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# In the Loop: A systemic approach to re-thinking the child protection system

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***Abstract:*** *The question of how to protect children from non-accidental harm has dominated child welfare discourse in England since the death of Maria Colwell in 1973. For over 40 years, the history of child care policy and in particular, child protection policy has been the history of the policymakers' responses to particular tragedies and scandals. The* Munro Review of Child Protection *(2011) is the most recent attempt to introduce major changes into the child protection system. This paper focuses on two particular aspects of the Review. Firstly, it examines how it constructs the meaning of 'child protection', as this is not clearly defined by the review. Secondly, the use of systems theory as the analytical framework is examined and some limitations of its focus on the organisational level of context are discussed. It is suggested that these two issues are interrelated and act to limit the possibilities of fundamental change in the child protection system. Drawing on the work of communication theorist, Gregory Bateson, and conceptual and practical developments within the Coordinated Management of Meaning (CMM) approach, it is argued that social workers are required to operate simultaneously within multiple, and often incompatible, contexts. For radical change to take place in the child protection system, the utopian bias that the system should prevent all non-accidental deaths needs to be abandoned.*

***Keywords:*** child deaths; meaning of 'child protection'; Munro Review; systemic approach; Gregory Bateson; utopian bias

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## Introduction

The Munro Review, commissioned by the English government and carried out by Professor Eileen Munro in 2011, is clearly a very important intervention into the longstanding and continuing debates about child care and child protection in England. The report is highly detailed and analytical and puts forward the overall aim of attempting to move from an over-bureaucratic and technocratic system for working with children to one that focuses on professional expertise and judgment. It has been suggested that the Review is seeking to achieve a paradigm shift in child protection policy (Parton, 2011). This paper seeks to focus on two particular aspects of the overall report which, it is argued, are closely related and when looked at together can offer some understanding of why the Review offers the beginnings of a new approach but does not go far enough. Both of the aspects of the Review referred to above are identified in Part One of the three-part Review and are actually mentioned in the title of the first Review report – T*he Munro Review of Child Protection, Part One: A Systems Analysis*.

What this title makes clear is that the review is about child protection and not child welfare or child care generally, or at least it is saying that child protection is the most important aspect of child welfare. Such an emphasis is hardly surprising as the letter to Eileen Munro from Michael Gove, the Education Secretary, announcing the review, stated in the first sentence that he had asked her to 'conduct an independent review to improve child protection' (Munro, 2010, appendix 1). The second aspect of the review mentioned in the title was that Part One was a systems analysis. Again, this focus was not a surprise as Munro has been drawing on, and writing about, systems ideas for many years (Munro, 2005a; 2005b; 2008). However, what was unusual was to have a report that made such a clear and unequivocal commitment to using systems theory as the basis for its analysis. As someone who has been interested in systems thinking and the application of the ideas in practice for many years, this was a very encouraging development.

However, although there are many interesting and creative insights arising from the Munro Review's use of systems thinking, there are a number of ways in which the systems ideas utilised by Munro do not go far enough to actually influence thinking about the child protection system. Part of the reason for this is that review focuses mainly on the organisational level of the child protection system and the negative effects this has on frontline practice, but does not analyse (or challenge) the meaning of the concept of child protection within the context of overall child welfare. In other words the report accepts that child protection (however it is understood) is taken for granted as the primary purpose of the whole child welfare system. This article outlines how an extended use of systems thinking, drawing on communication theories and social constructionist ideas, which might be better described as a systemic approach, could actually be used to re-think the meaning of child protection in this context. Such an approach can also be used to analyse why this emphasis on child protection, and

in particular, the political and public responses to non-accidental child deaths, has had a dominant and in many ways, detrimental effect on general child care practice.

## What is the meaning of 'child protection'?

In his letter to Eileen Munro setting up the Munro Review of Child Protection Michael Gove said that 'the system of child protection in our country is not working as well as it should. We need to fundamentally review the system' (Munro, 2010, appendix. 1). But he did not say what aspects of the system were not working nor did he explain why a fundamental review was needed. However, the letter did make clear that he wished to reform frontline social work practice and help social workers make 'well-informed judgments .. free from unnecessary bureaucracy and regulation' and proposed three key areas that might to be addressed by the review: early intervention; trusting frontline social workers; and transparency and accountability. So while one can make intelligent assumptions about why the review was taking place, it is never clearly stated what aspects of the child protection system are not working and, as a result, what outcomes are not being achieved.

This lack of clarity is also true of the Munro Review itself, as neither does it say what it means by 'child protection' or the 'child protection system'. At times it seems to suggest that it means the protection of 'children at risk' from serious harm, but at other times it appears to refer to a much broader category of children in need and how professionals involved in universal child welfare services should be aware of the need for early intervention. As Parton (2011) points out, the review says that 'the measure of the success of child protection systems, both local and national, is whether children are receiving effective help' (Munro, 2011, p.38) but no definitions or criteria are given to explain what might constitute such help. So while the Munro Review is undoubtedly a well-researched and detailed document with a clear analytical framework and identifies areas that could be improved, it does not say clearly what the child protection system is or how one would judge that it was operating properly. Parton surmises whether the aim of the review was to work towards a reduction in non-accidental child deaths but concludes that the review had a broader focus (2011, p.154). In fact, it looks as if Munro wished to position the review as different to previous inquiries as, on the face of it, it was not established in response to a political and public outcry following the death of a child or a child care scandal (Butler & Drakeford, 2003). She suggests that, as a result, this review was unusual in 'being conducted in a less emotionally charged atmosphere' (2011, p.17).

Nevertheless, this effort to suggest that the Munro Review was different to previous reports into child care tragedies and scandals needs to be seen in the context of the genesis of the review. While it is said that the review had been planned by the Conservative Party prior to coming into power in 2010 (Parton, 2011), it is not

necessarily the case that therefore it was a more dispassionate investigation free from the weight of political and public reaction following a non-accidental child death. During its time in opposition, the Conservative Party had taken considerable interest in social work and had established the Conservative Party Commission on Social Workers whose first report was entitled *No More Blame Game: The future of children's social workers* (2007). This report had called for better status and training for social workers, particularly in work with children. But the second report produced by the Commission (2009), which was a formal response to the Laming Report, was considerably more significant in terms of forming a background to the Munro Review. It contained a number of recommendations that were later echoed in Michael Gove's letter setting up the Munro Review such as: frontline workers to spend less time form filling and more time in direct contact with children; more emphasis on early intervention; preventive work with vulnerable families; improved training; and better inter-agency cooperation. But the most interesting aspect of the report was the Introduction written by Tim Loughton, the then Shadow Minister for Children and Young People. In the four and a half page document, he made no less than 12 specific mentions of child deaths, child murders and child tragedies, which included seven references to the Baby P case and he repeated a number of times that 'clearly the (child protection) system is still not working' (2009, p.9). Consequently, it seems fair to argue that this report provided a good deal of the background context to both the establishment of the review by the Coalition Government and to the review itself. So even though it was not an inquiry into a specific child death tragedy, it was apparently, for the government at least, heavily influenced by the death of Peter Connolly (Baby P).

This background context may explain why there is no definition of what child protection means either in Michael Gove's original letter or in the review itself. It is because it is taken for granted that everybody already knows what it is. The aim of the child protection system is, at the most basic level, to prevent children being killed non-accidentally. That is both the key purpose of the system and the proof of its effectiveness. Consequently, the Munro Review is not in fact a unique report but actually fits well into the existing pattern of the last 40 years of child abuse inquiries, which were, in most cases, an analysis of child deaths (Reder et al., 1993; Butler & Drakeford, 2012). This is not to take away from the detailed work of the review and the many creative and sensible recommendations that it makes. Rather, it is to suggest that the review is unlikely to produce any essential reform to the child protection system because it is the idea and purpose of the child protection system itself that needs to be re-thought.

## Family support or child protection?

As Corby (2000) has demonstrated, the history of state and voluntary agency responses to 'child abuse' has swung between a wish to support parents and protect the privacy of family life and the desire to intervene and regulate 'problem families'. Over the last 40 years, numerous writers have analysed how policy making in relation to children has oscillated between variations of these two poles. From targeting 'high risk' families in the 1980s to the *Every Child Matters* policy where all children might be 'vulnerable' at some points in their lives (Parton, 2006); or from children identified as suffering, or at risk of 'significant harm', to 'children in need' (Children Act, 1989; Laming Report, 2003); or from 'rescuing' children from irredeemable families to 'rehabilitating' them (Butler & Drakeford, 2012). With each of these opposites, the tension between them leads to instability and the next child death or some other child care scandal causes the pendulum to swing to the other side. Nigel Parton, who has written extensively about the history of these policy changes, makes the point that:

> While the focus for both assessment and possible intervention has thus considerably broadened between 1991 and 2006, *the forensic investigation of child maltreatment still inhabits the core of the system.* (2010, p.53, emphasis added)

This is certainly true, and it could be added that not only does child protection inhabit the core of the child welfare system, but also that non-accidental child deaths inhabit the core of child protection system. Consequently, it is the response of the public, the media and ultimately, the government to such deaths that keeps the child protection system in a state of unstable tension.

## Double binds and levels of context

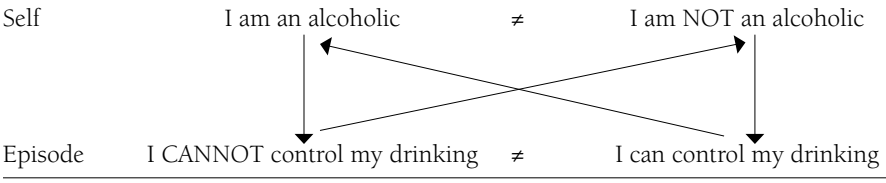
From one perspective, the polarities described above might just be dilemmas, in the sense that the people involved - the policy makers, the organisations or the practitioners - could decide to choose one position or the other. In other words, make a formal decision that the approach adopted in relation to children and families was either going to be family support all the time or intervention with problematic families. However, this is not possible because in fact this situation is a 'double bind', where social workers and their organisations are 'damned if they do and damned if they don't' (Bilson & Ross, 1999). If they 'do', then the examples of Cleveland and Orkney are used against them; if they 'don't', then the names of Maria Colwell, Jasmine Beckford, Victoria Climbié, Baby P and many more are recalled as reminders of their failures. Either choice leads to a negative outcome. That is the first 'bind' in the 'double bind' and neither choice is particularly palatable. But the 'double' in the 'double bind' is that social work is not free to reject the two options and therefore it swings between the two positions.

The theory of the double bind was originally developed by Gregory Bateson and his colleagues (1956) to describe the kind of paradoxical communication processes they suggested could lead to schizophrenia. It involved a person receiving two different levels of message in which one message contradicts the other but because of the importance of the relationship between the person receiving the messages and those giving them (such as parents and a child), it is not possible to either comment on the contradiction or to leave the relationship. Thus, the person is placed in a 'no-win' situation. A commonly used example of such contradictory messages is the injunction to 'Be spontaneous!'. If the person responds by doing something then, of course, they are not acting spontaneously but if they don't respond they are disobeying the injunction (Reder et al., 1993, p.108-9). Usually, the person who is told to be spontaneous would point out that this was a contradiction. However, if that is not possible for whatever reason, then the person is in a double bind. Bateson's research group argued that living in a context where the person had to respond to two contradictory messages simultaneously and where any logical response was also not allowed, potentially meant that the only 'sane' response was 'mad' behaviour (Bateson et al., 1956).

Bateson later developed the theory of the double bind to analyse paradoxical communications generally and, in a well-known article applied it to the treatment method used by Alcoholics Anonymous (AA) in its work with alcoholics (Bateson, 1971). His argument was that the AA 12-step model only worked if people followed the initial steps and admitted they were both powerless to control their drinking and that there was a power greater than them. It was only by accepting these conditions that the drinker could change their oscillating pattern of behaviour between bouts of drinking and abstinence.

These ideas were built on and developed as a theoretical and practical means of understanding the interaction between different levels of context and repetitive patterns of behaviour by Barnett Pearce and Vernon Cronen as part of their communicational approach called Coordinated Management of Meaning (CMM) (Pearce & Cronen, 1980; Pearce, 1989). Drawing on social constructionist ideas, CMM sees communication as the primary social reality and examines in very practical ways how patterns of communication shape our behaviour and our social world. They proposed that one way of understanding the process of the double bind was to see it as what they described as a 'strange loop' (Cronen, Johnson, & Lanneman, 1982; Pearce, 1989). Strange loops occur when different levels of communication contradict each other and lead to a repeating pattern of unhelpful behaviour, such as that associated with problem drinking and the AA treatment model (see Figure 1). Initially the 'alcoholic' abstains from drinking and things go well. However, as he is not drinking, he is not 'an alcoholic' and can have a drink, and so the loop goes around again.

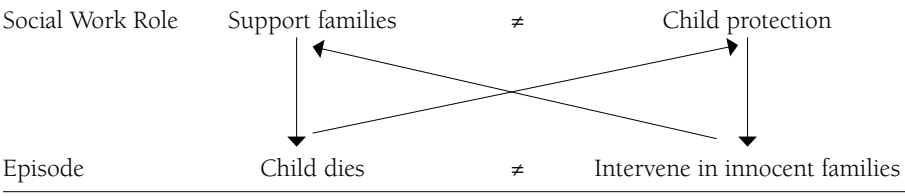
Figure 1.




If one follows the implications of the message on the left-hand side of the diagram, it leads to a position ('I cannot control my drinking') that is at odds with the message on the right-hand side ('I can control my drinking'). Consequently, there is a repeating loop between the two patterns of incompatible behaviours (Pearce, 1999). These loops are not merely contradictions, but take the form of a paradoxical or polarized pattern that operates like a figure eight rather than a circle (Oliver, 1996). As long as the drinker believes that he personally can control his drinking the loop of behaviour will continue. It is only when the drinker accepts that he cannot control his behaviour and that he must give away his power to a higher force can he escape from the 'loop'. Therefore, the way out of the double bind requires a change at a higher level of context to that of the two incompatible behaviours. If we apply this model to the family support / child protection dilemmas described above, one can see that social work is caught in a strange loop. If a social worker tries to support families and keep them together and a child dies, then they are forced to be more interventionist. If, on the other hand, they are more interventionist and many more innocent families are caught up in the child protection system, they are criticised for being heavy-handed.

What keeps this loop is kept in place is the outcry created by the media, public and policy makers whenever a child dies non-accidentally. This creates what has been described as the 'utopian bias', which is the higher-level message that no child should ever die non-accidentally (see figure 2) (Kearney, 2013).

Figure 2.



This bias is maintained by comments of politicians like the former English Children, Schools and Families Minister, Ed Balls, who said in relation to one particular case

> The case of Baby P is tragic and appalling. *It is our duty to take whatever action is needed to ensure that such a tragedy doesn't happen again*, that lessons are learned and that children in Haringey are safe'. (Guardian, 12 November 2008, emphasis added)

However, this is a very unhelpful message and damaging to overall child welfare services. Statistical analysis of the numbers of non-accidental child deaths demonstrates that they have been, and continue to be, very rare events. The most recent report from the National Society for the Prevention of Cruelty to Children (NSPCC) concluded that, on average, 55 children in England and Wales were killed at the hands of another person every year (NSPCC 2012). These figures are based on statistics from the Home Office (Smith et al., 2012) and two Office of National Statistics publications, International Classification of Diseases, tenth revision ICD-10, and Mortality Statistics Online. In relation to an overall population of about 11 million children aged under 18, an average of about 55 non-accidental deaths per year equates to the annual probability of any particular child being killed of around 0.0005% or 1:200,000. The probability of such an event affecting a particular child or social worker is slight. Therefore it makes no sense in probability terms that such a minimal risk should be one of the key drivers of the child care system.

## What is the 'right thing': Paradoxes of professional judgment

When considering the use of systems theory within the Munro Review, it can be seen that it focuses on the organisational level of context as the area of interest. In particular, the review draws on a systems analysis of the inter-relationships between organisations and frontline staff as being the main site of change for the child protection system. The discussion of single and double loop learning in Part One of the Review is a good example of its use of systems thinking (2010, p.14-15 and appendix 2). The first loop (single loop learning) is only concerned to know if the child protection system is doing what has been specified, that is whether performance matches the targets (p.14-15). When something goes wrong the issue for the organisation is to find out if the correct procedures were followed and if not, is another procedure or action (such as more training in procedures) needed. Munro points out that a restrictive loop like this can have 'ripple effects' or unintended consequences in that such a tight focus on procedures can result in staff stress and illness, or even leaving the organisation (2010, p.49).

On the other hand, in the example of double loop learning, the feedback from

the system allows the possibility of 'learning to learn' and to change the way the system operates. In other words, has the organisation specified the right thing for the child protection system to be doing? Are the prescribed targets achieving what the organisation wants to achieve? (p.50-51). Munro's argument is that organisations need to leave staff with more opportunity to use their professional judgment rather than prescribe all their responses.

The review identifies the difference between single-loop and double-loop learning as being between 'procedural compliance' and 'professional judgment'. Borrowing Drucker's phrase it describes it as the difference between a 'concern with doing things right versus a concern for doing the right thing' (2010, p.14).

While it is likely to be helpful if an organisation has the ability to use the information it receives as 'feedback' and not as an example of someone's failure to follow procedures, then it is also more likely to be able to make good judgments about what wider changes might be needed to the system in question in order to achieve the best outcomes. In turn, if the organisation is willing to allow frontline workers to use their professional judgment on occasion, rather than fully follow the prescribed procedure in order to achieve good outcomes for the child, then in theory, the system should work better. However, the experience of the last 40 years of inquiries into child deaths demonstrates that, in practice, what constitutes the 'right thing' is by no means straightforward. One of the reasons for this is that the systemic interactions are not just between the individual professional and the organisation but also with the wider context of politicians, policymakers, the media and the public. As with the example of the 'alcoholic' above, there is a higher-level message that comes into play every time a non-accidental child death reaches wider attention (see figure 2).

A worker using their professional judgment ('doing the right thing') is only 'right' if no negative outcome comes to public attention. If there is a negative outcome (that is, a child dies) then the 'right thing' quickly becomes the 'wrong thing' - as no doubt Sharon Shoesmith, the Director of Children's Services involved in the Baby P case, would testify. This is the difficulty of the key proposal of the Munro Review for organisations to allow greater use of professional judgment, because it is not at the organisational level that the child protection system is stuck. It is a higher level, what could be called the 'cultural' level of context, that keeps the child protection system oscillating between the two positions of prescription and professional judgment. This is the level of political, public and media outrage when a child dies non-accidentally. Therefore, what the review is proposing will only make a first-order change that is, within the existing system. What is needed is a second order change, for the actual child protection system to change in a significant way. The intervention needs to be at a higher contextual level.

## Conclusion

In his original letter to Eileen Munro setting up the Munro Review of Child Protection, Michael Gove said that his 'first principle is always to ask what helps professionals make the best judgment they can to protect a child' (2010, appendix 1). The final review report makes many thoughtful and helpful recommendations in response to the Minister's question including reducing procedures and increasing the scope for professional judgment; more flexibility in relation to timescales for assessments; encouraging multi-disciplinary work and suggesting improvements to social work education.

Such recommendations are undoubtedly useful and will benefit social work practice. However, the two issues of 'what constitutes good judgment?' and 'what exactly is meant by child protection?' remain unanswered by the review. As described above, both of these questions are circumscribed by the influence of a higher-level of context. For as long as another child death attracts extensive media coverage and public concern the judgment will have been wrong and the child not protected. It will again lead to:

> the 'unholy trinity' of media pillorying, detailed post-mortem recommendations about the operation of the system on the heels of inquiries and the increasing prescription of practice, resulting in social workers and other child welfare professionals becoming focused on the need to avoid a non-accidental death. (Devaney et al., 2011, p. 243)

In order to remove this 'double bind' it is necessary to change the higher level of context. Instead of responding to each new non-accidental child death as if it were unique, they need to be viewed as extremely rare, but regular, events that are, in fact, like mental health homicides, part of the human condition and will never be totally eliminated (Szmukler, 2000), But the way the system is currently structured makes it very difficult to respond in this way. Regular inquiries over the years into such deaths and the current system of Serious Case Reviews have distorted perceptions of both the frequency and predictability of such events. The tendency to generalise from single negative instances strengthens the public view that these cases can all be prevented and leads to biases in media, policymakers' and public's understanding of risk. While individual serious case reviews may produce some useful information for the local agencies involved, the government requirement for them to be carried out in every case and be made public gives far more emphasis to individual reviews than can be justified. As each deals with a specific case in a particular context, the general applicability of any findings is very limited.

Often these reviews are prefaced as being needed to 'learn the lessons' from the particular case. However, it has been established that on average each serious case review produces 47 recommendations (Brandon et al., 2012). If this figure were extrapolated to cover the 800 reviews analysed since 2003, this would lead to a

grand total of over 37,500 recommendations (Kearney, 2013). Either these reports are aimed at very slow learners or there is nothing new to recommend that might make the very rare incidents of child deaths more predictable or preventable.

Interestingly, Munro herself seems to be aware of the limitations imposed by higher-level context for the review, as the very first sentence of Part One offers an insight into why the system has continued the way it has for so long. The review opens with the words:

> Protecting children from abuse and neglect has been high on the political agenda for many decades. (2010, p.5)

Here the political context is identified as being of key importance in influencing how the child protection system operates. It goes on to say 'The problem is that previous reforms have not led to the expected improvements in frontline practice' (p.5). Unfortunately the review does not go on to analyse how the political context has influenced our understanding of child protection or to explain why previous reforms have not led to improved practice. By focusing on the organisational level of the system the Munro Review remains 'within the loop' of either family support or child protection. If the overall child welfare system is not to be determined by rare incidents of child deaths then, to quote Wittgenstein, the aim must be 'to show the fly the way out of the fly bottle' (1953, para. 309).

## References

Bateson, G. (1971) The cybernetics of self: a theory of alcoholism. *Psychiatry*, 31, 1, 1-18

Bateson, G., Jackson, D.D., Haley, J., and Weakland, J. (1956) Toward a theory of schizophrenia. *Behavioural Science*, 1, 251-264

Bilson, A. and Ross, S. (1999) *Social Work Management and Practice: Systems principles*. (2nd ed.) London: Jessica Kingsley

Brandon, M., et al., (2012) *New Learning from Serious Case Reviews*. London: Department for Education

Butler, I. and Drakeford, M. (2003) *Social Policy, Social Welfare and Scandal: How British public policy is made*. Basingstoke: Palgrave Macmillan

Butler, I. and Drakeford, M. (2012) *Social Work on Trial: The Colwell Inquiry and the state of welfare*. (revised paperback edition) Bristol: The Policy Press

Conservative Party Commission on Social Workers (Chaired by Tim Loughton MP.) (2007) *No More Blame Game: The future for children's social workers*. London: The Conservative Party

Conservative Party Commission on Social Workers (Chaired by Tim Loughton MP.) (2009) *Response to Lord Laming's Inquiry*. London: The Conservative Party

Corby, B. (2000) *Child Abuse: Towards a knowledge base*. (2nd ed.) Maindenhead: Open

University Press
Cronen, V., Johnson, K., and Lannaman, J. (1982) Paradoxes, double binds and reflexive loops: an alternative theoretical perspective. *Family Process*, 21, 91-112
Devaney, J., Lazenbatt, A., and Bunting, L., 2011. Inquiring into non-accidental child deaths: reviewing the review process. *British Journal of Social Work*, 41, 242–260
The Guardian (2008) 'Each agency has singly and collectively failed'. Report of a statement by Ed Balls, the secretary of state for children, schools, and families. *The Guardian,* 12th November
World Health Organisation (1994) *International Classification of Diseases. Tenth revision ICD-10*. Newport: Office of National Statistics
Kearney, J. (2013) Perceptions of non-accidental child deaths as preventable events: The impact of probability heuristics and biases on child protection work. *Health, Risk & Society*, 15, 1, 51–66
Laming, H. (2003) *The Victoria Climbié Inquiry: Report of an inquiry by Lord Laming.* London: TSO
Munro, E. (2005a) A systems approach to investigating child abuse deaths. *British Journal of Social Work,* 35, 4, 531-546
Munro, E. (2005b) Improving practice: child protection as a systems problem. *Children and Youth Services Review*, 27, 375-391
Munro, E. (2008) *Effective Child Protection*. (2nd ed.) London: Sage
Munro, E. (2010) *The Munro Review of Child Protection: Part One: A systems analysis.* London: Department for Education
Munro, E. (2011) *The Munro Review of Child Protection: Final Report: A child-centred system*. (Cm 8062) London: TSO
NSPCC (2012) Child homicide statistics [online]. Available from: http://nspcc.org.uk/Inform/research/statistics/child_homicide_statistics_wda48747.html [Accessed 26th November 2012]
Oliver, C. (1996) Systemic eloquence. *Human Systems*, 7, 4, 247-264
Office of National Statistics (2010) *Mortality Statistics Online*. Newport: Office of National Statistics
Parton, N. (2006) *Safeguarding Childhood: Early intervention and surveillance in late modern society.* Basingstoke: Palgrave Macmillan
Parton, N., (2010) 'From dangerousness to risk': The growing importance of screening and surveillance systems for safeguarding and promoting the well being of children in England. *Health, Risk & Society*, 12, 1, 51–64
Parton, N. (2011) The Munro Review of Child Protection: an appraisal. *Children & Society*, 26, 150-162
Pearce, W.B. (1989) *Communication and the Human Condition.* Carbondale: Southern Illinois University Press
Pearce, W.B. (1999) *Using CMM: The coordinated management of meaning.* California: Pearce Associates. www.pearceassociates.com
Peaerce, W. B. and Cronen, V. E. (1980) *Communication, Action and Meaning: The creation of social realities*. New York: Praeger

Reder, P., Duncan, S., and Gray, M. (1993) *Beyond Blame: Child abuse tragedies revisited*. London: Routledge

Smith, K., et al., (2012) *Homicides, firearm offences and intimate violence 2010/11: supplementary volume 2 to Crime in England and Wales 2010/11*. London: Home Office

Szmukler, G. (2000) Homicide inquiries: what sense do they make? *The Psychiatrist*, 24, 6-10

Wittgenstein, L. (1953) *Philosophical Investigations*. (trans. G.E.M Anscombe) Oxford: Blackwell