

**Title:**

The Representation Of The Family's Voice In Serious Case Review Reports Of Child Maltreatment

**Author:**

Dr. Siobhan E. Laird,  
Centre for Social Work, University of Nottingham,  
Nottingham, University Park,  
NG7 2RD,  
United Kingdom

Email: [Siobhan.laird@nottingham.ac.uk](mailto:Siobhan.laird@nottingham.ac.uk)

**Abstract:**

Australia and the United Kingdom have a mandatory system of case reviews, which are conducted whenever a child known to welfare or health services has died or been seriously harmed due to maltreatment. In the United Kingdom those conducting case reviews are required to involve family members in their deliberations. This study employed discourse analysis to examine the representation of family voices in 41 Overview Reports of Serious Case Reviews undertaken in England and published during 2014. The findings revealed that the contributions of family members were generally relegated or their legitimacy undercut by the positivist framing of most Overview Reports. However, the research also identified how the framing of family contributions within an interpretivist paradigm could engender highly complex understanding of deficiencies in child protection systems and lead to crucial new learning for professionals.

**Key Words:**

Family, child protection, child maltreatment, child abuse, case review, child death

## Introduction

Australia, the United Kingdom and the United States of America (barring a few states) have statutory requirements for the formal investigation by public welfare or health agencies into the deaths or serious injury of children caused by maltreatment (Fraser, et al., 2014). The United Kingdom is unique in routinely involving families in such case reviews (Vincent, 2014) although the state of Victoria in Australia did so up until 2014. All four of the constituent nations of the United Kingdom undertake case reviews with the involvement of families, however as England contains 84% of the total population according to the 2011 Census and conducts the majority of reviews, it comprises this study. In England, HM Government (2015) policy guidance requires each Local Safeguarding Children Board (LSCB), the body responsible for overseeing multiagency cooperation to protect children at a local level and to implement a local *learning and improvement framework*. This framework must ensure that when a child who is known to social care or other key public sector agencies dies or is seriously harmed there is ‘a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children’ (HM Government, 2015:72). This is achieved through the mandatory commission of a Serious Case Review by the LSCB to examine the circumstances surrounding a child’s death or serious harm. This generates an Overview Report, which draws out learning and makes recommendations to rectify identified problems and prevent repetition.

In England, a series of biennial analyses have been conducted on SCR reports, however none of these scrutinised family involvement, although they frequently criticised the relatively low numbers of SCRs evidencing family participation and the deficient incorporation of their

views into final Overview Reports (Brandon, et al., 2009, 2011, Ofsted, 2011). The most recent report in this series, Sidebotham et al. (2016) noted that most SCRs now evidenced family involvement, but the nature of that involvement was not investigated, and only two paragraphs out of its 277 pages concerned this topic. Apart from these periodic analyses of SCR reports, the rarity among post-industrial English speaking nations of family involvement in child death reviews, combined with lack of access to confidential case review reports, means that little literature exists regarding this phenomenon. An exceptional study by Morris, et al. (2012) explored the perspectives of professionals and family members towards family inclusion in case reviews (though not necessarily SCRs), but did not examine how the contributions of families were reflected in the official reports of case reviews or their recommendations.

In 2013 the British government introduced a presumption that the full Overview Reports of SCRs conducted in England be published unless there were exceptional reasons for not doing so (HM Government, 2013:67). Since then, these have been voluntarily placed in an online national repository administered by the National Society for the Prevention of Cruelty to Children. The unprecedented public access to SCR Overview Reports permits a unique opportunity to examine how investigations currently integrate information from different sources and reach their conclusions, including the attention given to the family's voice. By analysing how family involvement is constructed and incorporated into SCR Overview Reports this study will inform the conduct and reporting of case reviews in Australia and the United Kingdom. The study was initially motivated after delivering continuing professional development training to Overview Report authors in London during 2015, when it became clear that there was confusion regarding the role of the family in SCRs and how their

contribution should be treated. This study was conducted with the support of the University of Nottingham, but without external funding.

## **Methodology**

In order to strip back the assumptions and routines which underpin the representation of the family voice in SCRs this study posed four research questions.

1. How is the family facilitated to contribute?
2. What is the family asked?
3. How are family contributions represented?
4. To what extent do family contributions influence case review recommendations?

To investigate these research questions methods of textual analysis which rely on identifying patterns and themes utilising a variety of coding conventions were rejected in favour of discourse analysis. This approach was selected because coding techniques tend to break down text into small units of meaning. These approaches can neglect underpinning assumptions and structures which frame whole texts, or substantial passages thereof, shaping their organisation and how they represent people, events and points of view. By contrast discourse analysis investigates ‘relations of control over things, relations of action upon others [and] relations with oneself (Fairclough, 2007:28). Thus permitting an examination of how family members are constituted as subjects in relation to power within the review process. To comprehend how Overview Reports treat family involvement dynamically, it was necessary to analyse large segments of continuous text. Furthermore, discourse analysis could facilitate the piecing

together of the representation of the family from the scattered references which characterised many reports.

The study was conducted by the author using a series of templates to organise and recombine substantial chunks of text to facilitate reading across and analysing text from different Overview Reports. To preserve textual cohesion while permitting the categorisation of material, the templates comprised broad sections with large amounts of text placed in each for discourse analysis. These categories ordered the material into information regarding: which family members participated; how they were involved; whether family contributions were in separate sections or integrated into the Overview Report; the degree to which different perspectives were articulated in the report; the degree to which the terms of reference reflected professional or family concerns; and the degree to which recommendations linked to family contributions. It utilises five dimensions of discourse analysis identified by Fairclough (2007) which are outlined below:

*Intertextuality* – what explicit or implicit references does the text make to other external texts?

*Evaluation* – how does the text define what is desirable or undesirable?

*Dialogicality* – what different perspectives or possibilities are articulated by the text?

*Representations of actions, actors and events* – how does the author perceive him or herself, others and happenings?

*Inclusions and exclusions* – what things are highlighted, downplayed or absent in the text?

As the requirement to publish the full Overview Reports was only introduced in 2013 the national repository for them is also recent and currently holds only Overview Reports published since mid 2013. This study examined all the available Overview Reports and one

detailed Executive Summary from the 2014 archive, totalling 58 case reviews. These are publicly accessible and were downloaded from <http://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/>. The 58 total compares to 69 SCRs known to have been instigated due to the death of, or serious harm to, a child between 1<sup>st</sup> April 2013 – 31<sup>st</sup> March 2014 (Ofsted, 2014:7). Out of these 58 case reviews in 41 of them at least one family member had contributed to the investigation and these comprised the sample of Overview Reports for this study. As all these reports had been anonymised prior to online publication, no issues of confidentiality arose.

A proportion of the SCRs in the sample were conducted under a stipulation for family involvement articulated in HM Government (2010:239) and the rest under HM Government (2013:66-7). Despite the variation of wording both versions indicate that family members ought to be invited to participate in SCRs. Examination of the Overview Reports revealed no consistent differences in the treatment of the family voice as between SCRs conducted under the 2010 and 2013 government guidance. Current guidance, HM Government (2015:74) replicates the wording of HM Government (2013:66-7). Furthermore, since the introduction of HM Government (2013) local authorities in England have been free to conduct SCRs using a variety of methodologies as long as they met stipulated criteria regarding rigour. This has resulted in a wide variety of approaches, however the sample was too small to undertake a robust analysis of these in relation to representation of the family voice. Similarly, there were few reports published in 2014 written by the same author and therefore no analysis was undertaken in relation to Overview Report authors.

## **How Is The Family Facilitated To Contribute?**

Overwhelmingly the initial approach to kin was by letter from the LSCB or lead reviewer, followed by a single face-to-face interview at the family member's home, normally by the report author, independent SCR panel chair or LSCB business or development manager. It was exceptional for any other means to be utilised, although in three reviews telephone interviews were resorted to when face-to-face exchanges proved unfeasible. On only two occasions were there reports of meeting a family member on more than one occasion. In rare instances first contact was made through a third party, for example a mental health worker in the case of an ill parent (Southampton SCB, 2014). Almost one fifth of the sample reports provided no, or minimal, detail as to how family members were involved. There is no evidence in the SCRs examined that the professional engaging with the family did anything other than employ an interview format. The use of information communication technology is almost entirely absent, with only one example of an email exchange following on from a face-to-face meeting. There is no evidence from any Overview Reports that the notes taken of such meetings were shared with family members.

## **What Is The Family Asked?**

This section focuses on the sub-sample of 41 Overview Reports where at least one member of the family was involved in the case review. These reports, with a few exceptions, set out their terms of reference which include a list of questions or areas for exploration which the case review aims to address. Analysis of the terms of reference across Overview Reports showed them to be overwhelmingly directed to the individual agencies which were delivering services to the family or had contact with them. Consequently such questions exhibit a high

bias towards professional rather than family concerns. SCRs conducted under HM Government (2010:245-6) were obliged to adopt the detailed terms of reference set out in that statutory guidance, the first five of which are reproduced below. However, many of the case reviews conducted under HM Government (2013) which were not required to use these, continued to do so, often in a closely adapted form, for example Hull SCB (2014:67-8); Gloucestershire SCB (2014:53-4) and Southampton SCB (2014:57-8).

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?

The terms of reference adumbrated above evidence a professional preoccupation with the *technologies of practice* (Foucault, 1975) evident in copious mentions of 'relevant enquiries',



‘assessment’, ‘information recorded’, ‘care plans’, ‘reviewing processes’, ‘procedures for safeguarding’ and the *dividing practice* of recognising ‘indicators of abuse or neglect’ designed to separate out the families at risk who require social work intervention from those which do not. Such a framing of the terms of reference permits only professional perspectives. This is reinforced by the conception of children and families which emerges from the formulation of questions for practitioners and their managers. Verbs are attached exclusively to professionals who ‘ascertained’, were ‘acting on concerns’, engaged in ‘decision making’, or were ‘aware of’ or ‘sensitive to’ issues. Families and children are grammatically and literally the objects of professionals’ actions, to be done unto.

The extreme degree to which professionals are *activated* and represented as having control over processes and others, while children and families are *passivated* and portrayed as acted upon, is obfuscated by the frequent elision of the grammatical subject (Fairclough, 2003:145). So for example the question ‘Did actions accord with assessments and decisions made?’ is actually being posed exclusively to professionals and should read, were it written in full, ‘Did the actions of practitioners accord with assessments and decisions made?’. Even those questions which might notionally be addressed to children and families such as the question concerning the wishes and feelings of children is not in fact to be addressed to them, but instead has become several technical questions to be posed to professionals as to ‘when and in what way’ they took account of these. The audience for these terms of reference appears to be exclusively practitioners, their managers and their organisations. In only one case out of the sub-sample, that of West Sussex SCB (2014:para 2.1.8), did all the terms of reference appear sufficiently overarching to encompass both a family and a professional perspective for each, as demonstrated in the excerpt below.

How can we effectively identify, understand and manage risk to and from child sexual abusers?

How can we effectively respond to children who report sexual abuse by other children/young people?

How can we effectively support children who pose a risk of sexual harm to other children?

How can we effectively work with parents of children abused by other children when they are reluctant to engage?

These are all broad open questions which still address the particular circumstances in which a child sexually abused a number of his peers. Prima facie they could potentially elicit both a professional view and a family view of events and possible improvements to child protection systems. However their construction still reflects a professional frame of reference. The use of the first person plural ‘we’ in each question could be mistaken as referring to both professionals and family members. But phrases such as ‘manage risk’ and ‘effectively respond’ indicate that this plural pronoun refers only to professionals. *Managing risk* and *responding effectively* are not phrases normally recruited to describe the actions or expectations of family members. The word ‘effectively’ appears repeatedly and is evaluated as a desirable outcome, substituting for the broader less technocratic word ‘improvement’. This is not accidental and surely alludes to external texts regarding performance management and the drive for cost effectiveness, efficient use of resources, efficient work routines and optimal organisational infrastructure. These were all objectives of the modernisation project first introduced into social work by the New Labour Government in 1998, but which also underpin social services in North America (Gilbert et al., 2011; Parton, 2014). The hidden inter-textuality of the word ‘efficiency’ obfuscates the extent to which it refers to

technologies of practice in relation to performance management and therefore actually narrows the opening for family perspectives.

### **How Are Family Contributions Represented?**

Overview Reports were primarily constructed within a positivist paradigm, which assumes that social phenomena can be objectively observed and logical deductions made about their cause and effect relationships to one another (Blaikie & Priest, 2017). Hence Overview Reports purport to represent events, interactions and personal experiences as the truth of what took place. But they are essentially a summary of the past constructed from a set of reports produced by a manager in each of the agencies involved with the family, which in turn is a summary of information derived from agency held documents, sometimes supplemented by interviews with individual professionals. In some models of case reviewing the lead reviewers directly interview staff, producing written records of these, parts of which may be incorporated into the final report. Given that Overview Reports must be signed-off by Local Safeguarding Children Boards composed of the very agencies likely to have been working with the family, reputational management at senior level alongside pre-emption of critical media attention on publication can result in some amendment of ‘the facts’ as SCRs have become a mechanism for publically apportioning blame (Jones, 2014). In such circumstances the narrative form and processes of Overview Report construction can constrain the articulation of family voices.

In the sub-sample of SCRs which included contributions from family members 57% presented the view of family members in a separate section usually located near the beginning of the Overview Report, typically giving it little further consideration. No evidence

was found of verbatim quotations from digital audio recording of discussion with families or the incorporation of other mediums of direct communication with them into Overview Reports. Consequently, all passages purporting to be the family's view are based on notes taken by the author or another member of the review team and then edited down further for the purposes of inclusion in the report. In all Overview Reports the voices of professionals as well as those of family members are reported speech, and are therefore reconstructions of what was actually said, for example at a child protection case conference or in person to the author during a face to face meeting. Direct speech, in the form of quotation from transcripts of social interactions is absent. Consequently all voices are mediated by the Overview Report author who is constructing the narrative. The consequences of this for the majority of Overview Reports can be illustrated from the excerpt below reproduced from Southampton SCB (2014:para.2.12), which is described in the report as the family voice.

### **Family Involvement**

The general points made by Mother were that:

- She asked for help when she could not cope with Child I but did not receive an adequate response from children's social care.
- The support she received did not always meet her needs. She frequently felt judged and criticised and felt that she was being told what to do but not why. There was no one there for her who was not going to judge her.
- It was hard to build up relationships with social workers as staff were always "chopping and changing".
- Services were very confusing and she did not know what to expect from people and what they expected from her.

In Southampton SCB (2014) two children aged 2 and 4 years had died soon after each other in the care of their mother. No charges were preferred against her as the cause of death could not be determined. Child protection services had been involved with the family over a number of years due to concerns around neglect. All four of the points attributed to the mother, reproduced above, are highly critical of child protection social workers and allied professionals. The Overview Report author goes on to find that the mother was receiving multiple services and had learning disabilities likely to impair her comprehension, thus identifying some concurrence with her final point. But the articulation of her viewpoint is confined to these four lines out of a report 58 pages long and her views are unelaborated. The mother is reported to have asked for help, but precisely what help she asked for, and why she considered it inadequate, was apparently not elicited. She is said to have stated that the support from services did not always meet her needs, which needs did it not meet and what sort of services would have met her needs? In the above excerpt, the author writes that the mother 'felt judged' and thought that 'there was no one there for her'. What was it about her experience of professional interactions that lead her to feel this and how does she conceptualise someone being there for her? The mother is said to have stated that she was told what to do, but not why. How would knowing why she was being asked to do something have changed her decisions or behaviours?

It is doubtful that the working through of such questions can be achieved in single face-to-face meetings or one-off telephone calls, which characterised the overwhelming majority of SCRs. Without much greater elaboration of family views it is difficult to discern how they can prompt service improvement. Notably in this Overview Report the author comments that as a consequence of poorly maintained records in health and social services agencies the 'mother's input to the review has therefore been invaluable in clarifying the sequence of

events' (Southampton SCB, 2014:4.6). This echoes Sidebotham et al. (2016:215) in their triennial analysis of SCRs, which highlighted the importance of family contributions by quoting one Overview Report author who said 'The contribution by (mother) helped significantly in understanding this family's story and significantly filled in the gaps of information that was known to agencies'. Furthermore, out of ten recommendations, elements of just one refer directly to the mother requiring: a holistic approach by adults and children's services to assessment and service provision where a parent has a learning difficulty; ensuring the effectiveness of existing protocols; and better knowledge and skills among professionals for assessing the parenting capacity of adults with learning disabilities. These recommendations are at a level of generality and seem tangential to the more specific points raised by the mother.

Even when the family voice is integrated into the Overview Report, the potential for distortion remains. In the excerpt below from Walsall SCB (2014:4.3.25) contradictory views are expressed by a practitioner, the mother (found to have grossly maltreated one of her children) and the sibling of the victim.

At the initial conference, HT1 reported W3 'often' coming to school in his pyjamas, hungry and upset. It would appear that by way of an explanation for W3 appearing at school in his pyjamas, mother said she was obliged to carry him in like that when he was upset.

*Comment: the explanation lacked credibility and did not explain his observed hunger. When the author met with S2, he recalled being denied any breakfast cereal and being sent to school hungry on most days.*

The excerpt above at first sight appears balanced, incorporating as it does the views and observations of a health visitor, the mother, a sibling and comment added in italics by the author. But it is important to examine how language is being used to undermine some views while affirming others. The phrase ‘the explanation lacked credibility’ is employed by the author as a categorical statement and constructs this view as an unassailable fact, albeit that the recollection of the sibling is employed to corroborate it. Expressions by the author such as ‘in my opinion’ or ‘it could be that’, missing from the passage above, introduce modal verbs which indicate the attitude of the speaker towards their assertion, such as the degree of certainty they hold about it. If the negative evaluation of the mother’s explanation, as incredulous, had been constructed as the *opinion* of the author, albeit an expert one, it would have introduced dialogicality and the possibility of other opinions. Perspectives become superfluous if events are represented as ‘the facts’ in the absence of modality. Moreover, the author undermines the version of events given by the mother in how they represent them. Phrases such as ‘it would appear that’ and ‘by way of an explanation’ subtly convey an element of doubt regarding the reliability of the mother’s assertions. So while the author avoids modality in relation to their own opinion they employ it in representing the opinion of the mother.

In the above extract, the mother’s voice is formulated as an oppositional binary to that of the professional view. This sets it within a positivist frame of reference whereby only one perspective can be correct, thus constituting the ‘truth’ about events. The above representation of the mother’s voice, while ostensibly dialogical, actually neglects to explore the nature of these differing perspectives. Within an interpretivist paradigm social reality is understood to be constructed through multiple subjective experiences of the world (Blaikie & Priest, 2017). Enquiry therefore explores in what ways and why the perspectives of

individuals diverge and how this can inform interpersonal encounters between family members and professionals. This potential is demonstrated in the excerpt below from West Sussex SCB (2014) concerned with a youth who had sexually abused his peers. It is unique among the Overview Reports in that, at least in this section, the author applies an interpretivist perspective to explore three views in relation to the same event, that of the social worker, the perpetrator and the mother of the perpetrator respectively, all of which are explicit.

4.2.7..the social worker made 5 home visits, tried very hard to get John to ‘open up’, and challenged him about the inconsistency in his calm attitude to the allegations from the victims... The social worker used the process to flag up to John and his family that he was seen as a risk to others. However, John did not acknowledge his offending during the assessment. The social worker mentioned to the review team about feeling constantly anxious because the Police had told her she could only refer to one of the allegations and she was worried about sharing any information that was not allowed.

4.2.8 When John was visited in prison ...he talked about ...feeling frustrated because the social worker did not tell him why she was undertaking the assessment, but wanted to “know everything about me”. He said his response was to refuse to cooperate.

4.2.9 John’s mother was critical of the very limited information that was shared at this time as it limited her potential contribution to stopping John’s abusive behaviour. She was clear that she would have supported a multiagency response to manage the risk posed by John if she had been told the information she has since discovered was known at the time.



These three distinct perceptions of the same interaction concur around partially shared information which meant that the risk posed by the perpetrator was not fully conveyed to either the perpetrator or his mother who might have been enabled to better protect other children from sexual abuse by her son. All these agents are *activated* and represented as acting, interacting, reacting and reflecting on the reasons for their actions. There is a high level of dialogicality which leads not to an anarchic jumble of perspectives, but to concurrence of experience producing new insight and learning. This juxtaposition of perspectives reveals a systemic problem regarding information sharing between social workers and police officers which undercut support to families where a child is also a sexual abuser as acknowledged in the Overview Report (West Sussex SCB, 2014:para.5.22). One out of seven findings of this SCR related directly to the contributions of the family highlighted above and required remedial action by West Sussex SCB.

Read altogether the extracts from Overview Reports in this section are illustrative of the nature of family contributions which invariably described how things *have been*, but rarely how they *could be* and never how they *should be*. These modal verbs, indicating alternative versions of past or future do not figure in family contributions. Deontological assertions are reserved for the Overview Report author alone. No suggestions by family members for service improvement are described, even though only two Overview Reports out of the sample of 41 recorded the family as saying that nothing more could have been done. As a result, family contributions typically articulate entirely negative evaluations of child protection services. This accentuates the oppositional perspectives of family members and professionals producing little learning to inform recommendations.

## **To What Extent Do Family Contributions Influence Case Review Recommendations?**

SCRs in addition to promulgating a set of recommendations for each of the individual agencies involved with the family often make cross-cutting multi-agency related recommendations addressed to the LSCB. The total number of recommendations varies hugely ranging from around 10 in some Overview Reports up to 75 in others. This is further complicated as some reports include both cross-cutting and agency specific recommendations, while others only detail the former. However, what all 41 reports in the sub-sample exhibit, is the virtual absence of recommendations related to the family's contribution. Out of the sample 24 Overview Reports made no recommendations related to family inputs, 11 had just one recommendation, 5 evidenced two recommendations and just one had three or more recommendations related to the family's contribution to the SCR. Inevitably in wide ranging reviews of complex events, often extending over years and involving multiple professionals and several family members, there will not necessarily be direct explicit relationships between the inputs of particular individuals and case review outcomes. Even allowing for this effect, the findings reveal such an overwhelming paucity of family perspectives reflected in the findings and recommendations of SCRs as to raise doubts over the attention these are given in the case review process. This is consistent with Morris, et al., (2012:46-7) in which many families interviewed stated that the case review report did not reflect their contributions.

### **Conclusion**

Despite the involvement of family members in 41 out of the 58 cases initially examined, evidence from this study reveals that they are often treated primarily as sources of historical

details or missing information, exercising minimal influence on recommendations. Allocating more time to family engagement beyond the predominant one-off interviews with family members would enable lead reviewers to build rapport and ask more specific, complex and sometimes exacting questions of them. The findings also suggest that family members should be given the opportunity to assist in shaping some of the terms of reference in order to extend these to encompass issues they think central to the unfolding of events; a proposition also advanced by Morris et al (2012). This is not at all to suggest family members should be able to veto terms of reference or create self-serving parameters for a case review.

If family members are to contribute more authentically to reviews, they ought to be enabled to do so directly and without the heavy mediation of their voices by report authors. This study makes a case for the contemporaneous recording of interviews with family members or the use of material directly produced by them such as letters, emails, digital dairies and social media entries. Albeit that these will require consideration of confidentiality, consent and editing back for inclusion in an Overview Report. But such direct speech would, like the views and statements of professionals, have to be subject to interrogation and sometimes contradiction by the contributions of others. Rather than be corralled in a separate section within SCR reports, family voices ought to be conveyed in conjunction with those of professionals, both in terms of contradictions as well as concurrences.

The British government's National Panel (2014:7) criticised the majority of Overview Reports for largely listing events while inadequately addressing *why* things happened or examining people's motivations, thus failing to identify root causes. A positivist paradigm which advances chronological linear causal chains of events is likely to perpetuate this kind of report construction (Blaikie & Priest, 2017). An interpretivist approach by seeking to

uncover the meanings and understandings of events from the viewpoint of multiple family members and professionals is more effective at revealing the causal complexity of concurrent and consecutive interdependent actions and responses framed by wider systems. This approach is highly consistent with HM Government (2015:74) guidance which requires SCRs to: recognise complex circumstances; understand who did what and why; and understand practice from individuals' viewpoints at the time of events. This guidance also demands transparency as to how data are collected and analysed making the inclusion of modality in relation to report authors' perspectives a relevant consideration. Overview Reports of this nature would move away from chronologies towards linking contemporaneous, subsequent and ostensibly disparate events because they are crucially related through an individual's perception of them as associated. As demonstrated in the illustrative example from West Sussex SCB (2014) the integration and juxtaposition of differing perspectives can facilitate the emergence of complexity in multi-agency child protection systems and illuminate what lessons need to be learnt while indicating how failings can be remedied.

## References

- Blaikie, N. & Priest, J. (2017). *Social Research Paradigms in Action*. London: Polity Press.
- Brandon, M., Bailey, S., Belderson, P. Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C., & Black J. (2009). *Understanding serious case reviews and their impact: a biennial analysis of serious case reviews 2005-07*. London: Department for Children, Schools and Families.
- Brandon, M., Sidebotham, P., Bailey, S., & Belderson, P. (2011). *A study of recommendations arising from serious case reviews 2009-2010*. London: Department for Education.
- Fairclough, N. (2007). *Analysing discourse*. London: Routledge.
- Fraser, J., Sidebotham, Frederick, J. Covington, T., & Mitchell, E.A. (2014). Learning from child death review in the USA, England, Australia, and New Zealand. *The Lancet* 384 September 6 894-903.
- Foucault, M. (1975). *The birth of the clinic: an archaeology of medical perception*. New York: Vintage Books.
- Gilbert, N., Parton, N., & Skivernes, M. (eds.) (2011). *Child protection systems: international trends and orientations*. New York/Oxford: Oxford University Press.
- Gloucestershire SCB (2014). *Serious case review: subjects Abigail and her siblings Bobbie, Charlie and Daisy*. Retrieved from <http://www.gscb.org.uk/CHttpHandler.ashx?id=61214&p=0>

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

HM Government (2013). *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*. London: Department of Education.

HM Government (2015). *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/419595/Working\\_Together\\_to\\_Safeguard\\_Children.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf)

Hull SCB (2014) *Serious case review: child T born May 2010 died January 2013*. Hull: Hull Safeguarding Children Board.

Jones, R. (2014). *The story of baby P: setting the record straight*. Bristol: Policy Press.

Morris, K., Brandon, M., & Tudor, P. (2012). *A study of family involvement in case reviews: messages for policy and practice*. British Association for the Study and Prevention of Child Abuse and Neglect: York.

National Panel (2014) *First Annual Report*. National Panel of Independent Experts on Serious Case Reviews. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/474652/First\\_report\\_Serious\\_Case\\_Review\\_Panel.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/474652/First_report_Serious_Case_Review_Panel.pdf)

Ofsted (2011). *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*.

Retrieved from <http://www.ofsted.gov.uk>

Ofsted (2014) *Official statistical release: serious incident notifications (SIN) from local authority children's services*

<http://webarchive.nationalarchives.gov.uk/20141124154759/http://www.ofsted.gov.uk/resources/serious-incident-notifications-official-statistics-release>

Parton, N. (2014). *The politics of child protection: contemporary developments and future directions*. Basingstoke: PalgraveMacmillan.

Sidebotham, P., Brandon, M., Bailey, S. Belderson, P., Dosworth, J., Garstang, J., Harrison, E., Retzer, A. & Sorensen, P. (2016) *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014*. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/533826/Triennial\\_Analysis\\_of\\_SCRs\\_2011-2014\\_-\\_Pathways\\_to\\_harm\\_and\\_protection.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-_Pathways_to_harm_and_protection.pdf)

Southampton SCB (2014). *Serious case review child I and child M*. Southampton: Southampton Safeguarding Children Board.

Vincent, S. (2014). Child death review processes: a six-country comparison. *Child Abuse Review*, 23, 116-129.

Walsall SCB (2014). *Serious case review: Child W3*. Retrieved from <http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm0=C5139>

Wandsworth SCB (2014). *Serious case review: 'Zara'*. Retrieved from  
<http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm0=C5258>

West Sussex SCB (2014). *Serious case review: examines the responses of agencies to allegations of sexual abuse made by a number of young boys against another child, between January 2011 and March 2013*. Retrieved from  
<http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm0=C5083>