is intended – *expected* – to provide practitioners with situationally invariate, universal knowledge, ready-made for application where relevant. Such an archive would fail to admit Pink's (2011) and Fors et al's (2013) concept of multisensory emplaced learning, or at least would forget the possibility that such learning existed. It would fail to learn from the ongoing, mutual and emplaced learning of Morrison's (2000) therapeutic relationships. Even learning from the live, ongoing feedback so crucial to Munro's (2010) concept of reflective and adaptive double-loop learning would be omitted from the digest of pattern types. Van Oers's (1998) argument is that no such digest can ever exist, since knowledge depends on context for its meaning. A decontextualized archive of universal

lessons is meaningless. Rather than *learning from* SCRs, it would seem that to endorse typologies and digests as characteristics of an effective learning model would in fact significantly undermine the model's capacity to support learning.

SUMMARY

This chapter has examined a number of current models of learning in child welfare services in order to understand better the purpose and adequacy of models in improving practice. These models addressed learning at a number of service levels, from operation-level training, through the explanatory models of multi-disciplinary teams, the strategic leadership of practice in light of practice outcomes, and the child protection system as a whole. Each of these models acknowledged the complexity of learning when children's and families' needs were to be addressed. Horwath's (2001, 2007) model of change anticipated the provision of further training when individual professionals put learning into practice in 'complex situations'. Anning et al's (2010) study suggested multi-disciplinary child welfare teams do not always share the same explanatory model when articulating their understanding of childhood issues through their practice. Morrison's (2000, 2010) concern was that strategic bodies learn reflectively from practice outcomes. Munro's (2010) proposal of double-loop learning was intended to ensure that the child protection system reflected and adapted in light of feedback from frontline practice with children and families. Each of these models engaged with the transfer of learning from inter- and intra-organisational work to the frontline. None succeeded in adequately articulating how learning at any of these levels of child welfare practice could then transfer from this frontline of professional interaction with children and families to children's and families' private lives and be interpreted there for the purpose of preventing the conditions of serious maltreatment.

The chapter's second part examined two concepts that mediate between individuals and collective organisation knowing, organisational climate and archives. In the first example (Glisson and Hemmelgarn, 1998), it was noted that while the study claimed that children's positive outcomes following episodes of neglect and abuse could best be explained by the organisational climate of the professional child welfare offices that

worked with those children, the study did not account for children's experiences once they had exited state custody. It is not possible to say that the children served by offices with positive office climates while in custody continued to enjoy positive outcomes rather than neglect and abuse on either returning home or being accommodated elsewhere. In other words, however the offices studied by Glisson and Hemmelgarn (1998) learned to achieve such positive outcomes, the study does not account for its transfer to domains other than state custody.

The proposal to establish a general archive of SCR learning is well supported (Carlile, 2012; HM Government, 2013; DfE, 2014). Nevertheless, the necessary decontextualizing of knowledge and learning in order to archive SCR learning commandeers the decision about what is worth learning and recording away from diverse forms of frontline practice to centralised organisation. From the perspective of situated evaluation of learning, an archive would include only meaningless knowledge for learning.

Consequently, the formulation of 'any learning model' is likely to need to account for the character and situatedness of learning and the authority of what counts as worth learning within the model. It may also need to articulate its engagement with children's lived experiences beyond professional intervention, perhaps in the terms of learning transfer or the alternative concepts proposed by Beach (1999) and Van Oers (1998), for example.

Importantly, what this chapter has contributed to the aims of this thesis, in relation to the Toulmin (2003 [1958]) model presented in Figure 1A (see page 14), is that the statutory guidance (HM Government, 2013) mistakes individuals and organisations as the sites of learning. Rather, operational assessment practice, diverse team identity within child welfare work, board-level strategy and national-level systems are also valid and significant foci. This presents a challenge to the qualifier on the claim that 'any learning model' can help individuals and organisations (only) learn lessons from SCRs so that children are prevented from suffering serious maltreatment. The model that is being sought may need also be applied to the other dimensions of work undertaken by individuals and organisations examined in this chapter.

The primary contribution of this chapter to the aim of this thesis is to highlight the absence of children and their families from the development of any such model. Not only must strategy and systems, for example, be seen as valid dimensions of learning activity in SCRs, but also must children, their carers and their private lives be considered as crucial and dynamic dimensions for learning. The diverse characteristics of individual children, their environments and relationships, motivations and past experiences are obliterated in efforts to establish 'deeper lessons' of SCRs that might comprise a decontextualized, timeless archive of SCR lessons. This chapter indicates that 'any learning model' can only hope to be effective in its pursuit of its goal when it actively accommodates the individuality of children and their caring organisations (such as family), as well as the consequent unique interactions with child welfare practitioners, assessment operations, strategies and systems. It would err in the construction of a timeless archive that ignores their contributions to the conditions of learning.

CHAPTER FIVE

THEORETICAL POSITION AND METHODOLOGY

INTRODUCTION

One characteristic feature of serious case reviews (SCRs) is the fact that they anticipate orienting professionals to multiple orders of time simultaneously. In published form, they are retrospective analyses of historical events of significant or fatal child maltreatment. Their usage is intended to enable professionals to make adjustments to current professional practice when working with child welfare cases to prevent the children in those cases suffering significant harm. In order to do that practically, professionals must anticipate the relevance of the learning from SCRs in their current cases and must note that child maltreatment in current cases is a possibility unless relevant learning from SCRs is applied to the case's professional conduct. In this sense, SCRs orient professionals to the past, present and future. One implied outcome of serious case reviewing, as Chapters One and Two each highlighted, is the practical production of *serious case previews* within current child welfare practice.

Horwath (2011) has pointed out one outcome of this orientation to time for professional practice:

> whilst practitioners work with vulnerable children living in often unpredictable and uncertain worlds, in the last ten years, governments, fuelled by the media, are perceived to hold a view that all risk should be foreseeable and manageable. This has resulted in high levels of organisational, professional and personal anxiety, unrealistic expectations, media vilification and political concern about the quality of child protection practice. (Horwath, 2011, p 1072)

The kind of learning implied by the current dissemination model of SCRs reinforces this misconception, where the implementation of recommendations is expected to be

evaluated regularly. Similarly, Munro (2010) points out the difficulty in aligning learning from SCRs in current, unfolding child welfare practice and learning about historical, fixed cases in SCRs:

> The public tend to learn of cases of abuse after a child or young person has died or suffered serious harm and then, with the benefit of hindsight, make judgments on how it was easy to see that the child or young person was in danger and would have been safer if removed. This is of course not the way the issue looks for the professionals who only have foresight. (Munro, 2010, p 21, para 1.44)

These examples illustrate the different relationships between SCR learning, professional vision and time. The selective use of evidence in the retrospective analysis of serious cases highlights errors of omission or commission, missed opportunities for intervention or prevention, analysis of which formulate lessons to be learned and findings to be disseminated. Embedded within the currently unfolding, rapidly changing multi-disciplinary case work of 21st-century England, engaged with children and families, however, professionals have rarely the space or time to select which evidence in their environment ought to be considered as holding more relevance to the case at hand in terms of protecting children from maltreatment.

The national panel of independent experts on SCRs identified that a characteristic of an effective SCR is “A sharp focus on what caused something to happen and how it can be prevented from happening again” (DfE, 2014, p 8, para 28), without articulating how learning from one activity could effectively be transferred to the other and how this can br brought into sharp focus. However the current statutory guidance (HM Government, 2013) does at least attempt to provide for this gap between hindsight and situated practice. It urges LSCBs to conduct SCRs in a way which not only “seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did”, but also to seek “to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight” (HM Government, 2013, p 67, para 10). Even conducted in this way, however, SCRs are directed to consider what professionals *then* might have been able to see, rather than helping professionals *now and in the future* to learn from previous practice episodes in

order to develop new, more effective practice strategy. The current SCR model avoids engaging with the tricky task of articulating how learning is transferred across a range of domains, including time. Munro (2010) reminds us that, at every level of professional intervention, "child protection work, at its heart, involves forming relationships with children, their family members and others working to support the child" (Munro, 2010, p 16, para 1.22). Learning *how* and *when* lessons learned *from* SCRs contribute to these relationships is a critical aspect of SCRs that requires empirical investigation, since they are the crucial pivots in an effective learning model. Munro (2010) suggests that this 'know-how' and 'know-when' is located in a situated relationship not only between professionals and organisations but also between them and children and families.

> In practice, the tasks of obtaining information [such as learning from SCRs], making sense of it, and deciding what action to take are all dependent on the relationship skills of the people involved, both workers and families. (Munro, 2010, p 17, para 1.26)

From this perspective, learning effectively from SCRs implies something that is actively done together with children and families, as a situated activity, rather than a professional possession shared only by individual child welfare practitioners and organisations. Bereiter (1997) pointed to the use of artifacts that enable humans "to overcome" the situatedness of their cognition and interactions. An effective learning model may likewise require artifacts to enable learning to overcome its original setting and be effectively transferred, or recontextualised (Van Oers, 1998), in situated interactions with children and families elsewhere.

PROFESSIONAL VISION

This chapter articulates the methodological structure of the thesis's analysis of a sample of 13 SCRs. The purpose of the analysis is primarily to evaluate the contribution of current SCRs to the task of effectively learning from them. I have made the point throughout this thesis that effective learning from SCRs implies the ability of professionals to be orientated to multiple orders of time simultaneously in order to see

or preview serious cases before they unfold, in order to identify appropriate opportunities to intervene preventatively.

Pink's and her colleagues' (Pink, 2011; Fors et al, 2013) concept of multisensory emplaced learning appears to be best placed to capture this orientation, since it points to the constitution of cultural categories of sense to contextualise individuals' learning in specifically situated activity, in this case child welfare professionals' vision, their ability to review, see and preview. Pink's adoption of the concept of emplacement, however, did not fully articulate the future orientation of sensory learning, meaning how professionals can preview the unfolding of serious cases in order to intervene in a timely and robust way.

Consequently, I have looked beyond sociological and education domains for a practical methodological structure and have chosen to employ Goodwin's (1994) theory of professional vision, drawn from the field of anthropology. Professional vision, according to Goodwin (1994) is explained as follows:

> An event being seen, a relevant *object of knowledge* emerges through the interplay between a *domain of scrutiny* and a set of *discursive practices* (dividing the domain of scrutiny by highlighting a figure against a ground, applying specific coding schemes for the constitution and interpretation of relevant events, etc.) being deployed within a *specific activity* (arguing a legal case, mapping a site, planting crops, etc.) (Goodwin, 1994, p 606, emphases in original)

This thesis argues that this explanation holds good for a methodological framework for analysing the capacity of SCRs to support professionals to learn effectively from them. First, it takes 'relevant object of knowledge' to represent an effective serious case preview. 'Domain of scrutiny' represents published SCRs. Then, where 'discursive practices' represent Goodwin's three constituting aspects of vision (coding, highlighting and graphic representations), it takes 'specific activity' to be situated professional work aimed at safeguarding children's welfare and protecting them from maltreatment. What emerges, then, is an argument that Goodwin's formulation of 'professional vision' is a reasonable model to adopt to be able to do the following research activity:

> *An event being seen, a serious case preview emerges through the interplay between a published SCRs and a set of discursive practices (coding, highlighting and graphic representations) being deployed within child welfare practice.*

Goodwin (1994) claims that professional vision is lodged within "a community of competent practitioners" rather than individual heads and minds, and is therefore not homogenously distributed across social groups. Consequently, "Different professions – medicine, law, the police, specific sciences such as archaeology – have the power to legitimately see, constitute and articulate alternative kinds of events" (Goodwin, 1994, p 626). Professional vision, then, can be summarised as

> the discursive practices used by members of a profession to shape events in the domain of professional scrutiny they focus their attention upon. The shaping process creates the objects of knowledge that become the insignia of a profession's craft: the theories, artifacts and bodies of expertise that are its special and distinctive domain of competence. (Goodwin, 1994, p 606)

Goodwin (1994, p 606) argues that professional vision is constituted by three social and cultural practices. These are:

- *coding schemes*, which professionals use to transform neutral entities and materials into the objects of knowledge that would animate members of that profession;
- *highlighting*, which is the professional practice of marking specific phenomena in a complex field as being particularly salient and of relevance to the professional discourse;
- the production and articulation of *material representations*, which enable participants of a professional community to build but also contest professional vision.

The purpose of employing coding schemes is to enable disparate events to be observed equivalently, by transforming "the world into the categories and events that are relevant to the work of the profession" (Goodwin, 1994, p 608). Goodwin (1994) offers the example of archaeologists' use of Munsell Color Chart that enables them 'to see' the earth that they are currently excavating and to relate their current work to now

equivalent work undertaken previously by professional archaeologists. Goodwin (1994, pp 608-09) describes such coding schemes as

> an historically constituted architecture for perception [which] typically erases from subsequent documentation the cognitive and perceptual uncertainties that [in Goodwin's case, student archaeologists] are grappling with. (Goodwin, 1994, p 609)

The practice of highlighting, of identifying a figure against a ground, for example, structures the relevance of phenomena so that not only does the practice enable individuals to shape their perception but also that of others. Goodwin (1994) offers the example of the professional archaeologist drawing a circle around a perceived post hole in an excavation:

> The line in the sand has very powerful perceptual consequences. As a visible annotation of the earth it becomes a public event that can guide the perception of others. (Goodwin, 1994, p 610)

Finally, the practice of representing and organising phenomena relevant to particular professional communities in graphic form enables professionals to overcome the situatedness of their current work, for example by "collecting records of a range of disparate events onto a single visible surface", which is something that Goodwin claims that language cannot do (Goodwin, 1994, p 611). He points to the distinctive professional literacy of archaeological maps, such as profiles and plans. For example, being able to draw and understand such maps "would be expected of any competent archaeologist; it is an essential part of what it means to *be* an archaeologist" (Goodwin, 1994, p 615). This ability to construct and read professionally-relevant graphic representations of professional knowledge means that the unit of analysis is not individuals, but

> archaeology as a profession, a community of competent practitioners, most of whom have never met each other, but who nevertheless expect each other to be able to see and categorize the work in the ways that are relevant to the work, tools, and artifacts that constitute their profession. (Goodwin, 1994, p 615)

Goodwin's (1994) articulation of professional vision argues that the practices of coding, highlighting and graphically representing knowledge enable learning and knowledge to be made relevant, first, and then transferred across distributed but recognisably competent professionals of that same community and across time and space. Goodwin has also published further examples of such vision, addressing concepts of 'transparent vision' and 'seeing in depth', based on his ethnographic studies of the operations room of airlines and the laboratories of multi-disciplinary science teams on board research ships (Goodwin, 1995, 1996). What is common to each study is his analysis of each professional community's use of resources, such as graphic representations, to code and highlight relevant and salient aspects of the work at hand in the midst of complex environments. For example, Figures 5A reproduces the situated professional activity of the 'Ops Room' that was the subject of Goodwin's (1996) study.

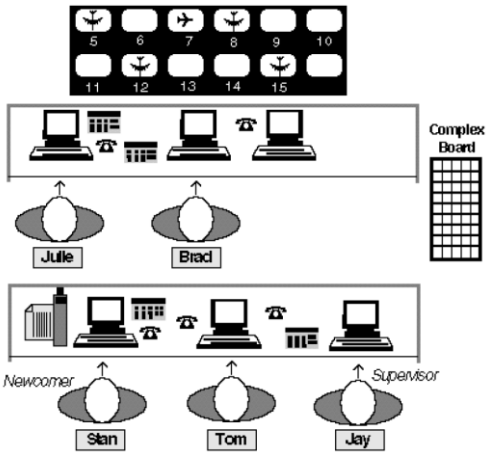

FIGURE 5A The 'Ops Room' and its human and non-human resources which constitute relevant professional vision (Goodwin, 1996, p 378)

Goodwin (1996) describes this professional situation as the "material sedimentation of solutions found in the past to the repetitive tasks and problems that constitute Ops work" (1996, p 378). His work focused on tension that existed between the repetitive aspects of the work of the Ops Room and the professionals' ability to improvise new solutions to unfolding emergencies. Indeed, an important outcome of the situated practices that Goodwin (1994, 1995, 1996) has studied empirically is that the necessary collaborative action to establish shared understanding of professional interests also exposes "relevant domains of ignorance, a process crucial to their remedy" (Goodwin,

1994, p 627). Consequently, Goodwin's model offers grounds for organising SCR learning according to these practices, in order that professionally relevant domains of ignorance – oversights, missed opportunities, unsuccessful improvisations, and so on – can possibly be remedied.

In summary, this thesis proposes to adopt Goodwin's (1994, 1995, 1996) articulation of professional vision in order to analyse SCR learning and to begin to understand better how learning from SCRs can contribute to efforts to identify opportunities to develop preventative actions at the frontline of interactions with children and families and 'to remedy' professional oversight. Goodwin (1995, p 257) argues that "Perception is something that is instantiated in situated social practices rather than the individual brain". This is important since it warns us against assuming that the currently available dissemination–implementation model of SCR learning adequately embeds learning within situated practices of preventative child welfare practice.

Chapter Three identified the concrete situation that this thesis has taken in order to study the possible transfer of learning across not only people and places and time, but also levels of intervention and prevention, for example. Drawing on statistical evidence from SCR evaluations, the situation examined is the prevention of child maltreatment in professional case work with children who have either been assessed at not being at risk of serious maltreatment or who simply do not present to their communities or children's welfare services as being at risk of maltreatment. The thesis focuses on the situated professional practices with these children in order to understand better the possible contribution that SCR learning and learning from SCRs, and an effective learning model, can make to the present and future prevention of child maltreatment.

PURPOSIVE SAMPLE AND CODING PRACTICE

In this sense, the thesis has already proposed *its own coding scheme*, by identifying a particularly vulnerable group of children whose assessment scatters them across the categories of children whose needs are served by co-ordinated but non-statutory early intervention services and those children whose needs are assessed as being more

complex and who receive statutory services, such as Child in Need status (1989 Children Act s17) or a Child Protection Plan (1989 Children Act s47), for example.

Maggetti et al (2013, p 131) advise that "Random sampling is not a viable approach when only a small number of cases are to be selected". Instead, they propose purposive modes of sampling when "design explicitly requires taking into account the occurrence of the outcome of interest on the dependent variable" (Maggetti et al, 2013, p 131), in this case the focus on the contribution of SCR learning on the prevention of maltreatment of children not known to children's social care investigative assessment.

The thesis displays obvious bias, then, towards coding child welfare practice according to a category that emerges only through the thesis's reading of 'key findings' of SCR evaluations. However, the corpus of SCRs itself represents a fundamentally difficult bias in relation to its representation of the general population. Citing research by Gilbert et al (2009), Munro et al (2014) highlight that, although each year 4-16% of children suffer physical abuse, 10% suffer neglect and 5-10% sexually abused, "less than a tenth of these appear in substantiated child maltreatment records" (Munro et al, 2014, p 63). Consequently, at best, SCRs represent only a minority of cases of children's serious maltreatment, and this has important consequences for the designing of risk prediction tools, since

> If future practice is premised on cases identified by the [current] instrument, then the bias will be compounded. (Munro etal, 2014, p 66)

This thesis has compiled a purposive sample of 50 published executive summaries of SCRs, completed by 36 English LSCBs between 2008 and 2011. Inclusion in the sample depended on the summaries satisfying the following criteria:

- The child subject to review was not subject to a Child Protection Plan at the time of the critical event which led either to the child's significant harm or death. The purpose of this criterion is to exclude from study those cases where children's needs presented to assessing professionals as sufficiently concerning to meet a threshold for statutory investigation under section 47 of the 1989 Children Act.

- The child under review belongs to a family unit and the child suffers abuse in the child's private home, rather than in institutions, such as nurseries or foster care arrangements, or violence against adults by children. The reason for adding this criteria was to enable the analysis to examine the possibility of learning transferring from situated interaction between professionals, children and services to the domains of children's private lives.
- The publication date of 2008 was chosen as the earliest date for inclusion in the purposive sample since formal early intervention frameworks, primarily the Common Assessment Framework (CAF), were expected to be embedded within local authority child welfare practices by that date. In this way, the cases admitted to the sample included children who had presented as in need of supportive rather than investigative intervention (for example, assessed under the CAF or CIN (section 17) assessment). The sample includes six SCRs from 2008 (12%), 20 from 2009 (40%), 23 from 2010 (46%) and one from 2011 (2%).

The criteria were chosen in order to develop a coherent sample. A challenge of SCRs is that what constitutes each SCR as a case is their distinctive equifinality: to qualify as a SCR, a child has either died or has been significantly harmed and there are concerns about the nature of the professional interactions with the child(ren) and family. However, diverse factors within each case can lead to those same factors. Consequently, it is not possible to collate a sample of SCRs that can clearly demonstrate the preventative actions that learning from SCRs is intended to produce. Instead, this thesis has chosen to collate a sample that is intended to develop a better understanding of the contribution of SCR learning to the prevention of child maltreatment.

The figure of 50 was chosen as a reasonable sample size for a single researcher to manage. The figure exceeds the sample size of Sinclair and Bullock's (2002) and Rose and Barnes's (2008) biennial analyses. It equals Ofsted's (2008) initial evaluation of 50 SCRs. Chapter Three indicated that published evaluations of SCRs draw upon diverse samples, including full cohort studies, purposive samples, and samples drawn from acknowledged 'dubious sources' which may be 'the best that could be collected under the circumstances'. Each of the SCRs that comprise the current sample of 50 satisfy the inclusion criteria but the thesis does not claim that it is a representative sample. A

number of sources had to be used in order to generate the 50 cases that constitute the sample. First, the National Society for the Prevention of Cruelty to Children's (NSPCC, 2012a) 'Inform' web pages, which include a reading list of recent SCRs (http://www.nspcc.org.uk/inform/), were accessed. Second, internet searches were undertaken using terms "serious case review 2008", "serious case review 2009", and so on. Finally, random searches of individual LSCB websites were undertaken to complete the sample. Each of the sample's executive summaries was publically available at the time it was generated. In two cases (Manchester and Hampshire SCBs), permission had to be sought from the LSCB in order to acquire the hardcopy of the review since an electronic copy was unavailable to download.

PURPOSIVE SAMPLE OF 50 SCR EXECUTIVE SUMMARIES

The final 50 SCR executive summaries that comprise this thesis's purposive sample are presented in the Appendix. Figure 5B represents the age profile of children subject to the sample's SCRs. Included in the number are children who were the parents of the children subject to review as well as two child victims of maltreatment whose harm played a significant part in the review being undertaken but who themselves are not the subject of the review.

<1 year	19
1-5 years	16
6-10 years	11
11-15 years	3
16+ years	6
DNS (SCR does not specify)	10
TOTAL	65 children (including parents)

FIGURE 5B FULL SAMPLE: Ages of children by total (including parents and victims of maltreatment but not subject to serious case review)

Figure 5C compares the proportion of children in this purposive sample by age with the published analyses of SCRs since 1998. It does not contain data from Rose and Barnes's sample (2008, p 77, table 1) since the children in that sample are categorised according to different age categories. Rose and Barnes's data (sample size 45 children, period 2001-2003) is illustrated in Figure 5D.

SCR analysis by year	Sample size (no. children)	<1	1-5	6-10	11-15	16+	DNS	Source
1998-2001	40	48%	33%	2%	13%	2%	2%	Sinclair and Bullock (2002, p 19, tbl 2)
2003-05	161	47%	20%	7%	16%	9%	0%	Brandon et al (2008, p 35, fig 2)
2005-07	189	45%	23%	10%	10%	11%	0%	Brandon et al (2009, p 18, tbl 1)
2007-09	268	45%	22%	9%	13%	11%	0%	Brandon et al (2010, p 11, tbl 3.1)
2007-08	50	42%	16%	2%	28%	12%	0%	Ofsted (2008, p 12, fig 1)
2008-09	219	32%	29%	15%	15%	9%	0%	Ofsted (2009, p 16, fig 1)
2009-10	194	36%	24%	13%	16%	11%	0%	Ofsted (2010, p 8, fig 1)
2008-11	**65**	**29%**	**25%**	**17%**	**5%**	**9%**	**15%**	**THESIS PURPOSIVE SAMPLE**

FIGURE 5C Comparison of proportion of children by age in available serious case review samples

<1	37%
1-4	27%
5-10	24%
11-14	9%
15	7%
16	4%
DNS	0%

FIGURE 5D Proportion of children by age in sample of Rose and Barnes (2008, p 77, table 1)

The purposive sample developed for this thesis's analysis differs from previous evaluation samples of SCRs. First, the purposive sample contains the lowest proportion of children aged one year and under (Figures 5C and 5D). The proportion of children aged one year and under in the purposive sample is 29%. In comparison with the other samples, the proportion of children aged one year and younger ranges from 47% in Brandon et al's (2008) sample of 161 children to 32% Ofsted's (2009) sample of 219 children. The purposive sample contains the highest proportion of children aged six to ten years. The proportion of children aged one year and under in the purposive sample is 17%. In comparison with the other samples, the proportion of children aged six to ten years ranges from 7% in Brandon et al's (2008) sample of 161 children to 15% in Ofsted's

(2009) sample. It contains the lowest proportion of children aged 11-15 years. The proportion of children aged one year and under in the purposive sample is 5%. In comparison with the other samples, the proportion of children aged 11-15 years ranges from 16% in Brandon et al's (2008) sample of 161 children to 28% in Ofsted's (2008) sample of 50 children. The purposive sample also includes the highest proportion of cases in which the age of the child subject to SCR is not specified in the review's executive summary (15%). The extent to which these figures can be attributed entirely to the sample's inclusion criteria is unclear.

Figure 5C illustrates the comparative representation of children by age in the purposive sample of 50 serious cases. It demonstrates that the majority of the sample's children (19/65 children) are concerned with the maltreatment of children aged one year and younger. The age category which is least represented is ages 11-15 years (3/65 children). The category of children whose ages were not specified in the reviews' executive summaries is substantial (10/65 children). By not specifying the children's ages, comparison with other SCRs is made significantly more difficult. Consequently, learning through comparison is inhibited, following Goodwin's (1994) point that coding schemes enable professionals to make equivalent observations and evaluations. This is unfortunate for a learning project which aims to prevent the harm of other children in future, a project which by necessity requires some comparative work between children who have suffered significant harm and children whose significant harm is to be prevented.

The sample was then reorganised according to the age of the youngest children subject to each review. The sample's executive summaries were renamed SCR1-50 (Figure 5E). The child subject to SCR1 is the sample's youngest child. As the SCR number increases, so does the age of the review's youngest child. The age of none of the children subject to SCRs 48-50 is specified. Figure 5F details the ages of each child identified within each SCR.

Thirty-two children out of the sample's 65 children died (53%). Figure 5G illustrates the proportion with regard to SCRs (29 out of 50 SCRs in the sample were concerned with a child's death). Speaking before a Children, Schools and Family Committee in December

2008, a member of Ofsted reported that 210 child deaths reported to Ofsted by English local authorities in a 17-month period were attributed to abuse or neglect (Gilbert, 2008).

	PUBLICATION DATE	LSCB	CHILD SUBJECT TO SCR
SCR 1	2009	Lewisham	Child CD
SCR 2	2010	Torbay	C18
SCR 3	2009	Hampshire	Baby F
SCR 4	2008	Plymouth	M
SCR 5	2010	Lancashire	Baby M
SCR 6	2009	South Gloucestershire	Child R & Child K
SCR 7	2010	Leicestershire & Rutland	Child B
SCR 8	2011	Southampton	Child E
SCR 9	2010	Manchester	Child K
SCR 10	2010	Manchester	I
SCR 11	2010	Reading	Children A & B
SCR 12	2009	South Gloucestershire	Baby S
SCR 13	2010	Sunderland	Child D
SCR 14	2009	Tameside	Child J
SCR 15	2008	Coventry	4
SCR 16	2010	Buckinghamshire	Child W
SCR 17	2010	St Helens	R
SCR18	2009	Birmingham	12
SCR 19	2009	Bristol	Baby Z
SCR 20	2009	Hampshire	Child H & Child G
SCR 21	2010	Coventry	Child CD
SCR 22	2009	Walsall	K
SCR 23	2009	Birmingham	8

SCR 24	2010	Bexley	Child A
SCR 25	2009	Coventry	5
SCR 26	2009	Derbyshire	Child H
SCR 27	2009	Leicester, Leicestershire & Rutland	Child W
SCR 28	2008	Rochdale Borough	Child P
SCR 29	2009	Salford	Child D
SCR 30	2009	Stockton-on-Tees	Child Y
SCR 31	2009	Birmingham	11
SCR 32	2008	Kingston with Surrey	Child F and Child G
SCR 33	2010	Hertfordshire	Child Y
SCR 34	2010	Nottinghamshire	BN
SCR 35	2008	Coventry	2
SCR 36	2009	Gloucestershire	508 Kevin
SCR 37	2010	Doncaster	J children
SCR 38	2010	St Helens	A,B,C
SCR 39	2010	Bedfordshire	Child J
SCR 40	2010	Tameside	C
SCR 41	2010	Leeds	Child R
SCR 42	2010	Herefordshire	Child HC
SCR 43	2010	Leeds	Child L
SCR 44	2008	Wakefield & District	Young Person A
SCR 45	2010	Manchester	Child J
SCR 46	2009	Blackburn with Darwen	Child A
SCR 47	2010	Surrey	Child A
SCR 48	2010	Redcar and Cleveland	Mary
SCR 49	2009	Birmingham	10
SCR 50	2009	Birmingham	9

FIGURE 5E Re-allocation of sample's executive summaries according to age of youngest child subject to SCR

	Child subject to SCR/other significant children	Age	Original age category	Total no. of children in SCR
SCR1	Child CD	Newborn	<1 year	1
SCR2	C18	10 days	<1 year	1
SCR3	Baby F	Six weeks	<1 year	1
SCR4	M	Six and a half weeks	<1 year	1
SCR5	Baby M	Seven weeks	<1 year	3
	Parents (n=2)	DNS	DNS	
SCR6	Child R	Seven weeks	<1 year	2
	Child K	Four years	1-5 years	
SCR7	Child B	"A few weeks old"	<1 year	1
SCR8	Child E	Three months	<1 year	1
SCR9	Child K	Three months	<1 year	1
SCR10	I	Nearly four months	<1 year	2
	H	Two years	1-5 years	
SCR11	Child A	Four months	<1 year	3
	Child B	Infant	<1 year	
	Parent (n=1)	DNS	DNS	
SCR12	Baby S	Four months	<1 year	1
SCR13	Child D	Five months	<1 year	1
SCR14	Child J	Six months	<1 year	1
SCR15	Executive summary 4	Six months	<1 year	1
SCR16	Child W	Eight months	<1 year	1
SCR17	R	Less than one year	<1 year	1
SCR18	Case no. 12	Infant	<1 year	1
SCR19	Baby Z	14 months	1-5 years	1
SCR20	Child G	14 months	1-5 years	2
	Child H	Three years	1-5 years	
SCR21	Child CD	15 months	1-5 years	1
SCR22	K	16 months	1-5 years	1
SCR23	Case no. 8	Under 18 months	1-5 years	1
SCR24	Child A	21 months	1-5 years	1
SCR25	Executive summary 5	23 months	1-5 years	1
SCR26	Child H	Two years	1-5 years	1
SCR27	Child W	Two years	1-5 years	1
SCR28	Child P	26 months	1-5 years	1

SCR29	Child D	Two years nine months	1-5 years	1
SCR30	Child Y	"Young child"	1-5 years	1
SCR31	11	"A child of pre-school age"	1-5 years	1
SCR32	Child F	Seven years	6-10 years	2
	Child G	Six years	6-10 years	
SCR33	Child Y	Eight years	6-10 years	1
SCR34	BN	Eight years	6-10 years	1
SCR35	Executive summary 2	Eight years	6-10 years	2
		Less than eight years	DNS	
SCR36	508 Kevin	Nine years	6-10 years	1
SCR37	J children	Ten years	6-10 years	4
		11 years	11-15 years	
	Victims of attack	Nine years	6-10 years	
		11 years	11-15 years	
SCR38	A	At least 16 years	16+ years	3
	B	10 years	6-10 years	
	C	"a child"	DNS	
SCR39	Child J	Primary school age	6-10 years	1
SCR40	C	Primary school age	6-10 years	1
SCR41	Child R	13 years 11 months	11-15 years	1
SCR42	Child HC	"School-aged child"	DNS	1
SCR43	Child L	16 years	16+ years	1
SCR44	Young person A	16 years	16+ years	1
SCR45	Child J	17 years	16+ years	1
SCR46	Child A	17 years	16+ years	1
SCR47	Child A	17 and a half years	16+ years	1
SCR48	Mary	DNS	DNS	1
SCR49	Case no. 10	DNS	DNS	2
		DNS	DNS	
SCR50	Case no. 9	DNS	DNS	

FIGURE 5F Full sample: ages of all children identified within each SCR in sample

	NO. OF CHILDREN IN SCR	DEATH/HARM
SCR 1	1	Death
SCR 2	1	Death
SCR 3	1	Harm
SCR 4	1	Harm
SCR 5	3	Death
SCR 6	2	Harm
SCR 7	1	Harm
SCR 8	1	Harm
SCR 9	1	Harm
SCR 10	2	Death
SCR 11	3	Death, no harm
SCR 12	1	Death
SCR 13	1	Harm
SCR 14	1	Death
SCR 15	1	Death
SCR 16	1	Harm
SCR 17	1	Death
SCR18	1	Death
SCR 19	1	Death
SCR 20	2	Death
SCR 21	1	Death
SCR 22	1	Death
SCR 23	1	Death
SCR 24	1	Death
SCR 25	1	Death
SCR 26	1	Harm
SCR 27	1	Death
SCR 28	1	Harm
SCR 29	1	Death
SCR 30	1	Harm
SCR 31	1	Death
SCR 32	2	Harm
SCR 33	1	Death
SCR 34	1	Death
SCR 35	2	Harm
SCR 36	1	Harm
SCR 37	4	Harm

SCR 38	3	Harm
SCR 39	1	Harm
SCR 40	1	Harm
SCR 41	1	Death
SCR 42	1	Harm
SCR 43	1	Death
SCR 44	1	Death
SCR 45	1	Death
SCR 46	1	Death
SCR 47	1	Death
SCR 48	1	Harm
SCR 49	2	Death
SCR 50	1	Harm

FIGURE 5G FULL SAMPLE: distribution of fatal maltreatment and significant harm

HIGHLIGHTING

Goodwin's (1994) second constituent practice of professional vision is highlighting, marking specific phenomena in a complex field as being particularly salient and of relevance to the professional discourse. It is used in this methodology to identify 13 'special cases' in the larger sample. Each of these 13 executive summaries include explicit statements which declare the review's author's conclusion that the case of serious child maltreatment under review was *preventable to at least some degree*. Figure 5H illustrates summaries of the authors' claims.

For example, 'preventability' in these special cases includes claims that sufficient resources were available to ensure an accurate assessment of a child's needs since it follows that an accurate assessment *would have prevented* the child suffering maltreatment (Figure 5H: SCR28 and SCR42). It also includes claims that the child's maltreatment could have been avoided since it follows that undertaking actions and decisions to avoid child maltreatment *would also have prevented* the child suffering maltreatment (SCR25 and SCR39). It includes a claim that a child could have been robustly protected since it follows that robust protection *would have prevented* the child suffering maltreatment (SCR26). Finally, it includes a claim that a child's maltreatment

was not inevitable since it follows that the prevention of the child's harm *was also a reasonable alternative outcome* (SCR46).

	SUMMARY OF SCR AUTHOR'S CLAIM
SCR6	Case was preventable
SCR16	Case was preventable
SCR19	Case was preventable
SCR25	Child's death was avoidable
SCR26	Child could have been robustly protected
SCR28	Child's needs could have been accurately assessed
SCR31	Case was preventable
SCR37	Case was preventable
SCR39	Child's sexual abuse was avoidable
SCR42	Child's needs could have been accurately assessed
SCR46	Tragic outcome was not inevitable
SCR48	Case was preventable
SCR50	Case was preventable

FIGURE 5H Special cases: SCR authors' claims that 13 of the 50 cases were 'preventable'

These 13 cases comprise 'crucial' cases, which Eckstein (1975, cited in Flyvberg, 2006) describes as one "that must closely fit a theory if one is to have confidence in the theory's validity, or, conversely, must not fit equally well any rule contrary to that proposed". This thesis wishes to examine these claims that SCRs are (to varying degrees) preventable in order to better understand the claim that SCR learning contributes to the prevention of child maltreatment.

Under Public Service Agreement 13 (HM Government, 2009), preventable and avoidable factors relating to children's deaths (rather than also significant but non-fatal harm) are defined as:

> events, actions or omissions contributing to the death of a child or to substandard care of a child who died, and which, by means of national or locally achievable interventions, can be modified. (HM Government, 2009, p 25, cited in NSPCC, 2012b)

The NSPCC defines 'preventable child deaths' as

> events, actions or omissions contributing to the death of a child or to substandard care of a child who died, and which, by means of national or locally achievable interventions, can be modified. (NSPCC, 2012b)

It defines a 'modifiable death' as

> where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. (NSPCC, 2012b)

The statements made in the purposive sample of SCR executive summaries are made not by Child Death Overview Panels but by the reviews' authors themselves, and not all of the statements relate to children's fatal maltreatment. Of the 13 reviews which contain such statements of preventability, only four concern the fatal maltreatment of children (SCR19, SCR25, SCR31 and SCR46). Incidentally, only 19 of the sample's 50 executive summaries contain explicit statements that the child's maltreatment *could not* have been prevented (SCR1, SCR5, SCR8, SCR9, SCR10, SCR12, SCR13, SCR17, SCR18, SCR20, SCR21, SCR24, SCR27, SCR29, SCR32, SCR38, SCR43, SCR45, SCR49).

Chapter Six examines each of the 13 case's statements as evidence of possible learning transfer. It also examines the sample's recommendations, in order to understand better what learning is expected and where it is expected to transfer to.

SUMMARY

The primary goal of this thesis is to understand better the possible contribution learning makes to 'any learning model' that LSCBs may adopt in order to undertake serious case reviewing. It has argued that SCRs currently organise learning in terms of *learning about* cases in order to *learn from* them so that current and future child welfare professionals *learn to prevent* serious child maltreatment. The inclusion of case chronologies and narratives in SCRs suggests that learning about a case is served by transmitting this information through publication (with the exception of those individuals and organisations who learned on the case at the time, before the case qualified for SCR,

although this aspect of situated learning is not the specific focus of this thesis). The production of recommendations indicates the model for learning from these cases, although again it suggests that transmission (dissemination–implementation and follow-up/testing) rather than any other articulation of learning transfer is sufficient. The crucial aspect of *learning how to prevent* is not articulated but is assumed to be self-apparent.

In order to undertake learning, SCRs make reference to the relation between professional vision, SCR learning and simultaneous orientation to multiple orders of time. For example, a principle of current statutory guidance relating to SCRs is that an effective SCR learning model "seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight" (HM Government, 2013, p 67, para 10). Such a model is expected to use a retrospective analysis in order to recapture the complex perceptual fields experienced by individuals and organisations undertaking child welfare work and anticipates that an analysis of that situated practice produces insight that can be transferred to presently unfolding cases by enabling professionals and organisations 'to see' relevant phenomena, such as opportunities for interventions, signs and symptoms of abuse, and so on.

In order to incorporate learning and professional vision methodologically, I have adopted Goodwin's (1994) anthropological study of professional vision. Goodwin's (1994) organisation of professional seeing into three distinct practices – coding, highlighting and graphic representation – is used to provide structure to the thesis's analysis of a SCR sample.

The coding scheme used is drawn from a recurring 'key finding' of SCR evaluations and established the primary criterion for inclusion in the original sample of 50 cases. By coding a number of SCRs in this way, the sample enables a better understanding of the contribution *learning about* this category of SCRs may make to current professional practice.

The practice of highlighting is adopted in order to focus on 13 instances in these cases where the author suggests that the case's evidence indicates that it was preventable. This thesis does not claim that these statements satisfy all criteria for articulating the

prevention of serious maltreatment. However, by adopting Goodwin's (1994) study of professional vision, it offers a theoretical articulation for the statements' occurrence in SCRs since the authors of these 13 SCRs are highlighting what they consider to be salient phenomena to be considered when *learning to prevent* cases of serious maltreatment.

Currently, SCRs do not provide evidence of Goodwin's (1994) third practice of professional vision, graphic representations. However, the call for learning models either to be adopted or developed indicates that a graphic model of learning may have an important contribution to make to enabling professionals 'to see' opportunities for transferring learning. Chapter Four examined a number of graphic representations of learning in children's welfare services. In light of the chapter's review, a number of suggestions were made concerning the place of children and families in any SCR learning model. Chapter Seven discusses the possibility developing a visual graphic representation for learning in light of Goodwin's (1994) theory and evidence from the learning sciences literature.

CHAPTER SIX

LEARNING ABOUT AND LEARNING FROM PREVENTABLE SERIOUS CASE REVIEWS

INTRODUCTION

The purpose of this chapter is to examine more closely the 13 'special cases' that comprise this study's purposive subsample. Each case represents a published serious case review (SCR) executive summary that includes an explicit statement by the review's author that the case being reviewed was, to varying degrees, preventable. This thesis explores these cases since, crucially, they present evidence of current professional perspectives of what constitutes *learning from* SCRs in order to prevent the recurrence of child maltreatment. As such, they highlight salient aspects of complex child welfare practice for professional vision of child welfare services.

This chapter contrasts learning about these cases with learning from them, and then with learning to prevent. This is possible since each of 13 cases offers a retrospective narrative describing the unfolding case; each also makes recommendations to be implemented; and, importantly, each offers an explicit statement that concerns an explanation of preventability. Part One of this chapter presents each of the case's retrospective narrative in order that we *learn about* each case. Part Two presents a collation of the 13 cases' recommendations, a compilation of what is to be *learned from* these cases. Part Three engages with each SCR author's unique statement of preventability, representing how individuals and organisations can learn to prevent serious child maltreatment. The chapter's summary focuses on the coherence of the relationship between these orders of learning. An effective, coherent learning model would embody a close relationship between what can be learned about a particular case and what it can highlight to other professionals in terms of transferring learning to their

own work, and clarify how this transfer of learning explicitly addresses the prevention of serious maltreatment.

The 13 cases are organised as individual case studies in Figure 6A.

CASE STUDY	SAMPLE REFERENCE	PUBLISHED SCR	SUBJECT (AGE)	CHILD OUTCOME
1	SCR6	South Gloucestershire SCB (2009)	Child R (seven weeks) and Child K (four years)	Significant harm
2	SCR16	Buckinghamshire SCB (2010)	Child W (eight months)	Significant harm
3	SCR19	Bristol SCB (2009)	Baby Z (14 months)	Death
4	SCR25	Coventry SCB (2009)	'Executive summary 5' (23 months)	Death
5	SCR26	Derbyshire SCB (2009)	Child H (two years)	Significant harm
6	SCR28	Rochdale Borough SCB (2008)	Child P (two years)	Significant harm
7	SCR31	Birmingham SCB (2008)	'Case no. 11' (pre-school age)	Death
8	SCR37	Doncaster SCB (2010)	J children (10 and 11 years)	Significant harm
9	SCR39	Bedfordshire LSCB (2010)	Child J (primary school age)	Significant harm
10	SCR42	Herefordshire SCB (2010)	Child HC (school age)	Significant harm
11	SCR46	Blackburn with Darwen LSCB (2009)	Child A (17 years)	Death
12	SCR48	Redcar and Cleveland SCB (2010)	Mary (likely to be at least secondary-school age)	Significant harm
13	SCR50	Birmingham SCB (2009)	'Case no. 9' (no age given)	Significant harm

FIGURE 6A Purposive subsample organised as 13 case studies

PART ONE: LEARNING ABOUT SERIOUS CASES

CASE STUDY 1: SCR6 (South Gloucestershire SCB, 2009)

Child R was the second child in his family and lived with his mother and father and older sister, Child K (four). When Child R was seven weeks old, his mother returned to her workplace to see colleagues there, and left him in his father's care. On her return, Child R was said to be pale and limp. In the following hours, Child R's mother took him to the hospital on two occasions due to her concerns for his health. On the second occasion, scans showed that Child R was bleeding in his brain. In November 2008 child R, aged 7 weeks old, suffered a significant injury resulting in a fractured skull and bleeding in the brain (cerebral haemorrhage).

> No history of trauma was offered by either parent. Without an explanation, the injury was considered indicative of a significant trauma and a shaking injury, probably of a non-accidental nature. (South Gloucestershire SCB, 2009, p 2, para 1.4)

It was not until a later police interview that Child R's father admitted that he had taken Child R to the loft and caught Child R's head when descending the ladder. When he realised the child had collapsed, father shook him four times in an effort to revive him. Further investigation of the family had found that Child R's older sister, Child K, had presented to medical professionals in her first year with serious bruising on a number of separate occasions.

Child R had been seen by professionals in the local hospital's neonatal intensive care unit following his birth and by health visitors prior to the critical event of his significant harm. At the time of Child R's acute head injury, neither Child R nor Child K was known to the local children's social care department. Instead, universal medical and education services (working with Child K) had no concerns regarding the children's care from their parents.

> Within the family there were none of the major risk factors often associated with abuse. There was no known parental mental ill health, substance or alcohol

> abuse or any documented domestic violence. Additionally both parents were engaged in secure jobs, had been in a relationship for many years and appeared loving and able parents. There were also no issues within either parents [*sic*] own childhoods that, according to the literature, may impact on parenting. Parent B [mother] especially appeared to be a suitable and engaging parent, using and cooperating with the universal services in a completely appropriate way. (South Gloucestershire SCB, 2009, p 9, para 3.2)

Both children were made subject to child protection plans *following* Child R's significant harm (South Gloucestershire SCB, 2009, p 9, para 2.33), and their father was bailed on condition that he lived away from home (South Gloucestershire SCB, 2009, p 8, para 2.30).

CASE STUDY 2: SCR16 (Buckinghamshire SCB, 2010)

Child W lived with her mother. No siblings are recorded in the review. Father was no longer resident in the family home but he did maintain contact with his daughter throughout her childhood. Child W was six months old when her mother reported to the police that Child W's father had threatened her with an air rifle in her home (Buckinghamshire SCB, 2010, p 3, para 4). Child W's mother fled from her home with Child W and returned only when Child W's father had left. Two months later, when Child W was aged eight months old, Child W's father returned to the home, assaulted Child W's mother and Child W's aunt, and threw Child W from the window of the second floor flat where she lived (Buckinghamshire SCB, 2010, p 3, para 5).

> W made a good recovery from her injuries which were life threatening and is now thriving and developing well. (Buckinghamshire SCB, 2010, p 3, para 6)

Father subsequently pleaded guilty to charges of grievous bodily harm with intent in respect of Child W, actual bodily harm in respect of Child W's mother and common assault of Child W's aunt (Buckinghamshire SCB, 2010, p 3, para 7). Prior to the critical incident of Child W's harm, Child W and her mother were known to the police, the local children's disabilities team, and a housing association.

CASE STUDY 3: SCR19 (Bristol SCB, 2009)

Baby Z died at home on 21st July 2007, aged 14 months, whilst in the care of his mother SZ, and her friend X. Both SZ and X have a history of drug misuse. When police attended they found evidence of drug taking, including spilt methadone. The cause of Baby Z's death is recorded as 'morphine and methadone intoxication'. (Bristol SCB, 2009, p 1, para 2.1)

Baby Z lived with his mother and had only limited contact with his father. His mother injected heroin and crack on top of a daily-supervised methadone prescription. The review records that Baby Z's mother sold sex to fund her drug use (Bristol SCB, 2009, p 2, para 6.1). His mother was known to a number of services, including probation and a specialist drug service in Bristol. This service described her as "doing amazingly well" (Bristol SCB, 2009, p 3, para 6.2). Following his death, his mother pleaded guilty to a charge of manslaughter and received five-year prison sentence.

Baby Z was not known to his local children's social care services at the time of his death. However, he had been referred for assessment before. Baby Z's mother had taken him to hospital to visit a friend there. Staff observed mother's friend pick up Baby Z by the ankle and swing him onto a bed. The social care's assessment concluded that the friend's limited mobility justified his handling of Baby Z and that there was a warm relationship between Baby Z and his mother (Bristol SCB, 2009, p 5, para 6.15).

CASE STUDY 4:SCR25 (Coventry SCB, 2009)

Coventry SCB's 'executive summary 5' (2009) concerns the death of the youngest child in a family in which the child's father was serving a prison sentence for drug-related offences and which had previously raised child protection concerns regarding an older sibling and before the birth of the child subject to this particular review. However, at the time of the child's death, the child was not known to children's social care agencies;

instead, “the mother had maintained contact with health agencies” (Coventry SCB, 2009, p 2).

The child “died at home when an electrical fault in a television set caused a fire in an upstairs room. The child died as a result of inhaling the fumes created by the fire” (Coventry SCB, 2009, p 1). The mother did not know that there was a fault with the television set. She had left the child at home while she instead attended a court. At the time that the review was published, the courts were considering professional concerns about the mother’s care for one of the child’s older siblings.

CASE STUDY 5: SCR26 (Derbyshire SCB, 2009)

Child H was two years old when she was “seriously sexually assaulted whilst staying at her mother’s place of work. The incident happened in the night, whilst the children were in the care of Stepfather; he had been drinking heavily” (Derbyshire SCB, 2009, p 6). There was insufficient evidence to convict Child H’s stepfather of rape; instead, he was convicted of unlawfully wounding and sexually assaulting a child, serving a minimum of 89 months in jail before consideration for parole.

Child H lived with her mother, stepfather, brother (aged three years) and a baby half-sister. A three-year-old child belonging to her stepfather was also part of the household when she was sexually assaulted. Her maternal grandparents lived nearby and “were well-respected and experienced carers within the local community” (Derbyshire SCB, 2009, p 4).

Four months prior to her assault, Child H presented at hospital with a “strong possibility” that her fractures and bruising were non-accidental (Derbyshire SCB, 2009, p 4). Subsequently, Child H and her siblings were all made subject to child protection plans. However, at a protection plan review conference soon afterwards, all professional reports were positive and the family agreed to collaborate with children’s social care services towards resolving Child H’s needs as a ‘child in need’, rather than a child at risk of significant harm (Derbyshire SCB, 2009, p 6). One month later, Child H’s stepfather assaulted her.

CASE STUDY 6: SCR28 (Rochdale Borough SCB, 2008)

Child P was a little more than two years old when, having been taken to hospital by the police for medical examination, she was found to have "extensive bruising and swelling to face, bite marks on shoulders and upper limbs, bruising to left leg, infected fingers, haemorrhage to right eye and fractures to ribs and left tibia and fibula" (Rochdale Borough SCB, 2008, p 4, para 1.7). Her mother's partner was subsequently arrested on charges of child cruelty.

Following her birth, Child P lived with her birth parents and was considered "well cared for as a baby", and professionals had "no concerns about her health and development" (Rochdale Borough SCB, 2008, p 3, para 1.1). However, following the end of her parents' relationship, Child P lived with her mother and mother's new partner. Subsequently, professionals were alerted a number of times to the risk posed by mother's new partner, especially with regard to Child P's wellbeing. First, Child P's father alleged to the police that the partner was a rapist (Rochdale Borough SCB, 2008, p 3, para 1.2). Second, Child P's maternal grandmother contacted children's social care to inform them that Child P had not been seen for some time and that she had bruising to her back and face last time she had been seen, and that the conduct of mother's partner was concerning her (Rochdale Borough SCB, 2008, p 4, para 1.5). Two days later, Child P's aunt contacted the police to inform them that she had been threatened by mother's partner and had also observed bruising to Child P on their last meeting (Rochdale Borough SCB, 2008, p 4, para 1.6).

Both police and children's social care had previously assessed Child P: a police officer had observed bruising and grazing to Child P's face and informed children's social care services. Subsequently, Child P was assessed by a social worker and staff at an accident and emergency ward. Medical staff concluded that the injuries to Child P were "consistent with the explanation offered by her mother" (Rochdale Borough SCB, 2008, pp 3-4, para 1.1-3).

Following Child P's aunt's call, the police located Child P and found her heavily bruised (Rochdale Borough SCB, 2008, p 4, para 1.6).

CASE STUDY 7: SCR31 (Birmingham SCB, 2009)

The child referred to as 'case no. 11' (Birmingham SCB, 2009) was of "pre school age" (Birmingham SCB, 2009, p 3). The child lived at home with both parents and at least one older sibling. Both mother and father were using heroin and crack cocaine on top of methadone prescriptions on a daily basis while caring for their children. Descriptions of the children's living conditions included drug paraphernalia, broken furniture, inadequate child equipment and dirt. The father was subject to a Community Rehabilitation Order and was being supervised by a number of agencies including the police and probation service. The children had earlier been subject to police protection on account of allegations of physical abuse (of the child's sibling). Investigations by the police and children's social care concluded that the older sibling's injuries were accidental and the children returned to their parents (Birmingham SCB, 2009, p 3).

The review highlights an apparent pattern that emerged in collaborative activities between the children's parents and child welfare professionals: the parents appeared "to co-operate and [improve] conditions for a short period [...] in an effort to appease professionals" (Birmingham SCB, 2009, pp 3-4). That the children were not known to children's social care at the time of the youngest child's death suggests that professionals were successfully appeased. Neighbours and extended family members raised concerns with professionals. The children's parents explained away their concerns as malicious (Birmingham SCB, 2009, p 4).

The child known as 'case no. 11' and the child's sibling ingested their parents' methadone. The parents were aware of what had happened but did not call for an ambulance until the following day. Instead, the father attempted to get the children to vomit up the methadone and then put them down to sleep off the effects. The youngest child died and the older sibling survived. Both parents were convicted of causing or

allowing the death of the child and neglect of the child's sibling and served prison sentences.

CASE STUDY 8: SCR37 (Doncaster SCB, 2010)

> A very serious assault occurred in the late spring of 2009. The victims of the assault were two boys aged 11 and 9 years old who did not know their attackers. The assault was perpetrated by two brothers aged 11 and 10 years old. [...] [T]he perpetrators had shown an escalating pattern of violence against other children and adults over a period of several months. (Doncaster SCB, 2010, p 4)

The assault took place near Edlington. The report refers to the two brothers as 'J' children. The SCR focussed upon the significant harm suffered by the two brothers rather than the two victims of their assault since it soon became apparent that the brothers had themselves suffered "sustained exposure to violence and neglect" (Doncaster SCB, 2010, p 5). Reviewing professional interaction with the brothers' family over the preceding 14 years, it became clear that, "this was a family where domestic violence was known about from 1995 onwards", and, "where on several occasions the children presented with injuries and evidence of their emotional and physical neglect" (Doncaster SCB, 2010, p 5). Professional collaboration with the family appeared to centre on the boys' mother rather than the children and, in their collaborations with the children, professionals found the children troublesome rather than their behaviour troubling:

> [T]hroughout the involvement with the family, the focus was primarily on the boys' mother who was able to exert too much influence on what individual professionals did. [...] [The boys] were primarily treated simply as naughty boys rather than as children in need whose behaviour required more effective intervention. (Doncaster SCB, 2010, p 6)

Professionals responded to the parents' "uncooperative and antisocial [...] attitude and behaviour" by relying on agreements and warnings to change their behaviour (Doncaster SCB, 2010, p 5, para 7). The review describes this type of collaboration between professionals, children, and the children's family as an "insufficiently

authoritative, consistent and assertive strategy" (Doncaster SCB, 2010, p 5, para 7). The two brothers pleaded guilty to a charge of grievous bodily harm with intent. However, the review does not provide any details of any criminal investigation of the brother's parents.

CASE STUDY 9: SCR39 (Bedfordshire LSCB, 2010)

Child J lived with her mother and her mother's partner. She attended a primary school. Child J's was assessed by children's social care as a 'child in need' and received services proportionate to this assessment. Child J's mother's partner was the child's primary carer. He was a registered sex offender, known to two police force Sex Offender Management units, and had past convictions for paedophile behaviour. He had been subjected to two independent risk assessments (Bedfordshire LSCB, 2010, pp 2, 5, paras 1.2.1, 3.01). Child J's birth father made "constant pleas" to professionals that mother's partner be removed from Child J's home (Bedfordshire LSCB, 2010, p 3, para 1.2.6). During the two-year period that professionals and Child J's carers collaborated for Child J's welfare, "it is now known that [mother's partner] committed serious sexual offences during this time" (Bedfordshire LSCB, 2010, p 2, para 1.2.3). Child J's mother's partner received a custodial sentence having been convicted in 2009 of indecently assaulting Child J (Bedfordshire LSCB, 2010, p 2, para 1.2.1).

CASE STUDY 10: SCR42 (Herefordshire SCB, 2010)

Child HC was a school-age child. He had lived originally with his birth parents and three younger siblings. When his parents separated in 2002, HC lived with his mother, her new partner, and two younger half-siblings (Herefordshire SCB, 2010, p 2, paras 1.2.1-2). During all of this time, HC was "beaten, verbally abused, and neglected by his carers, and the evidence from this Review has revealed that HC suffered greatly at the hands of the adults in the household" (Herefordshire SCB, 2010, p 3, para 1.2.5).

Each family unit that HC lived in was known to children's social care and the police, usually on account of anti-social behaviour and domestic violence issues (Herefordshire SCB, 2010, p 3, para 1.2.3). The review observes that, since many agencies (and the police in particular) saw HC as the cause of the family's difficulties, his own abuse went unnoticed, unidentified and unrecognised. The concerns of local people that HC and his siblings were being abused and neglected were consequently ignored (Herefordshire SCB, 2010, p 3, para 1.2.4).

HC and his siblings were eventually made subjects to child protection plans and later taken in to care. However, the review comments that, "at least two years before the children were made subject of a Child Protection Plan, a threshold had been crossed whereby it should have been obvious that there was a real risk the children were suffering significant harm" (Herefordshire SCB, 2010, p 7, para 3.01). Despite the obvious risk, the review acknowledges that

> HC's mother and her male partners were intimidating and verbally aggressive to staff, including health visitors and social workers. They were also highly manipulative, and they often managed to subvert the work being done to try and help the children develop and thrive. (Herefordshire SCB, 2010, p 3, para 1.2.7)

It was not until the children were fostered that they "described a harrowing catalogue of serious abuse, as well as clear indicators that they had been threatened into silence by the adults in their lives" (Herefordshire SCB, 2010, p 4, para 1.2.9). HC's mother and her partner received prison sentences having pleaded guilty to a number of charges of child cruelty.

CASE STUDY 11: SCR46 (Blackburn with Darwen LSCB, 2009)

Child A was 17 years old when a member of the public found her hanged. In the last three months of her life, Child A had spoken about her intention to commit suicide and made one attempt by overdose (Blackburn with Darwen LSCB, 2009, pp 6-7). Child A, and her older and younger siblings, had been raised in a family household in which there

were a number of marital and mental health issues. The children's mother had taken the children to live with her abroad without the consent of their father. The father successfully had the children returned to him and he later reported that his wife had committed suicide while living abroad.

When Child A reached the end of her compulsory school age, her father removed her from the family home. At this point, Child A was using drugs and committing criminal offences. For a period, Child A was homeless. Child A spent the last six months of her life living in two units in Blackburn and Darwen, where she continued to use drugs and drink heavily (Blackburn with Darwen LSCB, 2009, pp 6-7). Child A would not speak with any professionals other than staff at the second unit. Children's social care never undertook an assessment of her needs.

CASE STUDY 12: SCR48 (Redcar and Cleveland SCB, 2010)

Mary was a child with a disability. Although the review does not detail her specific age, it details that the Connexions service was in contact with Mary during the period of time that was reviewed by this report. Therefore, it is reasonable to assume that Mary was at least of secondary-school age at the time that the review was undertaken. She lived with her mother, mother's partner John and her half siblings, Ben and Eve.

> Mary made an allegation against John, who had been associated with Mary's family over many years, that she had been raped by him on a number of occasions. He admitted one offence of rape. In reviewing this case it became clear that John had previous sexual and other offences and that he had been subject to Multi Agency Public Protection Arrangements (MAPPA). (Redcar and Cleveland SCB, 2010, p 3, para 1:6)

Following John's conviction for raping Mary, her mother "acknowledged continuing feelings for John" (Redcar and Cleveland SCB, 2010, p 6, para 1:10).

John had been sentenced to more than 25 years imprisonment on account of previous violent and sexual offences (Redcar and Cleveland SCB, 2010, p 6, para 2:1), some of them against Mary's mother. Consequently, Mary and her siblings had been named for

three years on a local authority's Child Protection Register (Redcar and Cleveland SCB, 2010, p 6, para 2:2). The family moved across local authority boundaries but information regarding their particular welfare arrangements did not follow them (Redcar and Cleveland SCB, 2010, p 9, para 3:4). Mary's mother failed to inform child welfare staff of her relationship with John following John's release from prison: "this pattern was not recognised by professionals and thus no effective intervention [to protect Mary] took place" (Redcar and Cleveland SCB, 2010, p 11, para 3:8).

CASE STUDY 13: SCR50 (Birmingham SCB, 2009)

At the time of the critical event subject to SCR, the child known as 'case no. 9' (Birmingham SCB, 2009) was the second-youngest child of eight children. No specific age is given for the child other than the indicators that (1) the family's eight children had been born in a nine-year period and that, "as the children reached school age, [there were] inputs into the family from the school nurse and learning mentors" (Birmingham SCB, 2009, p 3), and (2) the critical event itself occurred on account of a home visit by social care and health visiting services (Birmingham SCB, 2009, p 4). With health visiting services involved, it seems reasonable to assume that the child is of pre-school age, with some of the older six siblings at primary school and the younger sibling at home. The children all lived with their birth parents.

The children's mother is described as having been in an "almost constant state of pregnancy" during her engagement with welfare services; many services supported the family since, following the second child's birth, "mother was finding it increasingly difficult to manage the growing demands of the children" (Birmingham SCB, 2009, p 3).

As a consequence of these difficulties, many routine health appointments for the children had been missed and the schools were concerned about "the apparent demeanour of the children", especially with regard to hunger and basic health care (Birmingham SCB, 2009, pp 3-4). Assessment of the children's home environment included notes that there was a limited number of beds amongst the children, and the house lacked heating.

When the professionals from social care and health visiting services visited the home, they found that the child subject to this review was "very unwell and was significantly underweight". The child was admitted to hospital to be treated for malnutrition and "action was undertaken to safeguard the remaining siblings" (Birmingham SCB, 2009, p 4). The children's mother's mental health precluded a court appearance. The father was convicted and sentenced to a suspended 12 months imprisonment and a 12-month Community Service Order. All eight children were subject to care orders at the time of the review's publication.

Part One presented what one may learn *about* the 13 special cases through a summary of each case's narrative. However, there is no clear indication what exactly we are to learn *from* them. Each case details children's experience of significant maltreatment and despite the deliberate selection of presented evidence, nonetheless each case presents a unique and singular picture of individual children's suffering of harm. Part Two turns directly to examine the recommendations made by the author of each of the 13 cases. These recommendations indicate what can be *learned from* these 'crucial' cases.

In Part Three, these 13 cases are revisited, this time to explore the reviews' authors' claims that each case was, to some degree, preventable. The implication of these claims is that learning from SCRs is possible and that each of these 13 cases can contribute to professional efforts to prevent other children, living elsewhere, at present or at some unspecified time in the future, and in contact with different child welfare professionals and services.

PART TWO: LEARNING FROM SERIOUS CASE REVIEWS (RECOMMENDATIONS FROM THE 13 SPECIAL CASES)

Each SCR's recommendations represent what the author considers worth learning from each SCR. There is no existing classification system of SCR recommendations. However, I have endeavoured to draw the sample's 323 recommendations into general categories so that key themes can be identified. Part Three, then, presents a kind of 'digest' or archive that was discussed in Chapter Four.

Figure 6B illustrates the recommendations made by the 13 reviews that relate to the prevention of child maltreatment and the situated activity of child welfare work. Three situated activities are distinguished: first, the child's private life; second, the collaborations between children, families and professionals; and third, the inter-professional collaborations of professionals only.

None of the reviews makes any recommendation concerning children's private lives.

Eleven of the 13 cases make recommendations concerning the collaborative activities of the children's workforce, children and their families (the exceptions being case studies eight and nine). All 13 cases, however, make recommendations regarding the discrete activities of professionals, involving no contact with children and their families. Therefore, in order *to prevent* the maltreatment of children within their private family lives, all the reviews' authors recommend changes being made to the way professionals work alone and together; no recommendations are made to the children or the child's carers within their private family lives.

Figure 6B presents the number of recommendations by each of the sample's reviews according to the domain of child welfare work that is expected to prevent the maltreatment of children within their own homes. The figure shows that, overall across 13 cases of preventable child maltreatment, eight in every ten of the sample's 323 recommendations concerns the discrete activities of inter- and intra-agency working, when not in direct interaction with children and families. Only two in ten concern the manner in which child welfare practitioners collaborate with children and their families.

This suggests that the reviews' authors consider the working domain of professional child welfare services as the site at which learning from SCRs will secure children's protection from maltreatment. Figure 6B indicates that 82% of the 323 recommendations made by the 13 'preventable' cases concern the transfer of learning from situated preventative collaborations between children, families and professionals to the situated activity of child welfare professionals only. Despite indicating that preventative action is possible within the situated activity of collaborations with children and families, nevertheless, the reviews' recommendations suggest that, in the majority

of cases, only professionals can learn from these cases in order to develop inter-professional skills capable of matching effective, situated collaboration with families.

	RECOMMENDATIONS (n=)		
CASE STUDY	**TO THE CHILD OR FAMILY DIRECTLY**	**TO THE SITUATED INTERACTION BETWEEN PROFESSIONALS, SERVICES, ETC. AND CHILDREN AND FAMILIES**	**TO INDIVIDUAL PROFESSIONALS AND ORGANISATIONS ALONE OR TO INTERACTIONS BETWEEN PROFESSIONALS ONLY**
1	0	2	10
2	0	12	33
3	0	8	19
4	0	4	15
5	0	6	7
6	0	7	16
7	0	6	11
8	0	0	18
9	0	0	17
10	0	1	16
11	0	11	53
12	0	7	100
13	0	5	8
TOTAL (n=)	**0**	**69**	**323**
TOTAL (%)	**0%**	**18%**	**82%**

FIGURE 6B Number of recommendations made in each case study and total subsample per situated activity of child welfare activity

Figures 6C and 6D illustrate the most recurrent themes of recommendations made. Of the 69 recommendations made in the sample of 13 reviews that concern the contribution of situated collaboration between children, families and professional services to the development of effectively preventative actions, the most frequently occurring theme is the formal assessment of children and their families.

> Staff need to consider the role of the father in assessments. (Buckinghamshire SCB, 2010, p 9, para 2)

The second most frequently occurring recommendation is to gather and record assessment information (such as parents' names) accurately (although only eight of 69 recommendations belong to this category). For example,

> All practitioners working with adult service users should record when they see children within the family, the details and condition of the child or children, and (in the child's own words) what the child says. (Bristol SCB, 2009, p 11, para 10.17)

Focus of recommendations to situated collaborative activity of children, families and professionals	**Total in sample (n=)**	**Case study source**
Assessment of child and family	13	2, 3, 11, 12
Gathering and recording accurate information in assessments	8	3, 4, 12
Engaging children's parents	6	2, 10, 13
Child-centred practice	5	7, 11, 12

FIGURE 6C Most frequently occurring recommendations in sample of 13 cases concerning situated collaborative activity of children, families and professionals

Figure 6D represents the most frequently occurring types of recommendation made in the 323 recommendations that relate the discrete activities of child welfare professionals in inter- and intra-agency working away from the 'frontline'. Their frequent occurrence may owe more to the fact that they fit broad, easily recognisable categories, such as 'training' and 'information sharing'. The figure indicates that, in order to learn from SCRs effectively, child welfare professionals require *training* (56 out of 323 recommendations). For example,

> Buckinghamshire LSCB should ensure that all level 1 safeguarding training includes the requirement and expectation that practitioners will formally challenge each other both within and between agencies if they believe that the agency is not responding appropriately to safeguarding concerns. (Buckinghamshire SCB, 2010, p 7, para 8.2)

> In order to ensure greater consistency for future serious case reviews the Doncaster Safeguarding Board should ensure that a programme of training is provided for senior officers who have the responsibility for endorsing and/or commissioning a review on behalf of their agency. (Doncaster SCB, 2010, p 9)

Current child welfare systems are in need of review or (39 out of 323 recommendations): where they are considered sufficient, they should be re-enforced (23 out of 323 recommendations). Where they are found lacking, new systems should be initiated (17 recommendations). Second only to training, however, professionals need to learn how *to share sufficient information* with one another so that the significant harm suffered by children not subject to Child Protection Plans is prevented (45 out of 323 recommendations). For example:

> South Gloucestershire Safeguarding Board should work with Avon and Somerset Constabulary to ensure there is timely and consistent information sharing. (South Gloucestershire SCB, 2009, p 11, para 4.7)

> Birmingham City Council – Housing Department to ensure effective information sharing between registered social landlords who provide housing to families subject to safeguarding concerns particularly when a family move to a new address. (Birmingham SCB, 2009, p 7)

Focus of recommendations to child welfare individuals and organisations only	**Total in sample (n=)**	**Case study source**
Professional training	56	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12
Information sharing between professionals	45	1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12
Review or audit current and existing practices/policies/procedures	39	3, 6, 7, 8, 9, 10, 11, 12, 13
Re-enforce current and existing practices/policies/procedures	23	2, 2, 4, 5, 6, 7, 9, 10, 12, 13
Initiate new system/procedure/policy	17	4, 6, 8, 11, 12
Supervision	16	1, 3, 4, 5, 6, 11, 12

FIGURE 6D Most frequently occurring recommendations in sample of 13 cases regarding situated activity of professionals or intra- or inter-agency collaboration

PART THREE: LEARNING TO PREVENT SERIOUS CASES OF CHILD MALTREATMENT

CASE STUDY 1: SCR6 (South Gloucestershire SCB, 2009)

> Without the historical knowledge concerning the bruising to child K it would be possible to conclude that the injury to child R could not have been predicted, as there were none of the major risk factors associated with abuse present in the family's life. However with full possession of the historical information a completely different picture emerges, one where the risk factors to both children, but especially to child R at such a vulnerable period of his life, could have been predicted and hopefully prevented. This review therefore concludes that if the indicators of abuse in child K had been recognised and appropriately acted upon then the injury to child R *may have been prevented*. (South Gloucestershire SCB, 2010, pp 10- 11, paras 3.12-14, emphasis added)

Child R's serious head injury and subsequent neglect by his father in seeking medical help *may have been prevented*. This conclusion rests on the availability of historical information regarding bruising to Child R's sibling in her first year, three years prior the critical injury to Child R, and professional access to and use of such recorded information. When professionals failed to avail of this recorded information, and consequently failed to analyse it in light of risks to any subsequent children born in the family, their engagement with Child R and Child K's family did not contribute to the child's positive outcomes but instead contributed to the child's negative outcome. The author contends that, had the professionals availed of historical information and analysed it in light of any subsequent children born to the family, professional engagement with the family would have contributed to Child R enjoying a beneficial outcome.

CASE STUDY 2: SCR16 (Buckinghamshire SCB, 2010)

> The root cause of the failure to address the needs of a child with a disability in a holistic way, which may have identified some of the risks to W seems to be the way in which social care services were structured and managed [...]. The root cause of the failure to assess risk to W lies in the lack of organisational

> understanding of the role of health and social care staff to build good relationships with service users within a framework of sceptical enquiry [...]. In addition, the root cause of the failure by Police to identify risk to W following the air rifle incident and to reduce the risk to mother from father to medium, lies in the lack of an integrated risk assessment model making sense of what high risk for adult perpetrators and victims means for children where domestic abuse is an issue. [...] The root cause of the injury to W lies in the behaviour of her parents and we do not know about the origins of that behaviour to go any further with this in this review. [...] The above analysis leads to the conclusion that the injuries and trauma experienced by W *probably were preventable*. (Buckinghamshire SCB, 2010, pp 5-7, paras 28-30, 32-34, emphasis added)

Although the review noted that "The relationship between her [Child W] and her mother was seen as positive and a good bond had been established" (Buckinghamshire SCB, 2010, p 3, para 6), Child W's parents' "behaviour" was the root cause of Child W's injury, which included assault and harm of her mother and aunt and being thrown by her father from a window to the ground, two storeys below.

The author identifies the absence of two particular devices which contributed to the collaboration of professionals and parents in the harm suffered by Child W. The first is 'a framework of sceptical enquiry', which professionals should employ while building good relationships with parents; the other is a model which might help police professionals analyse the degree of risk to which children are exposed in the event of incidents of domestic violence. The author contends that cultures of bold professional practice would have contributed to Child W being kept safe from harm. Presumably, this culture includes both professional engagement with children and their families as well as professional engagement with other professionals working towards a child's welfare. The statement does not describe practicable examples of boldness.

Although the review's author suggests that the structure and management of social care services contributed to the harm she suffered, Child W was not assessed either as a 'child in need' nor 'a child at risk of significant harm' at the time she witnessed her father assaulting her mother and aunt and was thrown from her window.

CASE STUDY 3: SCR19 (Bristol SCB, 2009)

> A study of the original overview report and individual management reviews, together with subsequent discussions and consideration, leads the second panel to conclude that Baby Z's death was *not predictable* but *may have been preventable*. The lack of *predictability* is based upon the fact that his mother had been caring well for him and staff are not aware of how to identify the effects of drug ingestion in children. The panel believes that the incident *was preventable* because: (1) there were sufficient concerns from the ward staff and drugs workers to merit a co-ordinated response to his care, and (2) his mother was facing considerable stress from April 2007 which was likely to lead to a relapse. (Bristol SCB, 2009, p 7, para 8.1, emphasis added)

The review's author makes a distinction between the predictability and the preventability of Baby Z's death: that Baby Z would ingest morphine and methadone could not reasonably have been predicted; however, Baby Z presented sufficient concerns to sufficient numbers of child welfare professionals to have qualified for adequately protective services. That Baby Z's death was preventable rests on an argument that there is a point at which 'sufficiency' of concern is satisfied and that, once reached, adequate services are provided.

The statement refers to Baby Z's mother's contribution both to his welfare and to his death. It also refers to the limited knowledge held by child welfare practitioners regarding the effects of drug ingestion in children but argues that professionals should have anticipated the consequences for Baby Z of the increasing stress experienced by his mother due to her care for a terminally ill friend.

CASE STUDY 4: SCR25 (Coventry SCB, 2009)

> The child's death was an accident [...] The child's death *could*, however, *have been avoided* if suitable adult care arrangements had been made. If a full assessment had been undertaken, the previous history had been fully considered or the wishes and feelings of the older siblings been fully considered a more accurate picture of their mother's limitations as a parent would have

> been clearer and a more comprehensive support plan might well have been in place. (Coventry SCB, 2009, p 2, emphasis added)

This review concerns an *avoidable* rather than preventable child death and argues that the necessary factors which would constitute an avoidable death are suitable care arranged by adults involved in the child's life and comprehensive collaboration between the child's mother and siblings and child welfare professionals, which would have revealed the mother's "limitations" as a person fit to care satisfactorily for the children concerned. The collaboration would have involved a full assessment of the mother and her children's circumstances, analysing the family's historical record and speaking with the child's older siblings. Once the mother's limitations had been accurately described, comprehensive support would have been provided to the family, thus *avoiding* the circumstances of the child's death.

CASE STUDY 5: SCR26 (Derbyshire SCB, 2009)

> None of the information known by child protection professionals or by the family at that time would have led to the prediction that Stepfather might commit a violent sexual attack. However, if information had been shared and all parties had been aware of Stepfather past history, his jealous behaviour and his tendency to aggression with drink, and had been able to discuss these openly and fully, the professionals and the family could have put in a *robust protection plan*. It is unlikely that Stepfather would have been allowed sole care of the children overnight, given his pattern of drinking. (Derbyshire SCB, 2009, p 6)

The review states that Child H's stepfather's violent sexual assault of a two-year-old child could not have been predicted. It does not state that it could have been prevented. However, it does argue that, had certain professional practices been undertaken and judgements made, then plans could have been made between professionals and the family that would have protected Child H robustly. I take 'robust protection' to mean that Child H would have been adequately protected from her sexual assault, and that this statement concerns the preventability of her harm.

The review points to three factors concerning to the relation between positive child outcomes – in this case, Child H *not suffering* a violent sexual assault while in the care of her stepfather – and the effective collaboration between child welfare practitioners and children's carers. The first is the acquisition of historical information relating to the stepfather, especially his history of convictions for violent offences (Derbyshire SCB, 2009, p 5). The second is the principle of sharing this historical information between the collaborators, namely the professionals concerned with Child H's welfare and her carers. The third are the conditions necessary for this information to be shared 'openly and fully'. This points to a relation between a child being protected from unpredictable harm and professionals and carers fully sharing information and concealing no relevant information from each other.

CASE STUDY 6: SCR28 (Rochdale Borough SCB, 2008)

> The review identified three significant missed opportunities to respond to the presenting needs of Child P which could have resulted in a more detailed assessment of her circumstances which may have *identified her as a child in need or a child at risk of harm*. The first instance was when Child P was noted to have a black eye by a GP and Health Visitor whilst visiting the surgery and they did not follow child protection procedures; the second instance was on the first occasion when Child P presented at hospital for examination she was seen by a doctor in Accident and Emergency rather than a paediatric specialist with greater knowledge of child protection, and the third instance was when her grandmother contacted Children's Social Care concerned about her welfare the Social Worker did not undertake an Initial Assessment. (Rochdale Borough SCB, 2008, p 4, para 1.1 emphasis added)

Child P's wellbeing was exposed to great risk following the end of her birth parents' relationship and her exposure to her mother's new partner. It appears that mother's new partner was physically violent towards Child P, a two-year-old child. In professional assessments, Child P's mother protected her partner rather than her daughter. However, Child P's extended family and father continued to express concern for her safety and sought collaboration with protective professional services in order to secure

her wellbeing. Ultimately, this collaboration secured Child P's safety. However, underestimating the extended family's concerns and accepting Child P's mother's explanation for her injuries continued to expose Child P to the physical violence she suffered by her mother's partner. Furthermore, Child P was inadequately assessed at the accident and emergency ward and on an earlier occasion when she had attended a GP surgery with a black eye.

CASE STUDY 7: SCR31 (Birmingham SCB, 2009)

> The parents did appear to be compliant with professionals but there was a failure to challenge and a willingness to accept their reassurances and excuses. This was despite repeated incidents of chronic neglect, and persistent inadequate parenting. The impact of two drug abusing parents caring for children was totally missed. Professionals failed to follow procedures, failed to intervene appropriately, failed to take effective action and thus the response to the obvious risks posed to the children was completely inadequate. It is therefore concluded that the death of the child could have been *prevented* and the probability of harm being caused to the child and the siblings could have been *predicted*. (Birmingham SCB, 2009, p 5, emphasis added)

The review's conclusion that the child's death was preventable rests on the observation that assessments of the children, collaborations with the children's parents and work to secure the children's welfare were all "completely inadequate" (Birmingham SCB, 2009, p 5). The statement of preventability goes some way to describe what might constitute an 'adequate' response: a professional unwillingness to accept parents' reassurances and excuses and a preference to challenge them instead; an understanding of the impact drug use has on those parents' care of children; following procedures correctly; intervening appropriately; and taking effective action. This adequate response encompasses collaborative activities between the child welfare practitioners and children's parents and carers as well as those between the child welfare professionals, all of which aim towards achieving beneficial outcomes for children's wellbeing. This adequate response takes place in collaborative activities with apparently compliant parents.

CASE STUDY 8: SCR37 (Doncaster SCB, 2010)

> The panel concluded that the assault was *a preventable incident*. Although the extent and severity of the assault could not have been predicted, the perpetrators had shown an escalating pattern of violence against other children and adults over a period of several months. There were opportunities to intervene more effectively right up to the week before the assault. (Doncaster SCB, 2010, p 5, para 6, emphasis added)

The review focuses on the 'J' children, two brothers exposed to domestic violence and neglect and whose access to adequately protective services was thwarted by uncooperative parents. Unlike all of the other case studies examined in this chapter, this review focuses on the preventability of the harm *caused by* the subjects of the serious case review, rather than the preventability of harm suffered by the subjects of the review. This is a significant distinction: the review does not examine whether or not the harm suffered by the 'J' children was preventable, even though it comments on the inadequate professional engagement on the children's behalf. Rather, the review's focus is whether or not the assault perpetrated by abused children could have been avoided. In other words, was the harm suffered by children not subject to this particular review – that is, the two victims of 'J' children's assault – preventable?

Consequently, it is difficult to determine precisely the review's subject. It examines the harm caused by one group of children, two brothers referred to as 'J' children, nominally the review's subjects. Its contribution to professional learning about preventing future harm to children, on the other hand, concerns the harm suffered by two different children, whose previous lives are otherwise left unexamined by the review.

The statement of preventability highlights the fact that the 'J' children were presenting to professionals as increasingly violent to others and that professionals should have anticipated how much more this violence could increase, and who would suffer on account of it. This anticipation – and subsequent appropriate intervention –would have prevented the 'J' children from violently assaulting two boys. Would anticipation of the boys' assault on two other children have represented an authoritative intervention in to

the lives of the 'J' children themselves, and resulted in adequately protective services being discharged to them? Perhaps the scale of violence perpetrated by children on other children distracted the review's focus on the perpetrators' own experiences of harm, resulting in its failure to comment on how the harm suffered by the 'J' children might otherwise have been prevented, and then relating these preventative interventions to prevention of the Edlington attack.

CASE STUDY 9: SCR39 (Bedfordshire LSCB, 2010)

> The sexual abuse perpetrated against Child J could have been avoided if basic critical and sceptical thought had been given by professionals to the obvious warning signs, not least the constant pleas from the father of the child to remove the danger from their home. (Bedfordshire LSCB, 2010, p 3, para 1.2.6)

The review argues that professionals were presented with 'obvious warning signs' regarding the risk of significant harm posed to Child J by her primary carer, her mother's partner. These warning signs included the partner's past convictions for paedophile behaviour in addition to his subsequent unsupervised access to Child J and her father's pleas. Nevertheless, children's social care assessed Child J as a 'child in need' and provided services proportionate to this assessment, which aim to support the child and family, rather than investigate suspicions that the child is suffering significant harm. Consequently, Child J never did receive adequately protective services and endured at least two years of daily serious sexual abuse. Adequate protection in this case required 'basic critical and sceptical thought' to be applied to the obvious warning signs. Preventing Child J's significant harm and securing her safety required collaborative activities between professionals and Child J's extended family.

CASE STUDY 10: SCR42 (Herefordshire SCB, 2010)

> Before these children were accommodated [following the revelations of abuse and neglect], very little was ever discovered by professionals about the maltreatment they were suffering, yet the evidence gathered for this Review has

> revealed that there were opportunities to have done so. There were many signs and indicators which should have led professionals to carry out *full enquiries and investigations* and to give the children a safe and trusting environment in which to report what was happening to them. (Herefordshire SCB, 2010, p 4, para 1.2.10, emphasis added)

This case does not state explicitly that the harm to Child HC could have been prevented. Rather, it argues that professionals were in possession of sufficient evidence to accurately assess Child HC's needs by undertaking 'full enquiries and assessments', despite hostility and manipulation by the children's carers. I take this to mean that, had professionals undertaken full enquiries and assessments, then the harm to Child HC and his siblings could have been prevented.

This case highlighted the fact that the child subject to SCR had, for much of the time that the child welfare professionals collaborated with him and his family, been seen as *a cause* of significant social problems within his family and neighbourhood. In other words, the child who was at risk of suffering significant harm and whose actual suffering harm was apparent to neighbours and should have been apparent to professionals was assessed, instead, as a source of problems to his carers and neighbours, especially in terms of anti-social behaviour. Consequently, Child HC did not receive appropriately protective services until *after* he had been accommodated in another family. Until that time, professional collaborations with his family had resulted in HC enduring negative welfare outcomes. The review records that professionals were manipulated and their efforts subverted.

Professionals were presented with sufficient 'signs and indicators' to change the nature of their interventions away from trying to change Child HC's anti-social behaviour towards an adequately protective intervention for Child HC and his siblings. These signs included neighbours' concerns for the children's abuse and neglect and parental manipulation and hostility, in addition to the neglected physical presentation of the children. The professionals had failed in their collaborations to discover much at all about the daily lived experiences of the children, and the review comments on how the professionals concerned ought to have provided a particular kind of context in which the children could have indicated the harm they were suffering, one which was built on

'trust' and guaranteed their safety. This context was finally provided when the children were accommodated with foster parents. However, the review suggests that this context should have been designed and built by professionals working with the children while still living together with their carers.

CASE STUDY 11: SCR46 (Blackburn with Darwen LSCB, 2009)

> The Review was clear that this tragic outcome was not inevitable. The Review has demonstrated that at different times, different decisions or actions, or the takings of actions, or the taking of decisions or actions which were absent at the time, may have led to an alternative course of events. (Blackburn with Darwen LSCB, 2009, p 7)

The review observes that Child A's life involved, from a young age, "disruptive and traumatic events" (Blackburn with Darwen LSCB, 2009, p 7). Child A spoke about and attempted suicide before she hanged herself. The review argues that Child A's suicide was *not inevitable*, and an alternative outcome was possible. This suggests that professionals working with Child A and her family had options available to them which, had they be taken, could have led to an alternative and less tragic outcome for Child A. Similarly, professionals working together to design interventions on her behalf – and in Child A's case, this included mental health, Connexions, schools, housing services, Youth Offending Teams and two Local Safeguarding Boards – had alternative decisions and actions available to them which, had they been chosen, may have constituted an effective intervention, preventing her death.

CASE STUDY 12: SCR48 (Redcar and Cleveland SCB, 2010)

> The overall conclusion is that if effective action had been taken during the work prior to the period of this SCR [i.e. five-year period prior to Mary's allegation of rape] and John [mother's partner] had been prevented from having contact with Mary and her half siblings both before and during the period of this SCR, Mary's

> abuse *would have been prevented*. (Redcar and Cleveland SCB, 2010, p 13, para 4:1, emphasis added)

The review argues that, had the agencies involved in protecting the public from the risk posed to it by John performed their role adequately, then Mary would not have had any further contact with the man who raped her. By failing to prevent John from returning to Mary's family, the protective mechanism of MAPPA (multi-agency public protection arrangements) failed. Preventing John from returning to Mary's family would have prevented John raping Mary. This preventative work, including the transfer of information between the local authorities where Mary and her family lived at different times, is the review's statement's "effective action".

CASE STUDY 13: SCR50 (Birmingham SCB, 2009)

> This case illustrates the complexity of dealing with a large family with a large number of children born in consecutive years at the same time recognising the needs of the children as individuals rather than the overall needs of the family. This serious case of neglect *was preventable*. (Birmingham SCB, 2009, p 4, emphasis added)

The review argues one acknowledged barrier to effective collaboration with the child's parents was the complexity of needs – children's needs, parents' needs, family needs – presented by a family which added a new infant child to its number each year for almost nine years. Each infant child and the growing siblings each required routine assessment and intervention by universal health services. Yet the children's mother's struggles with mounting responsibilities and needs compromised the effectiveness of such routine welfare intervention and challenged professional reluctance to intervene less supportively of the children's mother and more strongly on behalf of the children's welfare.

Nevertheless, the review argues that professionals and the children's parents could have collaborated to such an extent that the children's needs – and it appears their physical needs for food and adequate shelter predominated professionals' concerns – could have

been met and their neglect prevented. Without a more detailed account of the nature of this preventability, it must suffice to consider that preventability must rest in professionals' ability to engage with children and families in such a way that collective and individual needs can be distinguished, and the needs of the children (collectively and individually) be prioritised.

SUMMARY

Part One presented the very basic narrative of each of the 13 cases. Part Two presented what each case's author recommended should be learned from each case. Across all 13 cases, 323 recommendations are made. It was demonstrated that the sites of learning recommended by authors are the discrete working places of professional child welfare services and individuals. Part Three's review of SCR authors' justifications that a child's maltreatment could have been prevented illustrates that the primary site for learning how to prevent children not subject to Child Protection Plans from significant harm is the collaboration of child welfare professionals, children and the children's families. In other words, what needs to be learnt from SCRs of children not subject to Child Protection Plans may include the finding that preventative actions and decisions are most effective when they occur in collaborations with children and families.

It is apparent in the highlighting statements that the preventative action to be taken is not solely the responsibility of child welfare professionals. At times parents are identified as capable of undertaking the necessary action to prevent children suffering maltreatment. However, for the greater part, the 13 cases indicate that collaborative actions between children, families and professionals together are the site of preventative action. This implies that learning from SCRs is a collaborative action between children, families and professionals together and that learning transfers from published SCRs to situated activities of child welfare practice, rather than to the actions plans drawn up by LSCBs following a SCR. Yet the primary recommendation (or, *lesson to learning from*) is that professionals require further training.

CHAPTER SEVEN

DISCUSSION AND CONCLUSIONS

The purpose of this thesis has been to problematize the concept of learning. Primarily, the thesis intends to improve evaluations of the concept's contribution to the claim that learning from serious case reviews (SCRs) can help to prevent children suffering serious or fatal maltreatment. Historically, 'good practice' in reviewing serious cases included adopting a dissemination–implementation model of learning (Ofsted, 2011b). However, the quality of SCRs has been questioned by an independent panel of experts (DfE, 2014) and the recurring maltreatment of children is cited as evidence that child welfare professionals are failing to learn from published SCRs.

The current statutory guidance for safeguarding and promoting children's wellbeing and child protection (HM Government, 2013) has responded by indicating the government's willingness to admit "any learning model" (HM Government, 2013, p 67, para 11) to be adopted by Local Safeguarding Children's Boards (LSCBs) in order to raise the standard of review and possible learning. The conditions set on such a model include the statutory guidance's own principles for learning and improvement (see HM Government, 2013, pp 66-67, para 9).

In order to support LSCBs and policy makers in the development of an effective learning model, this thesis chose to focus its attention on *learning* especially, rather than data of serious child abuse or claims that its prevention was a rather unproblematic matter of simply reading published examples of SCRs and implementing their findings into local contexts. The reason for doing so is that the SCR literature has not yet addressed learning as a concept despite it being the crucial pivot on which the purpose of reviewing serious cases hinges. To give two examples: first, by permitting any learning model to be adopted, the statutory guidance (HM Government, 2013) offers no support to LSCBs in anticipating the necessary choices and trade-offs that come with developing an effective model that attempts to grapple effectively with the ambiguous nature of what learning actually is; second, although the national panel of independent experts'

own sketch of what an effective SCR should look like includes references to learning points and learning lessons, it does not include any theoretical, empirical or practical reference to the concept of learning's meaning itself (see DfE, 2014, p 8, para 28).

Chapter Three's review of perspectives on learning demonstrated that the concept of learning encompasses a wide range of social and cultural activity. For example, a monologic perspective assumes that learning is the cognitive acquisition of knowledge, which individual human minds collate and interpret to form structures of understanding and meaning. A dialogic perspective claims that knowledge only has meaning within a situated context and is actively constructed in relationship between human cognition and the material, social environment of which it is only one part. A trialogic perspective is concerned that both monologic and dialogic perspectives focus too simply on the reproduction of knowledge and culture and fail to account for the production of new knowledge. Those who hold the trialogic perspective argue that the 21st-century is a knowledge creating civilisation and that our focus on learning must account for humans' ability to fashion new solutions to wicked societal issues.

This thesis framed the next step as one of understanding the transfer of learning. Serious case reviews imply that the seeds of new knowledge (that is, the know-how to prevent the serious maltreatment of children) lie in old knowledge (that is, retrospective accounts of apparent failures of child welfare practice to assess children's lives adequately and formulate sufficiently protective professional partnerships). Serious case reviewing assumes that learning about historical cases transfers to current or future child welfare cases and makes a robust and effective contribution to intervention design. In short, one implied outcome of serious case reviewing is to support a new professional activity of serious case previewing.

This thesis noted that cases that qualify as sufficiently 'serious' for review are characterised by their equifinality – what each case shares is an acutely negative and tragic outcome for an individual child or children and in some cases concern about the interactions of professionals with the child and family. There is no other criterion for inclusion; understandably, the possible variety of interacting contributory factors that led to that outcome is vast. Nevertheless, given that the purpose of SCRs is to prevent

serious maltreatment, learning from apparent child welfare disasters is expected to transfer to cases that do not (yet) qualify as sufficiently serious to warrant being formally reviewed (other than by existing supervision and line management processes).

Serious case reviews and any learning model currently appear to take for granted that one characteristic of learning is its transfer across profoundly complex sociocultural domains. This thesis has argued that the transfer of retrospective learning to prospective professional action in many diverse cases requires a transfer of learning across multiple orders of time (past, present and future). Learning is expected to transfer across places, from one local authority (or only some addresses within that authority) to any other local authority, and from one child's private life to another child's private life. Learning transfers from specific children (the subjects of the review) to other children (not yet subject to review). Transfer occurs across service levels of intervention and prevention, and inter- as well as intra-agency organisation. Despite the complexity of this assumed transfer, LSCBs are not provided with any support to understand whether or not learning is a sufficiently stable concept to warrant the claim that learning about cases and learning from them supports efforts to prevent the occurrence of serious child maltreatment.

Chapter Three reviewed accounts of learning transfer within the each of the three presented perspectives on learning. Learning transfer appears in the literature as a tricky issue. On the one hand, the monologic perspective depends on the metaphor of transmission to explain the consequent acquisition of knowledge. On the other, it is argued that learning transfer understood in this way accounts for only a very restricted view of the other possible ways that prior learning is interpreted and deemed relevant for application to current pressing issues and problems. Furthermore, the situated characteristic of knowledge and knowledge evaluation has difficulty in articulating the transfer of knowledge across situations, since the situations themselves constitute knowledge, rather than the other way round.

This thesis presented a range of metaphorical explanations of transfer or alternative to the transfer concept; for example, transmission, productive knowledge, authoritative, accountable positioning, principled practical knowledge, consequential transitions,

continuous progressive (re)contextualisation and codified, mobile knowledge (see Beach, 1999; Bereiter, 2014; Greeno, 2006b; Van Oers, 1998; Hatano and Greeno, 1999; Kanfer et al, n.d.). In order that LSCBs proceed to develop an effective learning model for SCRs, there must be a robust account and explanation of that model's ability to support either the transfer or otherwise of learning across a wide range of personal, public, temporal, spatial and organisational domains.

How might the development of an effective learning model proceed? Although historically a dissemination–implementation model of serious case reviewing was adopted, one principle of learning and improvement of the current statutory guidance

> seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight [and 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 (HM Government, 2013, pp 66-67, paras 9, 10)

On the one hand, to seek to articulate temporally constituted professional vision suggests that any learning model would take a situated perspective regarding professional knowledge; on the other hand, the expectation that retrospective accounts of situated knowledge 'impact' effectively in current practice demands an explanation of transfer of some kind. A model must successfully transform *learning about* cases into *learning from* cases so that professionals and organisations *learn how to prevent* the serious maltreatment of children.

In order to grapple with this difficulty of learning, this thesis adopted Goodwin's (1994, 1995, 1996) anthropological theory of professional vision. According to this theoretical perspective, 'seeing' social phenomenon in discrete professional practice domains is constituted by historically developed and mutually adopted coding schemes, in order to allow professionals separated in space and time to compare findings and the contribution of their knowledge to the advancement of their particular profession. The practice of highlighting guides professional perception towards only particular aspects of a fully complex field of vision so that salient aspects of it become the focus of intent

professional work. Finally, Goodwin (1994) argues that coding and highlighting is embodied in graphic representations of the professional perceptual field, such as maps of archaeological excavation profiles.

Chapter Five adopted Goodwin's (1994) theory of professional vision in order to organise its methodological approach to 13 'crucial' cases, chosen from published executive summaries of SCRs. These 13 cases were considered 'crucial' since they each comprise an identifiable account of *learning about* a case (the chronological narrative), *learning from* a case (the recommendations made) and *learning how to prevent* the serious maltreatment of children (in a statement made from the perspective of the author of the SCR in light of retrospective analysis). Since SCRs comprise 'cases' on account of their equifinality and therefore do not map easily onto current and future instances of professional child welfare casework , it is not possible to suggest that in-depth examination of cases use familar case study approaches. When we learn about serious cases, it cannot be taken for granted that we are learning about current casework. As Weick (2002) pointed out, given the highly selective choices made in presenting a chronological narrative of historical serious cases, the lessons to be learned may never have happened.

Given this methodological difficulty, the ability of Goodwin's (1994) theory to offer next steps in articulating how temporally situated professional vision can transfer across temporal and spatial domains offered grounds for the organisation of the 13 cases so that a better evaluation could be made of the claim that SCRs contribute to the prevention of serious child maltreatment. The thesis 'coded' SCRs according to a statistical 'key finding' that emerged from published evaluations of samples of SCRs: that a significant number children who suffered serious maltreatment did not necessarily present to professional assessment as at risk of suffering significant harm. Some of course did, and were subject to formal Child Protection Plans at the time that they suffered the critical episode of maltreatment. However, given the legislative duty to investigate suspicion of child maltreatment (under Section 47 of the 1989 Children Act), the significant number of children not subject to protective plans that subsequently suffer maltreatment suggests that an appropriate focus of learning is how to assess the

features of their private lives in a sufficiently holistic way that maltreatment is prevented.

This coding enabled the thesis to present summaries of each case's chronological narrative and the sample's recommendations as a whole in order both to learn about these cases and learn from them. Review authors' statements that the cases were, to a greater or lesser extent, preventable or not inevitable, highlighted what was considered professionally salient in learning how to prevent the recurrence of such child maltreatment.

The 13 cases, however, do not share a professionally constituted material representation of the prevention of child maltreatment. Given the place of material representations of professionally salient phenomena to the constitution of a particularly professional practice of seeing (Goodwin, 1994), is this significant? Chapters Two and Four of this thesis presented a number of graphic representations of child welfare practice. Chapter Two illustrated how the apparently simple goal of supporting children's needs via the Common Assessment Framework's holistic approach, embodied in national government literature, was, in practice, a complex, interactive series of choices and trade-offs embodied in the example of a single local authority's CAF procedural guidance.

Chapter Four's models each illustrate professional learning at a particular level that expanded the statutory guidance's focus on individuals and organisations only. Horwath (2001, 2007) represented a model of individual practitioner change when learning when and how to adopt a new statutory assessment tool. Anning et al (2010) illustrated the situated explanatory models of interdisciplinary teams that guided their engagement with issues of childhood. Morrison (2010) represented the possible ways that bodies responsible for the strategic leadership of practice, such as LSCBs, can learn from practice outcomes, and highlighted that emphasising reflective-engaged learning at both the level of systems and individuals rather than emphasising compliance with established procedure presents opportunities for positively modifying practice outcomes. Munro's (2010) graphic of double-loop learning articulated her goal that the child protection system can learn how to reflect on feedback from the frontline of child

welfare practice in order to adapt the targets it sets in light of information about the individualised and unique features of frontline interactions between children, families, professionals and services.

It emerged that these graphic representations were grappling to articulate the contribution of children and families to professional learning. Horwath's (2001) professionals found that their learning 'lapsed' when their newly acquired skills came face to face with complex practice situations. Although one remedy was to offer further training, Charles and Horwath (2009) have already acknowledged that there is scant evidence to support the contribution of training to professional learning. Morrison (2000) acknowledged that an appropriately 'therapeutic partnership' with children and families was characterised by children, families, professionals and services working and learning together. However, his model (Morrison, 2010) of reflective-engaged strategic learning failed to articulate how authoritative, reflective practice on the part of individual professionals was constituted within effective partnerships of mutual learning. Munro's (2010) model of reflective and adaptive learning drew a distinct relation between frontline experience and systems-level change. However, it could not articulate how subsequent systems-level change would feedback beyond the frontline to effect positive reflection and adaptive learning within children's experiences of private lives.

These current examples of professional learning models indicate that it is likely that 'any learning model' that supports learning transfer from SCR situated activity of child welfare practice in effective partnerships with children and families will need to articulate how it will incorporate learning with children and families and the transfer of learning to children's private lives. For example, how might the incorporation of a third balancing loop to Munro's (2010) double-loop learning enable child welfare practice to consider seriously the concrete impact of learning in partnership from the perspective of children's and families' learning? Currently, the statutory guidance includes the following principle within its learning and improvement framework:

> 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. (HM Government, 2013, pp 66-67, para 9)

Given the methodological difficulty of assuming the transfer of learning from equifinal serious cases to cases not (yet) subject to review, it may be reasonable to invite children and families, not subject to review but sufficiently engaged in learning with child welfare professionals to contribute either to reviews or to activities that promote *learning from* published reviews. In that way, children *currently* being served by child welfare practices are at the 'centre of practice' and not only children subject to review. In this way, an attempt may be made to dissolve the bias absorbed from the current under-reporting of child maltreatment and embodied in risk assessment tools, statistical presentation and SCRs themselves, and help to bridge the gap between learning from SCRs and fully learning to prevent the maltreatment of children who do not present to professional assessment as at risk of experiencing significant harm (see Munro et al, 2014; see also Kenny et al, 2008; Wurtele and Kenny, 2010).

An example from the organisational learning literature (Weick, 2002, 2007) suggests one possible model of how this might occur. Weick (2002) is concerned to learn how to prevent the deaths of wildland firefighters, especially those who are found to have died with their tools beside them, and who

> In every case, […] died within sight of safety zones that could have been reached if they had been lighter and moved faster. (Weick, 2007, p 6)

Weick (2002) frames the issue as one in which firefighters need to learn how, why and when to drop their tools in order to adapt firefighting and survive. He quotes Lao Tzu (cited in Muller, 1999) in order to introduce the principle supporting the possible learning model he proposes:

> In pursuit of knowledge, every day something is acquired; In pursuit of wisdom, every day something is dropped. (Weick, 2002, s 15)

In his work, Weick (2007) explores a number of possible reasons why the firefighters who lost their lives failed to drop their tools as fire threatened to engulf them. Problems with hearing, trust, control, physical well-being, and calculation are explored as possible

explanations. Also, it may be that seeking the fire shelter is an even greater risk at the time than continuing to fight the fire, and may even be perceived as failure. Social dynamics may also explain why firefighters choose hold onto rather than drop their tools since, by persisting in holding on to tools, no firefighter is communicating possible doubts or fear to any others.

He also suggests that the value placed by firefighters on their tools discourages them from jettisoning their tools when the commanded strategy is to drop those tools. Another reason may be professional identity:

> it is perhaps oddest of all to imagine that the firefighters didn't drop their tools because they didn't think of their tools as separate from themselves. […] These tools are designed solely for firefighting, and their skilful use is the mark of a seasoned firefighter and central to that person's identity. (Weick, 2007, p 7)

When attempting to organise learning from such disasters, Weick (2007) argues that it may be an error to assume that learning about the assessments that firefighters made of the situation at the time can be mapped easily to firefighters' current assessment skills of fires and of fires they have yet to face. In fact, learning about assessments made at the time may in fact preclude learning from those situations to improve current practice. Weick (2007) argues that there is a danger in treating such knowledge as an acquisition and a personal property, which gets in the way of learning about a fire that a firefighter is currently fighting. Instead, Weick (2002) prefers 'public sense-making' to 'assessment' as a vehicle for learning to act wisely in acutely complex and rapidly changing situations. He offers the following five-part protocol that is being used increasingly by chiefs of firefighting crews to offer direction:

> Here's what I think we face;
>
> Here's what I think we should do;
>
> Here's why;
>
> Here's what we should keep our eye on;
>
> Now talk to me (i.e. tell me if you (a) do not understand, (b) cannot do it, (c) see something I do not. (Weick, 2002, s9)

Such a protocol, rather than an assessment tool, Weick (2002, 2007) might argue, fosters the kind of learning that would support Morrison's (2000) 'therapeutic relationship' and Munro's (2010) 'double-loop learning' that see vulnerable children enjoy positive rather than tragic outcomes.

The reasons that Weick offers include the following (see Weick, 2002, ss 9-10). First, the protocol provides direction and encourages updating through feedback from 'the frontline' (Munro, 2010). Second, it fosters respectful interactions that allow people to build a stable rendition of what they face (following Morrison's, 2000, 'therapeutic relationship'). Importantly, however, the protocol *animates people* and gets them "generating experiments that uncover opportunities", opening up the possibility of producing knowledge that liberate them from the current situation (Bereiter, 1997). What Weick's (2002, 2007) work suggests is that professional identification with skilful use of assessment tools and knowledge acquired at the frontline can in fact inhibit learning. Public sense-making with children and families, on the other hand, in a form such as that provided in the firefighting crew chiefs' protocol, may indicate a site of learning where *learning from* can begin to inform preventative actions, and where the agility and lightness that result from dropping one's tools enable children and professionals to choose safety rather than suffer the consequences of identification with tools and lack of familiarity with more beneficial alternatives.

A second possibility in progressing efforts to produce a learning model comes from the use of imagery in the learning sciences. Schwartz and Heiser (2006) argue that imagery is particularly relevant to issues of learning since

> people easily see what they have learned, yet they can completely overlook what they have not. Consequently, people often believe they perceive all there is to be seen in a situation. (Schwartz and Heiser, 2006, pp 284-85)

This argument suggests that professionals situated either in interactions with children or families or in inter- or intra-agency organisations are at risk of seeing and envisaging only what their experiences of learning have trained them to see, and are not necessarily in a position to generate those new possibilities that Weick's (2007) public sense-making protocol is designed to generate. Schwartz and Heiser (2006) suggest that

the use of imagery (including graphic representations) can support learners to imagine alternative ways of perceiving situations.

They identify four properties of perception that are particularly relevant to learning: effortless structure, determinism, perception action coupling, and pre-interpretation. According to Schwartz and Heiser (2006), these properties are ubiquitous and do not in themselves need to be learned. The 'effortless structure' of imagery supports learning since spatial representations "do not require intensive cognitive effort to manage" (Schwartz and Heiser, 2006, p 285).

Determinism is valuable since it prevents learning proceeding vaguely:

> People can say "the tree is next to the bush" but this statement is vague about exactly where the tree is. In contrast, vision is not vague; the tree is perceived as being in front, behind, left, or right of the bush. (Schwartz and Heiser, 2006, pp 285-6)

Coupling perception and action contributes to learning since images enable people to imagine the consequences of actions. Schwartz and Heiser (2006) argue that this is particularly important since it is essential that people imagine spatial changes or movements that they can accomplish in reality (2006, p 287).

Finally, the pre-interpretative property of imagery prevents current knowledge distorting the full range of possibilities embedded in situations, since the learner's perception of an image "often occurs prior to one's beliefs or knowledge about a situation" (Schwartz and Heiser, 2006, p 287).

Schwarz and Heiser (2006) suggest that these ubiquitous properties of imagery can be adapted to help situated humans go beyond experience and knowledge to create innovations in thought, since imagery, for example, can help people to move shapes into new configurations relatively easily compared to actual concrete practice. They cite the example of Finke (1990), who asked people, first, to imagine the letter 'C' and the letter 'J' and then, second, to imagine rotating the 'C' so it was on top of the 'J'. When asked what they saw, people often said an umbrella.

> Though people had not started with the idea of an umbrella, it emerged from the reconfiguration of the shapes in their imagination. (Schwartz and Heiser, 2006, p 293)

In addition to new configurations of the familiar, imagery is also capable of covariant spatial representations. Importantly, such representations *do not resemble* their referents. For example, a clock does not look like time. However, changes in time map neatly onto the changes displayed in the dials (see Schwartz and Heiser, 2006, p 294 for discussion). Covariant representations make it possible to represent non-spatial phenomena in spatial form.

I have chosen to incorporate Schwarz and Heiser's (2006) recommendation of imagery as a useful tool in learning as a contribution to the possibility that 'any *effective* learning model' may, in fact, be a graphic representation that supports child welfare professionals' vision to imagine alternative possibilities in current casework, in light of learning from SCRs. In other words, imagery may make it possible to transform serious case reviews into serious case previews. When examining the transfer of trialogic learning, Chapter Three noted Bereiter's (1997) claim that humans' situated ability to produce abstract knowledge enables them to overcome the situatedness of their understanding and solve problems in another situation. First, humans must "create symbolic representations of situations" and then must "carry out operations on those symbols" (Bereiter, 1997, p 291). Were an image capable of abstractly representing salient features of discrete professional child welfare work, it may enable professionals to recontextualise learning from SCRs with learning about current cases in order to envisage a fuller range of possibilities for action. For example, I have produced the following Venn diagram to represent covariate situations of children's and families' private lives and professional public child welfare service (Figure 7A). Their overlap represents the frontline situation. The lines indicate possible directions of learning transfer including learning from historical reviews of serious cases.

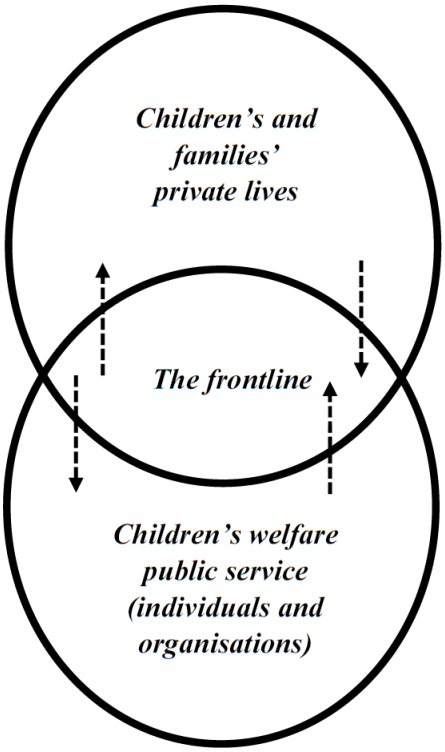

FIGURE 7A Possible use of imagery to produce a graphic representation of professional vision in child welfare interactions, with lines indicating possible routes of learning transfer or alternatives

Chapter Five noted that current SCR learning models neither provide nor produce the kind of graphic representations that Goodwin (1994) argued constituted spatially and temporally distributed professional vision, such as the excavation profile maps produced by archaeologists and which can be shared with other professional archaeologists present and not present at the excavation site itself.

It may be that 'any learning model' developed by LSCBs is a graphic representation that embodies those fundamental categories of situated practice that professionals and organisations consent to represent relevant sites of professional learning and practice, and which remain relatively stable across time. This framework may provide that 'perceptual architecture' (Goodwin, 1994) that would enable professionals to learn from historical cases in order to develop a collectively recognisable, shared vision in current cases of a serious case *preview*.

Munro et al (2014) recently advocated the use of 'INUS pies' as "pedagogical tools" with child welfare students or newly joined or newly graduated members of the professional child welfare workforce to support their ability to understand the inter-relationships of possible risk factors of child abuse in particular groups in particular contexts, which do not transfer across to other groups and other contexts (see Mackie, 1965) (Figure 7B). The pie illustrated below is an example of what Mackie (1965) would call a sufficient condition, rather than cause, of child abuse, for a perpetrator characterised by the pie's slices in that particular context.

Munro et al (2014, p 68) also noted their possible use as a "communication aid with families, in assisting discussions about risk and protection".

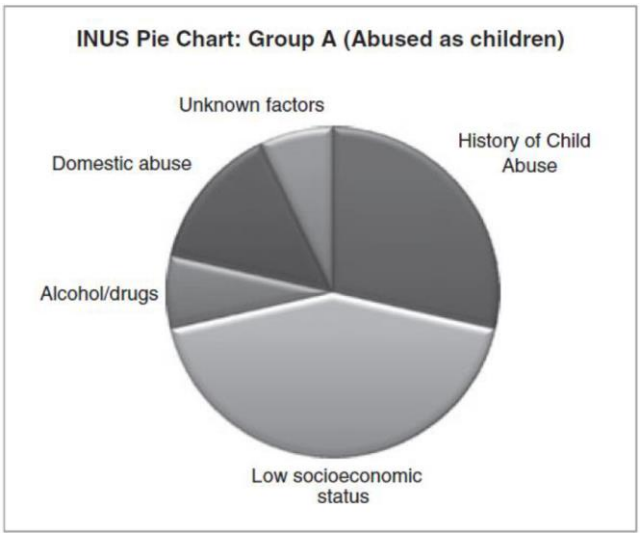

FIGURE 7B 'INUS pie' used for education of newly qualified practitioners (from Munro et al, 2014, p 68, fig 1)

The aim of this thesis was expressed in Chapter One with reference to the Toulmin (2003 [1958]) model of argument (see Figure 1A on page 14). First, the model structures the argument embedded within the statutory guidance, *Working Together to Safeguard Children* (HM Government, 2013) as follows: SCRs (*data*) can prevent the serious maltreatment of children (*claim*) when their lessons are learned by individuals and organisations utilising any learning model consistent with the guidance's principles of learning and improvement (*qualifier*). The aim of this thesis is to examine in closer detail

the extent to which a fuller account and deeper understanding of learning warrants this claim. In brief, the research presented in this thesis indicates the following:

- The *data* of SCRs requires of 'any learning model' the ability to accommodate the diverse factors that constitute SCRs beyond the equifinality of children's significant and at times fatal maltreatment. These factors include the interactions between children, families and professional child welfare organisations in addition to the unique characteristics of the individuals and organisations involved, their operations, team structure, strategies and systems. The retrospective emphasis of the reviewing process also requires of any learning model an ability to transform lessons generated through professional hindsight into productive actions dependent on professional foresight through the formulation of serious case previews. This transformation indicates that effective serious case reviewing requires attention to be paid not only to learning but to its transfer across a range of domains.

- The *warrant* that a fuller account of learning is necessary strongly suggests that the current dissemination–implementation model of SCRs represents only a very minimal interpretation of the available learning theory and that serious case reviewing would do well to engage critically and constructively with theories of learning and learning transfer in order to achieve its necessary goal of transforming retrospective analyses of apparent professional failure into prospective actions that successfully prevent children from suffering significant harm.

- The *qualifier* that any learning model consistent with the principles of learning and improvement with the statutory guidance (HM Government, 2013) is sufficient also overlooks the likely choices and trade-offs necessary in the formulation of an *effective* learning model based upon learning theory that accounts for the learning beyond professional individuals and organisations to include children and families, as well as operations, team structure and purpose, strategic leadership and child protection systems, through transfers of learning

that may be characterised diversely by knowledge acquisition, practice participation and authoritative positioning and knowledge building, for example.

Importantly, the research presented in the thesis to develop a fuller account of the warrant does not itself constitute a *rebuttal* to the claim. The explanation for this lies in the fact that serious case reviewing (and professional learning from tragic cases more generally) has not yet drawn from the full wealth of possible development made available through learning theory. It may yet be the case that the *claim* to prevent children's maltreatment on account of SCR lessons being learned by means of a learning model developed in line with robust theories of learning and learning transfer is a good, well-warranted claim. At best, however, the current dissemination–implementation model praised by Ofsted (2011) represents the minimal articulation of any such learning, and one which is at times accused of inadequacy.

The thesis employed Goodwin's (1994) theory of professional vision to better understand the dynamics of a model of learning that would transform serious case reviews into critical serious case previews. It was noted that graphic representations that constitute professional vision (according to Goodwin's theory) are currently absent from any model of SCR learning. Earlier, Chapter Three had suggested that Bereiter's (1997) argument in favour of abstract symbolic representations of learning may support the necessary transfer of historical, retrospective learning into future-oriented preventative action. This chapter has suggested two possible and initial routes of development, namely public sense-making protocols and imagery. The thesis strongly recommends that the effectiveness of such abstracted representations of historical knowledge for the purpose of improvising serious case previews that indicate robust here-and-now preventative actions is dependent on their inclusion of children and families' engagement with learning from SCRs, given that current learning models appear to sidestep consideration of children's and families' own positions as learners, situated at the heart of child welfare practice but also situated beyond its reach in the context of their private lives. This perspective, focusing on the identity of the learners addressed by 'any learning model', and unlike the warrant's focus on learning alone, *constitutes a rebuttal* to the argument of the

current statutory guidance. With reference to Figure 1A (see page 14), this thesis argues that, since a fuller account of learning and learning transfer may enable a learning model to be devised that sees individuals and organisations learn lessons from SCRs that prevent children suffering serious maltreatment, its argument is warranted *on the condition* that such a model positions children and families as valid learners, capable of engaging at the level of frontline interactions with professionals, their operations, teams, strategies and systems and at the level of their own private lives. 'Any learning model' must seek the engagement of children and families with abstracted symbolic representations of learning such as protocols and imagery in order to produce serious case previews capable of transforming historical analyses into the prevention of children's maltreatment within the spheres of their private lives. Unless this condition is met, the claim does not hold.

In conclusion, this thesis has indicated that learning as a concept in itself does not yet support the claim that SCRs can prevent the serious maltreatment of children. The reasons for this include the following arguments:

- *learning* has been assumed to be a uniform concept and has been insufficiently problematized given the debates in educational, sociological, ethnographic and organisational literature about its meaning and contribution to our understanding of social phenomena;

- the *transfer of learning* has equally been insufficiently problematized, which is particularly significant given the implied expectation that SCRs provide material for professionals to learn from, and the debates in the literature regarding the conditions of transfer and the usefulness of the concept;

- the sample of 13 SCRs indicates that SCRs do not yet coherently account for the manner in which learning about and learning from cases (that is, each case's chronological narrative and recommendations) informs authors' claims that SCRs enable professionals to *learn to prevent* serious child maltreatment.

In order to develop models that can claim to effectively support professional learning so that children are protected from suffering maltreatment, LSCBs must necessarily make choices and trade-offs concerning the characteristics of learning that they may wish to embody in a model. This thesis has suggested two possible next steps, one in terms of finding analogous material in other professional fields (such as firefighting protocols of public sense-making) and another in the use of imagery in education to provide professionally relevant architectures for perception.

APPENDIX

Bedfordshire LSCB (Local Safeguarding Children Board) (2010) *The Executive Summary of the Overview Report into a Serious Case Review of the circumstances concerning Child J.*

Bexley LSCB (2010) *Executive Summary Serious Case Review 'Child A', 18 May 2010.*

Birmingham SCB (Safeguarding Children Board) (2009a) *Serious Case Review Under Chapter VIII 'Working together to safeguard children' in respect of the death of Case No. 8.*

Birmingham SCB (2009b) *Serious Case Review Under Chapter VIII 'Working together to safeguard children' in respect of the death of Case No. 9.*

Birmingham SCB (2009c) *Serious Case Review Under Chapter VIII 'Working together to safeguard children' in respect of the death of Case No. 10.*

Birmingham SCB (2009d) *Serious Case Review Under Chapter VIII 'Working together to safeguard children' in respect of the death of Case No. 11.*

Birmingham SCB (2009e) *Serious Case Review Under Chapter VIII 'Working together to safeguard children' in respect of the death of Case No. 12.*

Blackburn with Darwen LSCB (2009) *Executive Summary of the Serious Case Review regarding Child A, June 2009.*

Bristol SCB (2009) *Serious Case Review Baby Z Executive Summary*, Reconstruct: Bath.

Buckinghamshire SCB (2010) *Executive Summary, Serious Case Review Overview Report: Child W.*

City of Salford LSCB (2009) *Executive Summary in respect of Child D aged 2 years and 9 months.*

Coventry SCB (2008a) *Serious Case Review – Executive Summary 2.*

Coventry SCB (2008b) *Serious Case Review – Executive Summary 4.*

Coventry SCB (2009) *Serious Case Review – Executive Summary 5.*

Coventry SCB (2010) *Executive Summary of the Serious Case Review in respect of Child CD, November 2010.*

Derbyshire SCB (2009) *Child H Executive Summary, June 2009.*

Doncaster SCB (2010) A *Serious Case Review 'J' children. The Executive Summary, January 2010.*

Gloucestershire SCB (2009) *Executive Summary 0508 Kevin (d.o.b. Aged 9).*

Hampshire SCB (2009a) *Serious Case Review Executive Summary Baby F.*

Hampshire SCB (2009b) *Serious Case Review Overview Report Executive Summary in respect of Child H & Child G. Submitted to Ofsted July 2009.*

Herefordshire SCB (2010) *The Executive Summary of the Overview Report into a Serious Case Review of the circumstances concerning Child HC.*

Hertfordshire SCB (2010) *Serious Case Review Executive Summary Case: Child Y.*

Kingston LSCB in collaboration with Surrey SCB (2008) *Serious Case Review in respect of Child F and G. Executive report, January 2008.*

Lancashire SCB (2010) *Serious Case Review Executive Summary Baby M Age: 7 weeks.*

Leeds SCB (2010a) *Serious Case Review in respect of Child L 01.02.10.*

Leeds SCB (2010b) *Serious Case Review in respect of Child R (26 July 2010) Executive Summary.*

Leicester, Leicestershire & Rutland LSCB (2009) *Executive Summary Child 'W'.*

Leicestershire and Rutland LSCB (2010) *Executive Summary of the Serious Case Review Child B.*

Lewisham LSCB (2009) *Child C: A Serious Case Review Executive Summary, September 2009.*

Manchester SCB (2010a) *Executive Summary of the Serious Case Review in respect of Child H & Child I.*

Manchester SCB (2010b) *Serious Case Review Executive Summary Child J.*

Manchester SCB (2010c) *Executive Summary of the Serious Case Review in Respect of Child K.*

Nottinghamshire SCB (2010) *Serious Case Review relating to BN Ethnic Origin: White British Executive Summary, March 2010.*

Plymouth SCB (2008) *Executive Summary M, July 2008.*

Reading LSCB (2010) *Serious Case Review Re Children A & B Executive Summary.*

Redcar and Cleveland SCB (2010) *Serious Case Review Executive Summary Review on: Mary.*

Rochdale Borough SCB (2008) *Executive Summary of Serious Case Review Child P, January 2008.*

South Gloucestershire SCB (2009a) *Baby S Serious Case Review Executive Summary.*

South Gloucestershire SCB (2009b) *Serious Case Review Executive Summary in respect of Child R and Child K, March 2009.*

Southampton SCB (2011) *Serious Case Review Executive Summary Child E.*

St Helens SCB (2010a) *Serious Case Review Executive Summary Subject: A Subject B Subject C.*

St Helens SCB (2010b) *Serious Case Review: R Executive Summary.*

Stockton-on-Tees LSCB (2009) *Serious Case Review Executive Summary. Review on Child Y. Date of Birth: Young child, December 2009.*

Sunderland SCB (2010) *Serious Case Review Executive Summary for Sunderland Safeguarding Children Board in respect of Child D.*

Surrey SCB (2010) *Executive Summary Child A, June 2010.*

Tameside SCB (2009) *Serious Case Review re 'J' – Child J – Executive Summary.*

Tameside SCB (2010) *Serious Case Review Executive Summary re child C, completed in February 2010.*

Torbay SCB (2010) *Serious Case Review C18 Executive Summary 15th November 2010.*

Wakefield & District SCB (2008) *Executive Summary: Serious Case Review – Young Person A, December 2008.*

Walsall SCB (2009) *Case Review Executive Summary.*

REFERENCES

Allen, G. (2011) *Early Intervention: The next steps. The independent report to Her Majesty's Government*, London: Cabinet Office.

Anda, R. and V. Felitti (2010) *The Adverse Childhood Experiences (ACE) Study*, available online at www.acestudy.org, (last accessed 12 February 2015)

Anning, A., D. Cottrell, N. Frost, J. Green and M. Robinson (2010) *Developing Multi-Professional Teamwork for Integrated Childen's Services: Research, policy and practice*, (2nd edn), Maidenhead: Open University Press.

Babatsikos, G. (2010) 'Parents' knowledge, attitudes and practices about preventing child sexual abuse: a literature review', *Child Abuse Review*, vol 19, pp 107-29.

Beach, K. (1999) 'Consequential transitions: a sociocultural expedition beyond transfer in education', *Review of Research in Education*, vol 24, pp 101-35.

Bedfordshire LSCB (Local Safeguarding Children Board) (2010) *The Executive Summary of the Overview Report into a Serious Case Review of the circumstances concerning Child J.*

Bereiter, C. (1997) 'Situated cognition and how to overcome it', in D. Kirshner and J.A. Whitson (eds) *Situated Cognition: Social, semiotic, and psychological perspectives*, Hillsdale (NJ): Erlbaum, pp 281-300.

Bereiter, C. (2014) 'Principled practical knowledge: not a bridge but a ladder', *Journal of the Learning Sciences*, vol 23, no 1, pp 4-17.

Bexley LSCB (2010) *Executive Summary Serious Case Review 'Child A', 18 May 2010.*

Bifulco, A. (2013) 'Risk and resilience in young Londoners', in D. Brom, R.P. Horenczyk and J. Ford (eds) *Treating Traumatized Children: Risk, Resilience and Recovery*, London: Routledge.

Birmingham SCB (2009a) *Serious Case Review Under Chapter VIII 'Working together to safeguard children' in respect of the death of Case No. 8.*

Birmingham SCB (2009b) *Serious Case Review Under Chapter VIII 'Working together to safeguard children' in respect of the death of Case No. 9.*

Birmingham SCB (2009c) *Serious Case Review Under Chapter VIII 'Working together to safeguard children' in respect of the death of Case No. 10.*

Birmingham SCB (2009d) *Serious Case Review Under Chapter VIII 'Working together to safeguard children' in respect of the death of Case No. 11.*

Birmingham SCB (2009e) *Serious Case Review Under Chapter VIII 'Working together to safeguard children' in respect of the death of Case No. 12.*

Blackburn with Darwen LSCB (2009) *Executive Summary of the Serious Case Review regarding Child A, June 2009.*

Bowker, G.C. (n.d.) 'Keeping knowledge local', occasional paper available online at http://www.ics.uci.edu/~gbowker/pubs.htm, last accessed 14 January 2015 via Geoffrey Bowker's homepage, www.ics.uci.edu/~gbowker/.

Brandon, M. (2009) 'Serious Case Reviews: implications for inter-agency trainers', *Repositioning Child Protection: Learning from good practice. The 16th National Symposium on Inter-agency Training, 1-2 December 2009*, (Keynote 2), London: NSPCC.

Brandon, M., A. Howe, V. Dagley, C. Salter and C. Warren (2006) 'What appears to be helping or hindering practitioners in implementing the Common Assessment Framework and Lead Professional Working?', *Child Abuse Review*, vol 15, pp 396-413.

Brandon, M., P. Belderson, C. Warren, D. Howe, R. Gardner, J. Dodsworth and J. Black (2008) *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A biennial analysis of serious case reviews 2003–2005*, (Research Report DCSF-RR023), Nottingham: Department for Children, Schools and Families.

Brandon, M., P. Sidebotham, C. Ellis, S. Bailey and P. Belderson (2011) *Child and Family Practitioners' Understanding of Child Development: Lessons learnt from a small sample of serious case reviews*, (Research Report DFE-RR110), Norwich: University of East Anglia and Department of Education.

Brandon, M., S. Bailey and P. Belderson (2010) *Building on the Learning from Serious Case Reviews: A two-year analysis of child protection database notifications 2007-2009*, (Research Report DFE-RR040), Norwich: University of East Anglia and Department of Education.

Brandon, M., S. Bailey, P. Belderson, R. Gardner, P. Sidebotham, J. Dodsworth, C. Warren and J. Black (2009) *Understanding Serious Case Reviews and their Impact: A biennial analysis of serious case reviews 2005-07*, (Research Report DCSF-RR129), Norwich: University of East Anglia and the Department for Children, Schools and Families.

Bransford, J.D., B. Barron, R.D. Pea, A. Meltzoff, P. Kuhl, P. Bell, R. Stevens, D.L. Schwartz, N. Vye, B. Reeves, J. Roschelle and N.H. Sabelli (2006) 'Foundations and opportunities for an interdisciplinary science of learning', in in R.K. Sawyer (ed) *The Cambridge Handbook of the Learning Sciences*, Cambridge and New York: Cambridge University Press, pp 19-34.

Bristol SCB (2009) *Serious Case Review Baby Z Executive Summary*, Reconstruct: Bath.

Buckinghamshire SCB (2010) *Executive Summary, Serious Case Review Overview Report: Child W.*

Burton, S. (2009) 'The oversight and review of cases in the light if changing circumstances and new information: how do people respond to new (and challenging) information?', *Safeguarding: Briefing 3*, London: C4EO.

Butchart, A., A.P. Harvey and T. Fumiss (2006) *Preventing Child Maltreatment: A guide to taking action and generating evidence*, Geneva: WHO and ISPCAN.

C4EO (Centre for Excellence and Outcomes in Children and Young People's Services) (no date) *Grasping the Nettle: Early intervention for children, families and communities. A practice guide to the challenges and opportunities in supporting children, families and communities through early intervention, based on effective local, national and international practice*, London: C4EO.

C4EO (Centre for Excellence and Outcomes in Children and Young People's Services) (2010) 'Safeguarding: directors' summary 6', London: C4EO.

Carlile, Lord (2012) *The Edlington Case: A review by Lord Carlile of Berriew CBE QC at the request of The Rt Hon Michael Gove MP, Secretary of State for Education*, London: Department for Education.

Cartwright, N. (2011) 'Predicting what will happen when we act. What counts for warrant?', Preprint submitted to *Preventive Medicine*.

Cartwright, N. and E. Munro (2010) 'The limitations of randomized controlled trials in predicting effectiveness', *Journal of Evaluation in Clinical Practice*, vol 16, pp 260-66.

Cartwright, N., A. Goldfinch and J. Howick (2009) 'Evidence-based policy: where is our theory of evidence', *Journal of Children's Services*, vol 4, issue 4, pp 6-14.

Cawson, P., C. Wattam, S. Brooker and G. Kelly (2000) *Child Maltreatment in the United Kingdom: A study of the prevalence of abuse and neglect. Executive summary November 2000*, (NSPCC Research Findings), available online at www.nspcc.org.uk/inform.

Charles, M. and J. Horwath (2009) 'Investing in interagency training to safeguard children: an act of faith or an act of reason', *Children & Society*, vol 23, pp 364-76.

Cicchetti, D. and K. Valentino (2006) 'An ecological transactional perspective on child maltreatment: failure of the average expectable environment and its influence upon child development', in D. Cicchetti and D.J. Cohen (eds) *Developmental Psychopathology. Volume 3: Risk, disorder and adaptation*, (2nd edn), New York: Wiley, pp 129-201.

City of Salford LSCB (2009) *Executive Summary in respect of Child D aged 2 years and 9 months.*

Council of Europe (1950/2010) *Convention for the Protection of Human Rights and Fundamental Freedoms (as amended by Protocols No. 11 and No. 14)*, Rome: Council of Europe.

Coventry SCB (2008a) *Serious Case Review – Executive Summary 2.*

Coventry SCB (2008b) *Serious Case Review – Executive Summary 4.*

Coventry SCB (2009) *Serious Case Review – Executive Summary 5.*

Coventry SCB (2010) *Executive Summary of the Serious Case Review in respect of Child CD, November 2010.*

Cox, A.D. (1998) 'Preventing child abuse: a review of community-based projects II: issues arising from reviews and future directions', *Child Abuse Review*, vol 7, pp 30-43.

Cusick, L. (2002) 'Youth prostitution: a literature review', *Child Abuse Review*, vol 11, pp 230-51.

Daniel, B., J. Taylor and J. Scott (2009) *Noticing and Helping the Neglected Child: Literature review*, (Research Brief DCSF-RBX-09003), London: DCSF.

Daniels, H., J. Leadbetter and P. Warmington with A. Edwards, D. Martin, A. Popova, A. Apostolov, D. Middleton and S. Brown (2007) 'Learning in and for multi-agency working', *Oxford Review of Education*, vol 33, no 4, pp 521-38.

Davies, L. (2004) '"The difference between child abuse and child protection could be you"': creating a community network of protective adults', *Child Abuse Review*, vol 13, pp 426-32.

Derbyshire SCB (2009) *Child H Executive Summary, June 2009.*

Derrida, J. (1996) *Archive Fever: A Freudian impression*, Chicago (IL): University of Chicago Press.

DfE (Department for Education) (2010) *Children in Need in England, including their Characteristics and Further Information on Children who were the Subject of a Child Protection Plan (Children in Need Census, Final) Year Ending 31 March 2010*, London: Department for Education.

DfE (Department for Education) (2010) *Preventable child deaths in England: Year ending 31 March 2010*, London: DfE.

DfE (Department for Education) (2011) *Child death reviews: Year ending 31 March 2011*, London: DfE.

DfE (Department for Education) (2014) *First Annual Report: National panel of independent experts on serious case reviews*, London: DfE, (REF DFE-00531-2014).

DfE (Department for Education) (2015) *Revisions to Working Together to Safeguard Children: Government consultation*, London: DfE.

DfES (Department for Education and Skills) (2004) *Every Child Matters: Change for children*, (reference DfES/1081/2004), London: DfES.

DoH (Department of Health) (1995) *Child Protection and Child Abuse: Messages from research*, London: DoH.

DoH (Department of Health) (1998) *Quality Protects: Framework for action*, London: Crown Copyright.

DoH, DfEE and HO (Department of Health, Department of Education and Employment and the Home Office) (2000) *Framework for the Assessment of Children in Need and their Families*, London: The Stationery Office.

Donaldson, M. (1978) *Children's Minds*, London Fontana.

Doncaster SCB (2010) *A Serious Case Review 'J' children. The Executive Summary, January 2010.*

Eckstein, H. (1975) 'Case study and theory in political science', in F.I. Greenstein and N.W. Polsby (eds) *Handbook of Political Science*, (Vol 7), Reading (MA): Addison-Wesley, pp 79-137.

Edwards, A., H. Daniels, T. Gallagher, J. Leadbetter and P. Warmington (2009) *Improving Inter-professional Collaborations: Multi-agency working for children's wellbeing*, Routledge: Abingdon.

Flyvberg, B. (2006) 'Five misunderstanding about case-study research', *Qualitative Inquiry*, vol 12, no 2, p 219.

Field, F. (2010) *The Foundation Years: Preventing poor children from becoming poor adults. The report of the Independent Review on Poverty and Life Chances*, London: Cabinet Office.

Finke, R. (1990) *Creative Imagery: Discoveries and inventions in visualization*, Hillsdale (NJ): Erlbaum.

Fish, S. (2009) 'Learning together to safeguard children: a 'systems' model for case reviews', *Social Care Institute for Excellence (SCIE) 'At A Glance' 01*, September, London: SCIE.

Fors, V., Å. Bäckström and S. Pink (2013) 'Multisensory emplaced learning: resituating situated learning in a moving world', *Mind, Culture and Activity*, vol 20, pp 170-83.

Frost, N. (2005) *Professionalism, Partnership and Joined-Up Thinking*, Dartington: Research in Practice.

Gardner, J. (1968) *No Easy Victories*, New York: Harper.

Gilbert, R. C.S. Widom, K. Brown, D.M. Ferguson, E. Webb and S. Janson (2009) 'Child maltreatment 1: burden and consequences of child maltreatment in high-income countries', *The Lancet*, vol 373, pp 68-81.

Glaser, D. and V. Prior (1997) 'Is the term child protection applicable to emotional abuse?', *Child Abuse Review*, vol 6, pp 315-29)

Glennie, S. (2007) 'Developing interprofessional relationships: tapping the potential of inter-agency training', *Child Abuse Review*, vol 16, pp 171-83.

Glennie, S. and J. Horwath (2000) 'Inter-agency training: broadening the focus', *Child Abuse Review*, vol 9, issue 2, pp 148-56.

Glisson, C. and A. Hemmelgarn (1998) 'The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems', *Child Abuse and Neglect*, vol 22, no 5, pp 401-21.

Gloucestershire SCB (2009) *Executive Summary 0508 Kevin (d.o.b. Aged 9).*

Goddard, C. and G. Bedi (2010) 'Intimate partner violence and child abuse: a child-centred perspective', *Child Abuse Review*, vol 19, pp 5-20.

Goodwin, C. (1994) 'Professional vision', *American Anthropologist*, vol 96, no 3, pp 606-33.

Goodwin, C. (1995) 'Seeing in depth', *Social Studies of Science*, vol 25, pp 237-74.

Goodwin, C. (1996) 'Transparent vision', in E. Ochs, E.A. Schegloff and S. Thompson (eds) *Interaction and Grammar*, Cambridge: Cambridge University Press, pp 370-404.

Gough, D. (1994) 'The literature on prevention', *Child Abuse Review*, vol 3, pp 317-22.

Gove, M. (2012) 'Publication of the serious case review (SCR) overview report regarding the "J" children, Edlington', Letter sent by Rt Hon Michael Gove MP, Secretary of State, Department of Education to MPs Caroline Flint, Rosie Winterton and Ed Balls, 29 March 2012.

Greeno, J.G. (2006a) 'Learning in activity', in R.K. Sawyer (ed) *The Cambridge Handbook of the Learning Sciences*, Cambridge and New York: Cambridge University Press, pp 79-96.

Greeno, J.G. (2006b) 'Authoritative, accountable positioning and connected, general knowing: progressive themes in understanding transfer', *Journal of the Learning Sciences*, vol 15, no 4, pp 537-47.

Haapasalo, J. and T. Aaltonen (1999) 'Mothers' abusive childhood predicts child abuse', *Child Abuse Review*, vol 8, pp 231-50.

Hampshire SCB (2009a) *Serious Case Review Executive Summary Baby F.*

Hampshire SCB (2009b) *Serious Case Review Overview Report Executive Summary in respect of Child H & Child G. Submitted to Ofsted July 2009.*

Hart, D. and J. Powell (2006) *Adult Drug Problems, Children's Needs: Assessing the impact of parental drug use. A toolkit for practitioners*, London: National Children's Bureau.

Hatano, G. and J.G. Greeno (1999) 'Commentary: alternative perspectives on transfer and transfer studies', *International Journal of Educational Research*, vol 31, pp 645-54.

Hemmelgarn, A., C. Glisson and L.R. James (2006) 'Organizational culture and climate: implications for services and interventions research', *Clinical Psychology: Science and Practice*, vol 13, no 1, pp 73-89.

Herefordshire SCB (2010) *The Executive Summary of the Overview Report into a Serious Case Review of the circumstances concerning Child HC.*

Hertfordshire SCB (2010) *Serious Case Review Executive Summary Case: Child Y.*

HM Government (2005) *Common Core of Skills and Knowledge for the Children's Workforce*, Nottingham: DfES Publications.

HM Government (2006) *The Common Assessment Framework for Children & Young People: Practitioners' guide. Integrated working to improve outcomes for children and young people*, London: DCSF.

HM Government (2009) *Public Service Agreement 13: Improve children and young people's safety*, London: HM Treasury.

HM Government (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, Crown Copyright: Department for Education.

Horwath, J. (2001) 'Child care practice innovations: using a model of change to develop training strategies', *Child Abuse Review*, vol 10, issue 1, pp 18-34.

Horwath, J. (2007) 'The missing assessment domain: personal, professional and organisational factors influencing professional judgements when identifying and referring child neglect', *British Journal of Social Work*, vol 37, pp 1285-1303.

Horwath, J. (2011) 'See the practitioner, see the child: the Framework for the Assessment of Children in Need and their Families ten years on', *British Journal of Social Work*, vol 41, pp 1070-87.

Horwath, J. and T. Morrison (2000) 'Identifying and implementing pathways for organizational change – using the Framework for the Assessment of Children in Need and their Families as a case example', *Child and Family Social Work*, vol 5, issue 3, pp 245-354.

Howe, D. (1992) 'Theories of helping, empowerment and participation', in J. Thoburn (ed) *Participation in Practice – Involving families in child protection*, Norwich: Social Work Development Unit, University of East Anglia.

Howes, D. (2005) *Empire of the Senses: The sensory culture reader*, Oxford: Berg.

Howes, N. (2010) 'Here to listen! Communicating with children and methods for communicating with children and young people as part of the Assessment Process', in J. Horwath (ed) *The Child's World: The comprehensive guide to assessing children in need*, (2nd edn), London: Jessica Kingsley Publishers, pp 124-39.

Iwaniec, D. (1997) 'An overview of emotional maltreatment and failure-to-thrive', *Child Abuse Review*, vol 6, pp 370-88.

Jack, G. (2004) 'Child protection at the community level', *Child Abuse Review*, vol 13, pp 368-83.

Johnson, B. (1994) 'Teachers' role in the primary prevention of child abuse: dilemmas and problems', *Child Abuse Review*, vol 3, pp 259-71.

Kanfer, A.G, C. Haythornwaite, G.C. Bowker, B.C. Bru ce, N. Burbules, J. Porac and J. Wade (n.d.) 'Modelling distributed knowledge processes in next generation multidisciplinary alliances', occasional paper available online at http://www.ics.uci.edu/~gbowker/distribk.pdf, last accessed 13 January 2015 via Geoffrey Bowker's homepage, www.ics.uci.edu/~gbowker/.

Kenny, M. C., Capri, V., R., R., Thakkar-Kolar, Ryan, E. E. and Runyon, M. K. (2008), Child sexual abuse: from prevention to self-protection. Child Abuse Rev., 17: 36–54

Kenny, M.C., V.R. Capri, R. Thakkar-Kolar, E.E. Ryan and M.K. Runyon (2008) 'Child sexual abuse: from prevention to self-protection', *Child Abuse Review*, vol 17, pp 36–54.

Kingston LSCB in collaboration with Surrey SCB (2008) *Serious Case Review in respect of Child F and G. Executive report, January 2008.*

Kozulin, A. (1998) *Psychological Tools: A sociocultural approach to education*, Harvard University Press: Cambridge (MA) and London.

Lancashire SCB (2010) *Serious Case Review Executive Summary Baby M Age: 7 weeks.*

Laulik, S., J. Allam and K. Browne (2014) 'Maternal borderline personality disorder and risk of child maltreatment', *Child Abuse Review*, (only available in online edition, as of 21 February 2015).

Lave, J. (2012) 'Changing practice', *Mind, Culture, and Activity*, vol 19, no 2, pp 156-171.

Leeds SCB (2010a) *Serious Case Review in respect of Child L 01.02.10.*

Leeds SCB (2010b) *Serious Case Review in respect of Child R (26 July 2010) Executive Summary.*

Leicester, Leicestershire & Rutland LSCB (2009) *Executive Summary Child 'W'.*

Leicestershire and Rutland LSCB (2010) *Executive Summary of the Serious Case Review Child B.*

Lewisham LSCB (2009) *Child C: A Serious Case Review Executive Summary, September 2009.*

Loughton, T. (2010) 'Publication of serious case review overview reports and Munro review of child protection', Letter from Tim Loughton MP, Parliamentary Under Secretary of State for Children and Families, Department of Education, to LSCB Chairs and Directors of Children's Services, 10th June 2010.

Loughton, T. (n.d.) *Launch of the Munro review on Back to the Frontline for Child Protection*, Written Ministerial Statement of Tim Loughton MP, Parliamentary Under Secretary of State for Children & Families, Department of Education.

Mackie, J.L. (1965) 'Causes and conditions', *American Philosophical Quarterly*, vol 2, pp 245-64.

Maggetti, M., F. Gilardi and C.M. Radaelli (2013) *Designing Research in the Social Sciences*, London: SAGE.

Manchester SCB (2010a) *Executive Summary of the Serious Case Review in respect of Child H & Child I.*

Manchester SCB (2010b) *Serious Case Review Executive Summary Child J.*

Manchester SCB (2010c) *Executive Summary of the Serious Case Review in Respect of Child K.*

Marmot, M. (2010) *Fair Society, Healthy Lives: The Marmot Review. Strategic review of health inequalities in England post-2010*, London: The Marmot Review.

Mason, C., C. May-Chahal, S. Regan and D. Thorpe (n.d.) 'Differentiating common assessment cases from other types of cases – The research evidence for CAF responses', *Oldham CAF Research*, Lancaster: Lancaster University Management School, (Case 007), (available online at http://www.lums.lancs.ac.uk/files/ccips/7115.doc).

Massey, D. (2005) *For Space*, London: Sage.

Morrison, T. (2000) 'Working together to safeguard children: challenges and changes for inter-agency co-ordination in child protection', *Journal of Interprofessional Care*, vol 14, no 4, pp 363-73.

Morrison, T. (2010) 'The strategic leadership of complex practice: opportunities and challenges', *Child Abuse Review*, vol 19, issue 5, pp 312-29.

Muller, W. (1999) *Sabbath: Restoring the sacred rhythm of rest*, New York: Bantam.

Munro, E. (2010) *The Munro Review of Child Protection. Part One: A systems analysis*, (DFE-00548-2010), London: Department for Education.

Munro, E. (2011) *The Munro Review of Child Protection: Final Report. A child-centred system*, (Cm 8062), London: The Stationery Office Limited.

Munro, E. (2012) *The Munro Review of Child Protection: Progress report. Moving towards a child centred system*, London: Department of Education.

Munro, E., J.S. Taylor and C. Bradbury-Jones (2014) 'Understanding the causal pathways to child maltreatment: implications for health and social care policy and practice', *Child Abuse Review*, vol 23, pp 61-74.

Nagle, A. and G. Watson (2008) 'Parental substance misuse: an Islington perspective', *Child Abuse Review*, vol 17, pp 444-53.

Nottinghamshire SCB (2010) *Serious Case Review relating to BN Ethnic Origin: White British Executive Summary, March 2010.*

NSPCC (2012a) 'Serious case reviews published in 2012', *Inform: Child Protection Resource*, available at http://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/serious_case_reviews_2012_wda88142.html, last accessed 04 September 2012.

NSPCC (2012b) 'Child killings in England and Wales: explaining the statistics', available online at http://www.nspcc.org.uk/Inform/research/briefings/child_killings_in_england_and_wales_wda67213.html, (downloaded 31 January 2012).

NSPCC (National Society for the Prevention of Cruelty to Children) (2011) *Child Cruelty in the UK 2011: An NSPCC study into childhood abuse and neglect over the past 30 years*, available online at www.nspcc.org.uk.

Ofsted (The Office for Standards in Education, Children's Services and Skills) (2008) *Learning Lessons, Taking Action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008*, London: Ofsted.

Ofsted (The Office for Standards in Education, Children's Services and Skills) (2009) *Learning Lessons from Serious Case Reviews: Year 2. Ofsted's second year of evaluating serious case reviews: a progress report (April 2008 to March 2009)*, Manchester: Ofsted.

Ofsted (The Office for Standards in Education, Children's Services and Skills) (2010a) *Learning Lessons from Serious Case Reviews: Interim report 2009-2010. Ofsted's evaluation of serious case reviews 1 April to 30 September 2009*, Manchester: Ofsted.

Ofsted (The Office for Standards in Education, Children's Services and Skills) (2010b) *Learning lessons from serious case reviews 2009–2010: Ofsted's evaluation of serious case reviews from 1 April 2009 to 31 March 2010*, Manchester: Ofsted.

Ofsted (The Office for Standards in Education, Children's Services and Skills) (2011a) *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*, Manchester: Ofsted.

Ofsted (The Office for Standards in Education, Children's Services and Skills) (2011b) *Good Practice by Local Safeguarding Children Boards*, Ref no 110079, Manchester: Ofsted.

Ofsted (The Office for Standards in Education, Children's Services and Skills) (2011c) *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*, Manchester: Ofsted.

Øvreitveit, J. (1993) *Coordinating Community Care: Multidisciplinary teams and care management*, Buckingham: Open University Press.

Paavola, S. and K. Hakkarainen (2005) 'The knowledge creation metaphor – an emergent epistemological approach to learning', *Science & Education*, vol 14, pp 535-57.

Piat (2008) *Make a Difference: Tools for developing and assuring quality in inter-agency relationships and training*, London: NSPCC.

Pickering, A. (1995) *The Mangle of Practice*, Chicago (IL): University of Chicago Press.

Pink, S. (2011) 'From embodiment to emplacement: re-thinking competing bodies, senses and spatialities', *Sport, Education and Society*, vol 16, no 3, pp 343-55.

Plymouth SCB (2008) *Executive Summary M, July 2008.*

Protchaska, P.O. and C.C. di Clementi (1982) 'Transtheoretical therapy: towards a more integrative model of change', *Psychotherapy: Theory, Research and Practice*, vol 19, pp 276-87.

Radford, L., S. Corral, C. Bradlet, H. Fisher, C. Bassett, N. Howat and S. Collishaw (2011) *Child Cruelty in the UK 2011: An NSPCC study into childhood abuse and neglect over the past 30 years*, London: NSPCC.

Rasmussen, J. (2000) 'The concept of human error: is it useful for the design of safe systems in healthcare?', in C. Vincent and B. de Mol (eds) *Safety in Medicine*, Amsterdam: Pergamon, pp 31-48.

Raynes, B. (2011) 'Why do we not learn from serious case reviews?', *Community Care*, online edn 14 July 2011, (available online at www.communitycare.co.uk/articles/2011/07/14/117167/whydowenotlearnfromserious casereviews.htm?printerfriendly=true), originally published in the 21 July 2011 edition of *Community Care* under the headline, "Let's stop repeating the same mistakes".

Reading LSCB (2010) *Serious Case Review Re Children A & B Executive Summary.*

Redcar and Cleveland SCB (2010) *Serious Case Review Executive Summary Review on: Mary.*

Reder, P., S. Duncan and M. Gray (1993) *Beyond Blame: Child abuse tragedies revisited*, Abingdon (Oxon): Routledge.

Rochdale Borough SCB (2008) *Executive Summary of Serious Case Review Child P, January 2008.*

Rose, W. and J. Barnes (2008) *Improving Safeguarding Practice: Study of serious case reviews 2001-2003*, (Research Report DCSF-RR022), Nottingham: Department for Children, Schools and Families.

Sanders, M.R., W. Cann and C. Markie-Dadds (2003) 'Why a universal population-level approach to the prevention of child abuse is essential', *Child Abuse Review*, vol 12, pp 145-54.

Scaife, V., M. O'Brien, R. McEune, C. Notley, A. Millings and L. Biggart (2009) 'Vulnerable young people and substance misuse: expanding on the risk and protection-focused approach using social psychology', *Child Abuse Review*, vol 18, pp 224-39.

Scardamalia, M. and C. Bereiter (2006) 'Knowledge building: theory, pedagogy, and technology', in R.K. Sawyer (ed) *The Cambridge Handbook of the Learning Sciences*, Cambridge and New York: Cambridge University Press, pp 97-115.

Schwartz, D.L. and J. Heiser (2006) 'Spatial representations and imagery in learning', in R.K. Sawyer (ed) *The Cambridge Handbook of the Learning Sciences*, Cambridge and New York: Cambridge University Press, pp 283-98.

Sfard, A. (1998) 'On two metaphors for learning and the dangers of choosing just one', *Educational Researcher*, vol 27, no 2, pp 4-13.

Sidebotham, P., M. Brandon, C. Powell, C. Solebo, J. Koistinen and C. Ellis (2010) *Learning from Serious Case Reviews: Report of a research study on the methods of learning lessons nationally from serious case reviews*, (Research Report DFE-RR037), Norwich: University of East Anglia and University of Warwick.

Sinclair, R. and R. Bullock (2002) *Learning from Past Experience – A review of serious case reviews*, (Report no. 28159), London: Department of Health.

Smith, T.K., A. Duggan, M.H. Bair-Merritt and G. Cox (2012) 'Systematic review of fathers' involvement in programmes for the primary prevention of child maltreatment', *Child Abuse Review*, vol 21, pp 237-54.

South Gloucestershire SCB (2009a) *Baby S Serious Case Review Executive Summary.*

South Gloucestershire SCB (2009b) *Serious Case Review Executive Summary in respect of Child R and Child K, March 2009.*

Southampton SCB (2011) *Serious Case Review Executive Summary Child E.*

Spratt, T. (2000) 'Decision making by senior social workers at point of first referral', *British Journal of Social Work*, vol 30, pp 597-618.

Stanley, N. and J. Manthorpe (eds) (2004) *The Age of the Inquiry: Learning and blaming in health and social care*, Abingdon (Oxon): Routledge.

St Helens SCB (2010a) *Serious Case Review Executive Summary Subject: A Subject B Subject C.*

St Helens SCB (2010b) *Serious Case Review: R Executive Summary.*

Stephenson, P. (2008) 'Serious case reviews: why aren't lessons being learnt?', *Community Care*, online edn 14 July 2008, (available online at www.communitycare.co.uk/articles/2008/07/14/108848/Serious-case-reviews-why-aren39t-lessons-being-learnt.htm?printerfriendly=true, originally published in the 17 July issue of *Community Care* magazine under the heading, "Little known facts".

Stevens, I. and P. Cox (2008) 'Complexity theory: developing new understandings of child protection in field settings and in residential child care', *British Journal of Social Work*, vol 38, pp 1320-36.

Stockton-on-Tees (2010) *Multi-agency Safeguarding Children Information to Assist Good Practice: Common Assessment Framework procedure*, Stockton-on-Tees: Stockton-on-Tees Children's Trust Board and LSCB.

Stockton-on-Tees LSCB (2009) *Serious Case Review Executive Summary. Review on Child Y. Date of Birth: Young child, December 2009.*

Sunderland SCB (2010) *Serious Case Review Executive Summary for Sunderland Safeguarding Children Board in respect of Child D.*

Surrey SCB (2010) *Executive Summary Child A, June 2010.*

Tameside SCB (2009) *Serious Case Review re 'J' – Child J – Executive Summary.*

Tameside SCB (2010) *Serious Case Review Executive Summary re child C, completed in February 2010.*

Tickell, Dame C. (2011) *The Early Years: Foundations for life, health and learning. An independent report on the Early Years Foundation Stage to Her Majesty's Government*, London: Department of Education.

Torbay SCB (2010) *Serious Case Review C18 Executive Summary 15th November 2010.*

Toulmin, S. (2003 [1958]) *The Uses of Argument*, (updated edn), Cambridge and New York: Cambridge University Press.

UN (United Nations) (1990) *Convention on the Rights of the Child. Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20*

November 1989. Entry into force 2 September 1990, in accordance with Article 49, Geneva: UN.

UNICEF (2003) *A League Table of Child Maltreatment Deaths in Rich Countries*, Florence: United Nations Children Fund Innocenti Research Centre.

Van Oers, B. (1998) 'The fallacy of decontextualization', *Mind, Culture, and Activity*, vol 5, no 2, pp 135-42.

Van Oers, B. (2004) 'Steps towards a sociocultural theory of learning', Lecture presented at the University of Jyväskylä, Finland, 10 December 2004, last accessed 13 January 2015 via Bert Van Oers homepage, http://www.bertvanoers.nl/page4.php.

Wakefield & District SCB (2008) *Executive Summary: Serious Case Review – Young Person A, December 2008.*

Walsall SCB (2009) *Case Review Executive Summary.*

Weick, K.E. (2002) 'Puzzles in organizational learning: an exercise in disciplined imagination', *British Journal of Management*, vol 13, ss 7-15.

Weick, K.E. (2007) 'Drop your tools: on reconfiguring management education', *Journal of Management Education*, vol 31, no 5, pp 5-16.

Wenger, E. (2000) 'Communities of practice and social learning systems', *Organization*, vol 7, no 2, pp 225-46.

Wertsch, J.V. (1985) *Vygotsky and the Social Formation of Mind*, Cambridge (MA): Harvard University Press.

White, S., C. Hall and S. Peckover (2009) 'The descriptive tyrant of the Common Assessment Framework: technologies of categorization and professional practice in child welfare', *British Journal of Social Work*, vol 39, pp 1197-1217.

Wolfe, D.A. (1993) 'Child abuse prevention: blending research and practice', *Child Abuse Review*, vol 2, pp 153-65.

Wurtele, S.K. and M.C. Kenny (2010) ‘Partnering with parents to prevent childhood sexual abuse’, *Child Abuse Review*, vol 19, pp 130-52.