DARTINGTON SERVICE DESIGN LAB

The Role and Value of Reviews, Investigations and Inquiries in Order to Learn Lessons in the Field of Public Services

Report of a Centre for Social Policy Seminar
King's College, London
29th October, 2018

Introduction

At first glance, serious case reviews and other statutory inquiries or investigations have a clear function and relatively simple task, namely to find out what happened and why when a vulnerable person, patient or service user dies, is seriously harmed or is at risk of such as a result of suspected abuse, neglect, professional incompetence or system failure, and then to determine what can be learned to reduce the likelihood of it ever happening again. In some circumstances, several responses may take place in parallel or consecutively; these can include inquests, public inquiries, management reviews, professional tribunals or criminal trials and the findings of one may have consequences for others, such as when coroners' verdicts open the door to criminal proceedings or compensation claims or when national inquiries lead to law reforms or organisational restructuring. But the function of serious investigations or reviews is often more discrete; the aim being to identify ways that local professionals and agencies can improve their safeguarding of citizens.

In the UK, there is now a substantial collection and practice history of reviews covering health, mental health, adult and child social care and criminal justice. Indeed, it stretches back to Victorian times. Thus, given all this experience, it is opportune to stand back and assess if their aims are being achieved and how they influence policy and practice, minimise the recurrence of past tragedies and are cost effective.

Background to the seminar

The origins of this seminar begin nearly ten years ago at a CSP Seminar in Dartington. It was in June 2009 that Wendy Rose and Gillian Downham gave presentations on the topic of learning lessons from children's serious case reviews and independent mental health inquiries. Wendy (with Julie Barnes) had already produced a review of child deaths and serious injuries in England *Improving Safeguarding Practice: a study of serious case reviews 2001-2003*. Gillian co-authored a 2009 article published in the *International Journal of Mental Health and Capacity Law* entitled *Learning Lessons, Using Inquiries for Change* which was based on her experience of chairing mental health homicide inquiries. In addition to these, Roger Bullock (with Ruth Sinclair) had published *Learning from Past Experience: A Review of Serious Case Reviews* in 2002 and, with Nick Axford, *Child Deaths and Significant Case Reviews: International Approaches* in 2005 and *Core Skills, Specialist Competencies, Training and Material for Understanding Reviews of Child Deaths and Serious Injurie*s a year later.

That seminar led to the setting up in 2010 of a social enterprise not-for-profit limited company called Sequeli. Gillian Downham and Roger Bullock were co-directors. Wendy Rose, Androulla Johnstone, James Blewett and Jill Manthorpe were associates. Jill had co-edited a wide ranging review of inquiries entitled The Age of the Inquiry: Learning and blaming in health and social care, published in 2004, and is Director of a NIHR Policy Research Programme that developed the first repository and analysis of adult services case reviews. Sequeli aimed to support children's serious case reviews, mental health investigations, domestic homicide inquiries and adults serious case reviews (now termed safeguarding adults reviews).

At the time, such reviews and investigations differed in their statutory remit and the methodologies they employed, a variation partly explained by the fact that they addressed different circumstances and client groups and emanated from different government or local departments. Sequeli challenged this approach by advocating an integrated methodology. It was guided by a simple principle: the same workers from the same state agencies were sometimes involved with the same families who experienced the same kinds of problem with the same distress. For example, a family might be receiving services for domestic violence, mental health problems or family functioning, although this was not always the case, especially when older people were the client group concerned. Sequeli believed that any examination of untoward incidents or allegations of abuse or neglect should adopt a cross-boundary approach, if appropriate, and should make cross-agency recommendations and lead to cross-agency learning to develop the capacity among those responsible for reviews and investigations. To facilitate this, Sequeli developed its own integrated cross-boundary training tools called the Core Competencies.

Sequeli was supported from the outset by Sir Ian Kennedy, the distinguished academic lawyer, and In conjunction with King’s College, London ran well-attended seminars both for the chairs of reviews and investigations and for those responsible for commissioning them. Based on its Core Competencies, Sequeli developed training tools for the Home Office to train its chairs of domestic homicide reviews. Using the same materials, Sequeli worked with the NSPCC and for a whole year trained a new cohort of chairs of children’s serious case reviews on a programme commissioned by the Department for Education. Marian Brandon of the University of East Anglia was appointed to evaluate that initiative.

At its peak, when Sequeli was advocating one training system across all types of independent review and investigation in the health and social care arena, it

seemed there was some real understanding of the need for a common approach and common skills.

Sequeli drew to a close in October 2017 but three months ago during a general conversation, Androulla Johnstone remarked to Gillian Downham, "You would not recognise the world of mental health investigations now". Her comment raised the question 'is it possible to discern any new trends in the way lessons are learned?' and this provided the stimulus for this seminar. After all, the political landscape has clearly changed, there has been an increase in the privatisation of provision, austerity has limited what can be done, experts are increasingly disrespected, survivors have found a louder voice, more types of exploitation are included in investigations and some inquiries are scrutinising events that occurred several decades ago. So the key question is 'has all this change made any difference to the role and function of reviews?'

Three fundamental questions

To give some structure to the discussion, Gillian Downham posed three questions about serious case reviews (for the purpose of this summary the terms 'reviews' and 'investigations' are used interchangeably).

What are reviews and investigations for?

As explained above, the easy and much cited answer is 'to learn lessons' but are there other spoken or unspoken reasons, for example simply to demonstrate compliance with a requirement to carry out a review, to argue for more funding, anticipate blame, answer critics and demonstrate that action is being taken. This leads on the question of whether there is there an overarching government vision that determines what reviews are for and whether all types of review can and should share the same purpose. Then there are theoretical questions, such as where do the concepts of justice and independence fit, if at all, and is there any empirical evidence in terms of outcomes on how current functions match what serious case reviews should be about?

Who are reviews and investigations for?

This raises the question of who are the target audiences - researchers, local and national politicians, commissioners, service providers, service users/patients, professionals, the bereaved and/or the public - and do all of these expect the same thing from reviews and, if not, how do their expectations fit together? Similarly, when does the local focus of a review become a matter of national interest? For instance, the Hillsborough Inquiry is often cited as a good model; it certainly had relevance to football stadia word-wide.

Are reviews and investigations good value?

Finally, there are administrative questions of whether reviews offer good value for money in terms of benefits to services and survivors, what constitutes a good review, how this is judged and by whom and whether any overviews have been able to identify the conditions for successful completion, acceptance and effect?

Five presentations elaborating these questions

Five participants then discussed these questions in the light of their experiences. They were Gillian Downham (mental health), Androulla Johnstone (NHS), Jill Manthorpe (adult social care) and James Blewett and Wendy Rose (children's social care in England and Wales).

The five presenters all agreed that the aims of 'learning lessons to improve agency performance' remain the prime focus and that frequent recommendations include calls for better inter-agency cooperation, more robust protection procedures, heightened professional development and increasing similarities in codes of practice. But, unfortunately, these worthy ambitions are often complicated by broader issues, such as expectations among victims, survivors and their families that reviews and inquiries will resolve any expectations of blame and justice, the difficulties of handling the sometimes unhelpful contributions of the media and social media and mollifying public anxieties about scandals.

This change has affected two areas: the organisational and conceptual context in which reviews are conducted and the process of undertaking them.

The experience and technical skills of investigators will always be developing but not always in the same direction. For example, there has been noticeable divergence in the extent and breadth of the guidance available, such as in the recent NHS investigations, Department for Education inquiries following the Wood review and the Care Act 2014 guidance, whereas there has perhaps been greater convergence with regard to the methods used or required by the various review commissioners with growing use of common theoretical approaches, such as systemic and root-cause analysis.

Thus, there remain some common features of reviews in all the service or client group areas, for example with regard to the legal authority under which they operate, the focus on local practice, the limited exploration of the series of 'why' questions, the nature of the explanations for the event and the recommendations. But there are also major changes afoot, for example, the 2018 Working Together for children's services promotes the National Child Safeguarding Practice Review Panel, encourages rapid reviews by safeguarding practitioners locally, the use of methodologies appropriate for the task and local

conditions and the publication of reports. In contrast, the Care Act 2014 moved safeguarding adults reviews to a statutory footing. With regard to operation, Manthorpe and Martineau's latest analysis of the corpus of safeguarding adult reviews, focusing on mental health law implications, found communalities, such as unclear interface of mental health services with safeguarding, poor inter-agency co-ordination, limited understanding of complex legal rules, inconsistent practice around capacity assessments, failures of support and challenges and missing or incomplete guidance. All of these situations and observations may apply across the board and suggest the difficulty of improving individual practice when systems do not support this.

But much more significant, especially within the NHS and criminal justice settings, is the shift in ethos in recent years with the notion of 'justice' becoming dominant in the eyes of the public, an expectation that blame will be attributed and an increasing distrust of expert opinion. Hence, the wishes of commissioners for learning and service development are increasingly at odds with those who see reviews as a vehicle for delivering justice - perhaps the only one. Growing political and media attention with an associated demand for press conferences and public launches of reports are further confounding matters. The situations scrutinised in reviews are inevitably complex and emotional but these new pressures may create unrealistic expectations and put investigators under stress. As one contributor concluded, 'there needs to be a move away from the fixation on investigation methodology onto one that focuses on the method the team uses'.

These changes have highlighted several fundamental questions that were always bubbling under the surface but which have become much more salient. One is the distinction and relationship between justice, accountability, culpability and learning; a second what the widely used term 'independence' means in reality. There are also questions about the ownership of the methodologies employed and whether, in the end, they make any difference to the outcome as the recommendations are often very general and predictable. Participants were also keen to stress that serious case reviews and inquiries are only one source of learning and most managers and practitioners develop their expertise in other ways.

But pessimism should not prevail. The UK system of reviews is admired throughout the world and for all its faults, sometimes does give a voice to the voiceless and gives them some confidence that the process will be 'fair'. Some reviews have also led to beneficial changes, such as increased resources, better training, coordination of services, involvement of disparate agencies and better child protection in most situations. Wendy Rose described improvements in Wales

brought about by closely involving practitioners early on in this country's review system, establishing a clear time-line, asking for help from families in the compilation of the report and presenting nuanced findings relevant to them and the local area. Reports are short, anonymous, concentrate on recent work with families, are published and focus on learning. One symbolic change was the replacement of the phrase 'learning lessons' to just 'learning'.

The fear, therefore, is that serious case reviews have become too much of an 'industry'. even though the numbers have remained consistent over the years. Many make the same recommendations without any follow-up on whether they are implemented or make a difference. Indeed, there is a danger that the setting up and conduct of the review become the end in itself and that it can be safely kicked into the long grass once it is over. In addition, some participants expressed deeper concerns, that the process has been affected by the intrusion and demands of non-professional interest groups and those seeking financial reward, either in compensation or professional fees, although there is not (yet) the equivalent of 'ambulance chasing lawyers' in this field. Finally, fears of a growing public expectation that reviews will automatically attribute blame was a major worry. Unless commissioning takes into account a different approach to the setting of terms of reference, reviews and investigations will always focus on core agendas which do not always reflect local issues and needs. Basically, if you ask the same questions you will always get the same answers; this needs to change.

Conclusions

The plenary discussions following the presentations highlighted seven issues as follows.

The need for clear terms of reference

The confusion between the functions of different types of investigation means that expectations do not always match official aims. Thus, the terms of reference of a review or investigation are critical in determining not just what it can address but also how it is perceived. The danger is that a narrow focus on learning may cause them to be seen as a cover up and thus damage the integrity of the professionals involved. Some of the factors affecting what happens to victims and survivors are societal, such as poverty and overcrowding, and these can compound enduring personal problems, such as illness or addictions, and punitive policies of other agencies, such as school exclusion, eviction or eligibility for benefits. These problems are not readily amenable to local practice reforms, so the terms of reference of any inquiry need to address some of these contexts

and acknowledge their significance when relevant, otherwise the impact of the findings and recommendations will be reduced.

The importance of independence

The question of independence may enhance the perceived objectivity and fairness of the review, although not all reviews need to claim independence. Indeed, independence applies at different levels: is it the chair, the review members (if there is more than one), a majority of them or the liaison people in the agencies that provide the information? Independence can be comprised at all these levels. It also raises the question of membership of the review panel (if there is one) and who selects them, and on what basis? There was concern that there does not seem to be much research evidence on this and so it remains unclear whether this affects outcomes.

An important aspect of independence is the involvement and support of those who are personally affected by the subject matter of reviews to assist the process or, in some circumstances, the chair or the team. In most reviews, contact is offered via a central phone number or email, but in some rare instances there have been occasions where the personal contact details of members have been given to those providing forms of testimony on the grounds that their duty of care is a 24/7 commitment. There was some surprise at this among the participants, reflecting contrasting views about appropriate boundaries and risk management.

Standards of evidence

Given the sometimes fraught situations covered by reviews and inquiries, evidence may be contentious. So what standards should be applied, given that reviews may encounter inconsistencies between and within statements and case records, conflicting evidence, mendacity, concealment, cover up and false or incomplete memories? The stance that should be taken by reviewers needs to be decided upon: should they disbelieve everyone and stick with tangible evidence or should they pursue avenues where they suspect that human rights have been abused even if information is scant? A related question is this: how and when should the reviewer reach conclusions as to the 'truth' in such an imbroglio. Again, there seems to be a dearth of information on tis topic. The position is not helped in some areas, for example mental health investigations, by the absence of any guidance on this point. The word 'evidence' is rarely used in these non-statutory reviews and there is no legal basis for deciding which account of events is true. Nowhere is it suggested the decision should be made on the balance of probabilities (deciding that one account is more likely to be true than another). At the seminar, some participants described dealing with the problem by not coming

to any conclusion at all when accounts differed. In this confusing setting, it is not surprising that misunderstandings about justice and blame arise. It would be helpful if the limitations of reviews and investigations were set out clearly at the start so that unrealistic expectations could be avoided.

Greater awareness of practical constraints on professionals

Several participants mentioned that reviews sometimes pay insufficient attention to the practical constraints on professionals and 'what happened in the office that day', although this is not always the case. Practical difficulties such as contacting the right individual, getting through to an agency, getting it to act and the demands of other work sometimes lead to delays or inaction that can have devastating consequences. This is not to make excuses for poor practice but to acknowledge that processes, communications and responses do not always operate smoothly and that this is not because of any recalcitrance on the part of those involved.

Sensitive support of participants and avoiding secondary trauma

One of the problems of reviews and inquiries is that sometimes those who have been harmed or placed at risk also provide testimony or accounts to the review and may be children, young people or vulnerable adults. While the techniques of gathering information from such people are generally well embedded in some areas of practice, it is not always realised how much the review experience and the need to relive past events might cause secondary trauma which can be damaging. Family and peer relationships might also be affected. The unintended consequences of well-intentioned actions must always be high in people's minds when commissioning and conducting reviews.

Similar secondary effects can occur when a staff member is suspended while inquiries are conducted. This is often perceived as a neutral act but can have harmful effects if appropriate support is not put in place or even considered. Limits to the permitted contact with suspended staff members can compound the detrimental effect on their mental health of being implicated in a review.

The need to do more with reviews

Participants agreed that there were probably too many reviews taking place and in some cases they often tend to keep suggesting the same things. The focus of the recommendations is not only repetitive - inter-agency/professional collaboration, record keeping, supervision, training, mental health awareness - but is also often expressed in general terms, such as 'more', 'better' and so on, rather than anything specific. It may be that this is all that can be said without

changing the system but the risk is that this approach often leads to organisational solutions to what are social or effective practice problems. So there is likely to be more 'paperwork', more intrusive assessments, more committees, more meetings, new managerial posts and stronger inspection rather than imaginative (albeit unproven) policy or practice initiatives. In addition, there is a danger that much of the communal learning soon dissipates and gets lost in day-to-day work, especially as there is high staff turnover in human services. While the published overviews have been illuminating, they tend to concentrate on organisational reforms and the proposal for some system or organisation to bring everything together and develop systemic thinking remains a chimera.

Of course, it was pointed out that reviews repeat the same recommendations because the same problems exist - and we need to know that. But perhaps the repeated search for a perfect organisational solution is the enemy of the good review. Almost all reviews and investigations are ambitious and understandably aim high by seeking to bring about great change. But disappointment can follow when there is little impact, which can feel like failure. However, the seminar heard how smaller-scale local reviews have more modest ambitions and this can helpfully reduce expectations leading to a greater sense of achievement, though they miss the national picture. There is no perfect answer except that reviews should make it clear at the outset what can and cannot be done. And maybe the best that can be hoped for is learning which simply provides the greatest likelihood of protecting the most individuals from harm.

The need for a better understanding and explanation of probabilities

The recent changes described in respect of NHS investigations and children's services reviews need to be more in tune with professional development activities and not reflect an unduly simplistic perception of events and unrealistic perception of what is 'preventable'. Tragedies rarely occur because of a single incident of gross professional misconduct or system failure (although it has to be said that this does happen). Most occur 'out of the blue' or as an aberration within a context of calculated risk. To borrow an explanatory model from history, and echoing Eileen Munro's suggestion that air accident investigations might offer a useful way to unravel the causes of tragedies, there are generally several chains of events leading up to an incident, each of which may be independent, logical and easily charted. What is hard to predict is the collision when two of these independent chains meet. For instance, if a pedestrian is run over crossing the road, there is perhaps a perfectly logical explanation why he or she is in that place at that time, and this can be mapped and understood by asking a series of retrospective 'why' questions. The same applies to the car driver. What is

exceptional is that the two people happen to be in the same place at the same time and for some 'final cause' reason crash into each other. Failure to appreciate this chance element in the scenario can produce unrealistic expectations about the extent to which incidents might have been prevented, especially as the events covered by serious case reviews are relatively rare. This does not mean that nothing is preventable as we know from road safety that a package of measures, such as MOTs, breathalysers, tyre technology, safety belts and so on - have greatly reduced the number of accidents, but they still occur and need investigating to see what can be learned. Review teams are generally fully aware of the limits regarding prediction, probability and prevention and are able to present this knowledge with confidence in their reports and in public appearances.

In closing, it seems that the effects of these problems are varied. While confusion over functions, more rigorous testing of evidence, varied expectations and external pressures have made the task more difficult and perhaps led to a scarcity of suitable people putting themselves forward as panel members, it was generally felt that with the increasing variety of approaches, the quality and depth of reviews and investigations have improved over the years, although this does not address the problem of whether there are too many of them and the difficulties of implementing their recommendations.

Participants felt that this seminar produced fascinating discussions across the specialist areas. Because of the varied procedure and style of reviews and investigations, there is a wealth of information available for comparison. That allows for constant development and improvement of reviews, perhaps with innovation. Ideally, it would be beneficial to have one academic centre dedicated to further study and research on this extensive topic.

Appendix A - List of those attending

James Blewett (Research Director, Making Research Count)

Danielle Bryan Clark (Researcher, King's College, London)

Roger Bullock (Former Director, Dartington Social Research Unit)

Hedy Cleaver (Emeritus Professor of Social Work, Royal Holloway College)

John Diamond (CEO The Mulberry Bush)

Gillian Downham (Barrister and mental health tribunal judge, England, Wales and Guernsey)

Gill Duncan (Duncan-Johnstone consultancy)

Finlay Green (Researcher, Dartington Service Design Lab)

Sonia Jackson (Professor, Institute of Education, London)

Bob Jezzard (Child and adolescent psychiatrist)

Androulla Johnstone (former CEO HASCAS and Director of Duncan-Johnstone Consultancy)

David Lane (Former Director of Social Services and NI Abuse Inquiry member)

Kath Lane (Former residential social worker)

Jill Manthorpe (Professor of Social Work, King's College, London)

Arran Poyser (Former Inspector Dept of Health and CAFCASS)

Wendy Rose (Former Assistant Chief Inspector, Dept of Health)

Jane Tunstill (Emeritus Professor of Social Work, Royal Holloway College)

Keith White (Residential services manager)

Richard White (Family law specialist lawyer)

Appendix B - The legal and policy landscape around children's reviews

In July 2015, new *Working Together* guidance was published by DfE. Chapter 4 of the guidance states:

> The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.
>
> Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. These processes may be carried out alongside reviews or at a later stage. Employers should consider whether any disciplinary action should be taken against practitioners whose conduct and/or practice falls below acceptable standards and should refer to their regulatory body as appropriate.

A new regulatory framework was established in June 2018. At regulation 3, the National review criteria is explained as**:**

> The criteria to be taken into account by the Panel for the purpose of section 16B(1) of the Act include whether the case in question—
>
> (a) highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;
>
> (b) raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment;
>
> (c) highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.

In July 2018, the Minister for Children and Families explained that:

> "We want to improve care and support for every child, which is why it is so important we reflect and learn from the most serious cases of abuse or neglect, to help ensure the right protection is in place for some of the most vulnerable children in our society.

The new Child Safeguarding Practice Review Panel will play an important part in improving this understanding. Led by Edward Timpson, it will support local areas to make improvements to services where they are needed and reduce the risk of future harm to children.

The six panel members announced today will bring valuable experience from different professions with responsibilities for safeguarding children, including the police, children's social care, school and health sectors. They include:

- Sarah Elliott - Non-Executive Director at Avon and Wiltshire Mental Health Partnership NHS Trust and the Chair of the Local Safeguarding Children Board (LSCB) for Poole, Bournemouth and Dorset. She was previously Regional Chief Nurse for NHS England South;
- Mark Gurrey - Chair of the South Gloucestershire Improvement Board and Chair of the LSCB for Devon & Wiltshire. He has a wealth of experience working to bring about improvements at authorities in intervention;
- Karen Manners - Deputy Chief Constable of Warwickshire Police, she has 32 years of experience in policing. She is also the national lead for policing on the Vulnerability Action Plan;
- Professor Peter Sidebotham - Associate Professor in Child Health at Warwick Medical School, Consultant Paediatrician at South Warwickshire NHS Trust and a designated doctor for safeguarding children at Coventry and Warwickshire Clinical Commissioning Group (CCG);
- Dale Simon CBE - a qualified barrister and previously the Director of Public Accountability and Inclusion at the Crown Prosecution Service. She is currently the Non-Executive Director at the Parole Board; and
- Dr Susan Tranter – Executive Headteacher of Edmonton County Schools and Chief Executive of Edmonton Academy Trust. She is a member of the Mayor's Office for Policing And Crime (MOPAC)

Strategy Group and is a member of the Audit and Risk Committee of the Office of the Children's Commissioner.

The Child Safeguarding Practice Review Panel will be responsible for identifying and reviewing serious child safeguarding cases which the panel believe raise issues and themes that are complex or of national importance. It will look at what could be done differently to improve the protection and welfare of children, and what implications these cases have on current and future policy or practices.

A further panel member will be appointed from the What Works Centre for Children's Social Care, and a final position is occupied by the Chief Social Worker for Children and Families, Isabelle Trowler.

The panel will begin operating on 29 June 2018 and will work closely with the What Works Centre to build a stronger evidence base to help improve outcomes for children and share effective, innovative practice".

Writing in the New Law Journal in 1986, Robert Dingwall quotes with approval the following study by B. A. Turner, Man-Made Disasters (1978). This study is based on a sample of 84 from 449 accident and disaster reports published by the British government between 1965 and 1975:

https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1468-2230.1986.tb01700.x

Turner accepts that the total prevention of all untoward events would require an impossible omniscience. Nevertheless, an attempt to specify in ideal terms what would be involved in such a task can help us to identify the limitations of the real world. It seems that we would need to be aware of each point in a network channelling information relevant to the event in order to make sure that ambiguities were clarified, information was not overlooked and ignorance dispelled. The network would have to provide continuous, accurate feedback to all its members so that their information and plans were constantly and smoothly readjusted to conform to developing real-world events. From this, we can go on to ask what actually stops people acquiring and using relevant information so that untoward events are prevented. In general terms, the answer is that the information is not available to them at an appropriate time in a usable form.

This information can be classified into four types, each of which entails a different policy response.

1) **That which is completely unknown**. Here the response is to try to improve the procedures for locating possibly-relevant information or to develop new knowledge.

2) **That which is known but not fully appreciated**. We need to ask why it was not correctly interpreted, which seems to involve factors like a false sense of security, pressure from competing tasks, distrust of the information source, being "decoyed" by a different problem, and having difficulty in classifying the information or distinguishing it from a flood of irrelevant data.

3) **That which is known but not fully assembled**. Information may be distributed between several organisations or even wilfully withheld. The trouble arises because no one person sees enough of the picture to recognise its imminence.

4) **That which is available to be known but does not fit current modes of understanding**. All our knowledge of the world is selective, so that we recognise some potential hazards and discount others. When presented with information about these we are slow to respond. The remedy is not so much to improve the flow of information as the structure of the channels by which it is received. "

Dingwall argues that the power of Turner's analysis however lies less in this diagnosis than in his insistence that the underlying disorder does not have a specific pathology but is intrinsic to the nature of organisations in modern societies. One of the defining features of advanced societies is an elaborate division of labour.

Appendix C - References

Axford, N. & Bullock, R. (2005) *Child Deaths and Significant Case Reviews: International Approaches*, Insight 19, Scottish Government

Axford, N. & Bullock, R. (2006) *Core Skills, Specialist Competencies, Training and Material for Understanding Reviews of Child Deaths and Serious Injurie*s, Report for the Scottish Office, Dartington Social Research Unit

Barnes, J. & Rose, W. (2008) *Improving Safeguarding Practice: a study of serious case reviews 2001-2003*, DCSF Research Report DCSF.RR022

Downham, G. & Lingham, R. (2009) Learning Lessons, Using Inquiries for Change, *International Journal of Mental Health and Capacity Law*, 18, 57-69

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

Stanley, N & Manthorpe, J. eds, (2004) *The Age of the Inquiry: Learning and blaming in health and social care*, Basingstoke, Routledge

King's College London's Analyses of Adult Safeguarding Reviews

Manthorpe, J. & Martineau, S. (in press) Safeguarding Adult Reviews; implications for mental health law reform, *The Journal of Adult Protection*

Manthorpe, J., Martineau, S., Stevens, M. & Norrie, C. (2017) 'Managing difficult encounters with family members', in Cooper, A. and White, E. (eds), *Safeguarding Adults under the Care Act 2014*, London, Jessica Kingsley, pp 163-177

Manthorpe, J. & Martineau, S. (2017) Engaging with the New System of Safeguarding Adults Reviews Concerning Care Homes for Older People, *British Journal of Social Work*, 47 (7), 2086–2099, https://doi.org/10.1093/bjsw/bcw102

Manthorpe, J. & Martineau, S. (2017) Pressure points: learning from Serious Case Reviews of failures of care and pressure ulcer problems in care homes, *The Journal of Adult Protection*, 19(5), 284-296, https://doi.org/10.1108/JAP-11-2016-0029

Manthorpe, J. & Martineau, S. (2014, online) Serious Case Reviews into dementia care: an analysis of context and content, *British Journal of Social Work*. Open Access

Manthorpe, J. & Martineau, S. (2013, online) 'What can and cannot be learned from Serious Case Reviews of the care and treatment of adults with Learning Disabilities in England? Messages for social workers', British Journal of Social Work

Manthorpe, J. & Martineau, S. (2012) ' "In our experience": Chairing and commissioning Serious Case Reviews in adult safeguarding in England', Journal of Social Work, 12(1): 84-89

Manthorpe, J. & Martineau, S. (2011) 'Serious case reviews in adult safeguarding in England: An analysis of a sample of reports', British Journal of Social Work, 41(2): 224-241