SBNI

Safeguarding Board for Northern Ireland

Learning from CMR'S

2021 -2022

Case Management Review Learning 2021 -2022

Case Management Reviews (CMRs) are a statutory function of the SBNI which are undertaken by the Case Management Review Panel.

The CMR Panel meets on a monthly basis, is independently chaired by Mr Andrew Thomson, Board Member and includes membership from senior representatives of agencies represented on the Board. The Panel's role is to consider notifications in respect of serious incidents involving children and young people to identify;

- where there have been positive outcomes for children and young people or
- where things have not gone well and there is significant learning,

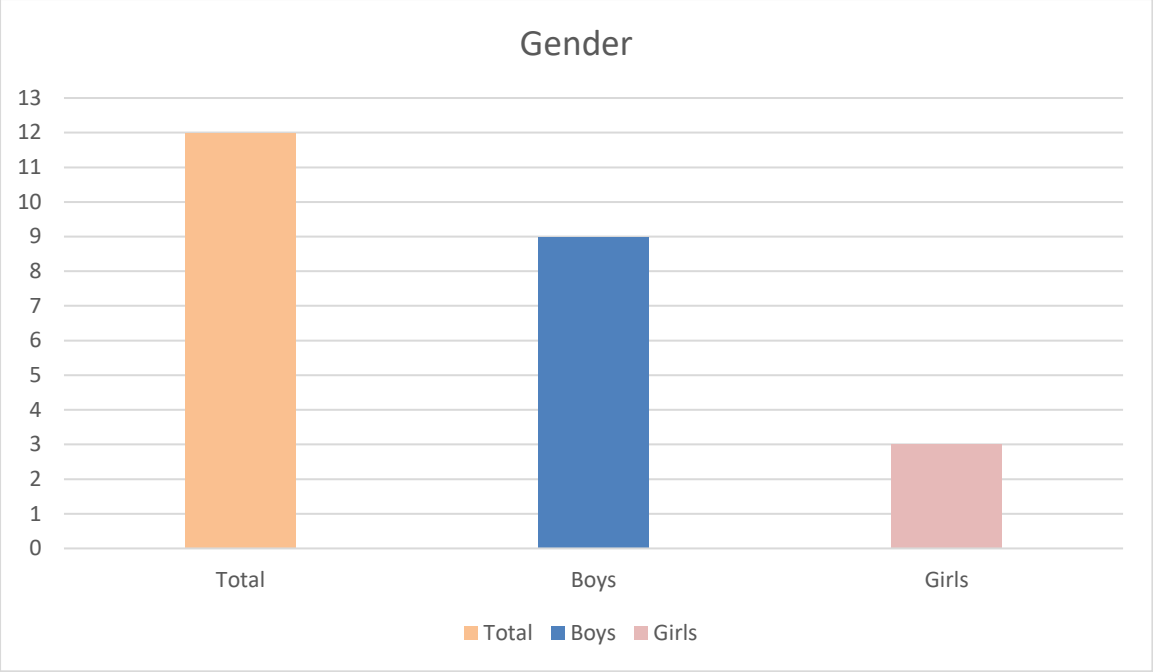
The purpose of this is to enable the child protection system to be strengthened thereby further protecting children and young people in Northern Ireland. The CMR Panel interrogates the information provided to it by the notifying agency and makes a recommendation to the Board as to whether or not to commission a CMR. The recommendation is considered by the Board which decides whether or not a CMR should be undertaken.

During 2021 - 2022, as a consequence of the Covid 19 pandemic, the Case Management Review Panel continued to meet via a 'virtual' platform. Panel meetings continued on a monthly basis.

CMR Notifications

During 2021-2022, 12 CMR notifications in respect of 12 children were received by the SBNI. Of these notifications, 3 Case Management Reviews were commissioned.

9 children were boys and 3 children were girls.



Gender of children subject to CMR Notification

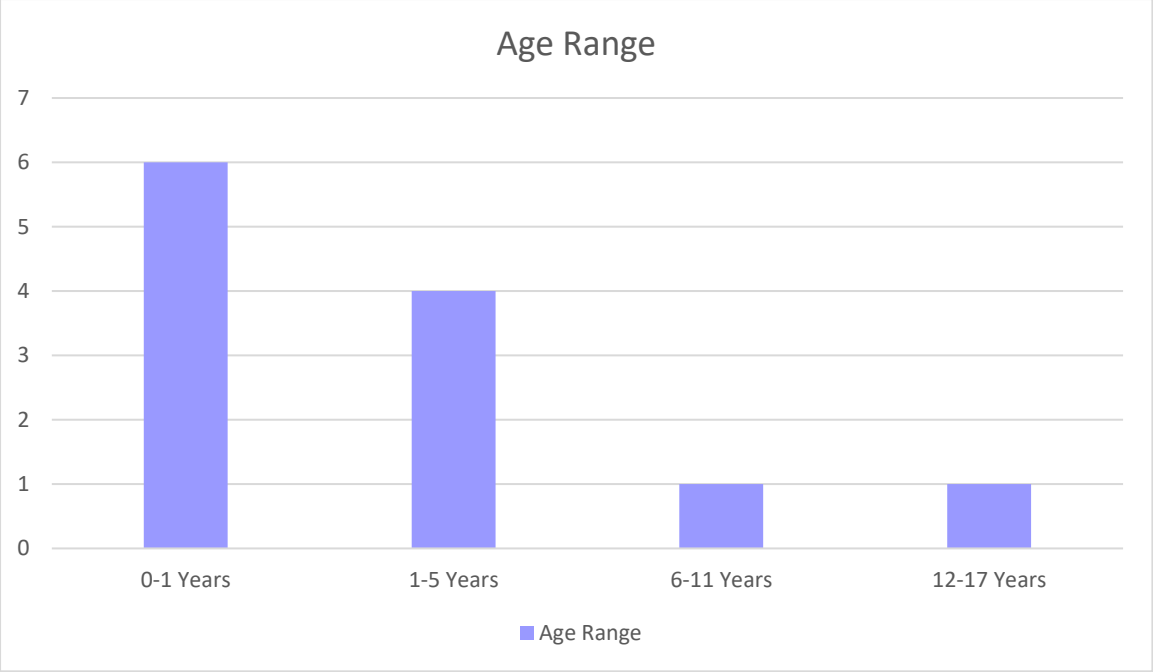
The age range of these children were as follows

0 – 1 Year- 6 children

1 year – 5 years - 4 children

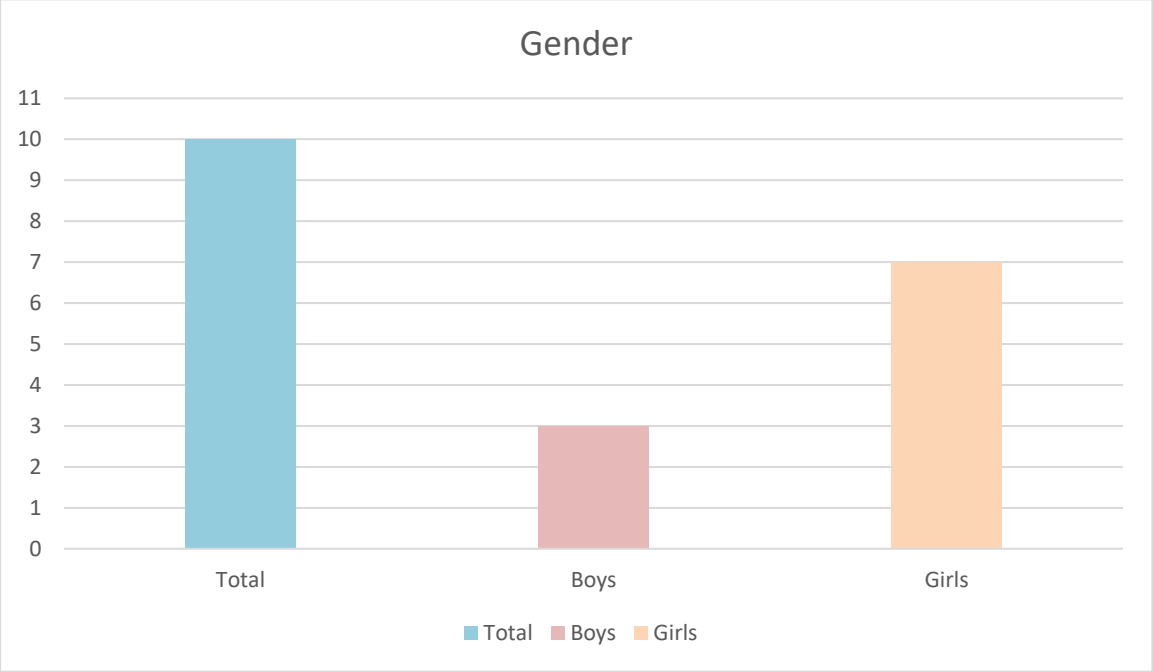
6 – 11 Years - 1 child

12 – 17 years - 1 child



Age range of children subject to CMR Notification

During 2021 – 2022, 6 completed Case Management Reviews were presented to and approved by the Board. These reviews focused upon 10 Children (3 males and 7 females).



Gender of children involved in completed Reviews

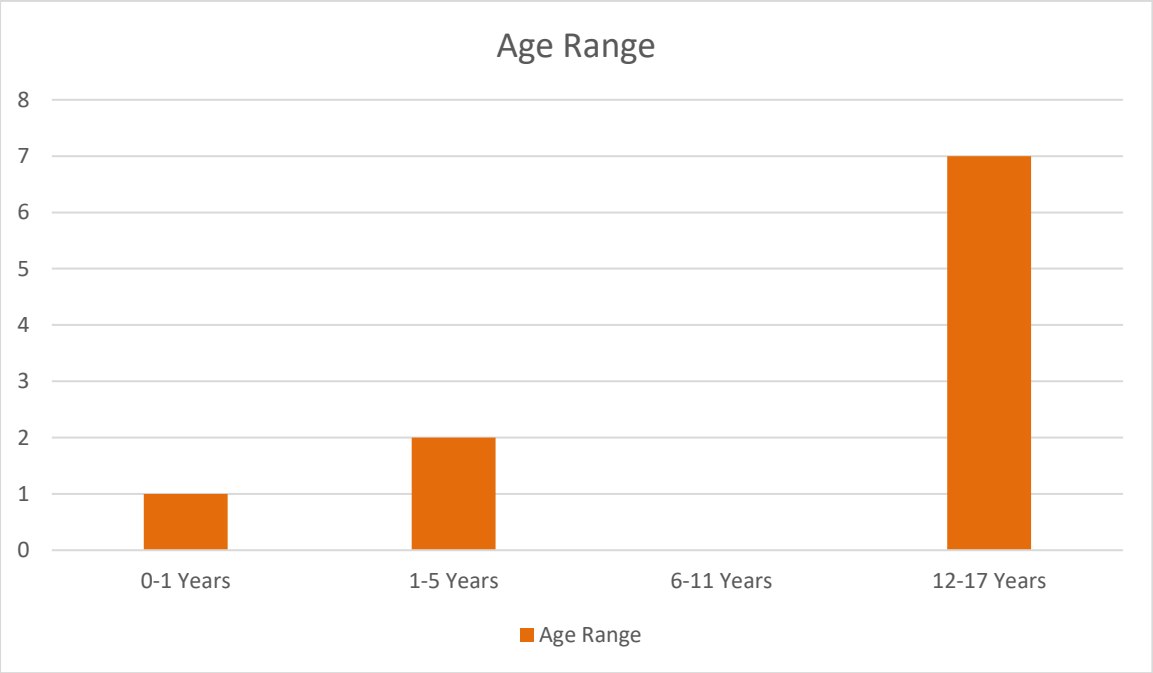
The age range of these children were as follows

0 – 1 year – 1

1 – 5 years - 2

6 – 10 years - 0

11 – 17 years – 7 children



Age range of children involved in completed Reviews

Prior to the onset of the Covid 19 pandemic the average time taken to undertake CMRs was 9.5 months. This timeframe has been significantly impacted as a consequence of the various lockdowns and circuit breakers in 2020 – 2021. Work in undertaking the reviews has been affected by the unavailability of staff members from member agencies to complete Individual Agency Reviews (IAR's) as a consequence of both Covid and workforce pressure. Timelines consequently required to be adjusted. Despite these interruptions staff endeavoured to ensure as timely a response to the completion of reviews as was possible in the difficult and uncharted circumstances. It is anticipated during the next business year timelines for the completion of reviews shall significantly reduce.

Summary of learning arising from these Reviews

There were 34 recommendations associated with the completion of these reviews which fall into broad themes associated with;

1. Child Sexual Exploitation and peer on peer domestic abuse
2. Physical abuse; and
3. Harmful Sexual Behaviour

Child Sexual Exploitation and peer on peer domestic abuse:

- the HSCT and the PSNI consider a review of their governance arrangements for the timely sharing of information between the Trust and the PSNI CSE team, to include a review of their processes
- relevant agencies should consider raising awareness and training in respect of domestic abuse among young people to include coercive control
- the HSCB should consider the provision of training to all the Trust's field work and residential staff in respect to domestic abuse among young people within the Looked After Children population and the responses to it
- the HSCB as commissioners of children's homes should consider wakened night staff within the children's homes to support the implementation of the safety plans for the respective young people
- the SBNI to liaise with NISCC to highlight the issues in respect of (a) relationship with RQIA and expectation regarding inspection and (b) clarify the requirement on the provision of induction between recruitment agency and Trust/employer
- the SBNI to liaise with RQIA to highlight the issues on how inspections against NISCC Standards in Children's Residential Homes are undertaken including the potential for "thematic" inspections
- the DoH to consider a review of the Protecting Looked After Children Guidance (DoH. February 2018) to include the appropriateness of the role of risk management meetings

- following consideration of the review mentioned above, DoH to consider the appropriateness or necessity of revising Co-operating to Safeguard Children Guidance to include guidance on multi-agency risk assessment in particular "high risk" Looked After Children
- the HSCB in collaboration with HSCTs should undertake a review of existing community based residential care to consider (a) whether capacity is sufficient to meet the complex needs of Looked After Children and (b) whether rationalisation of children's homes, staff turnover, recruitment and retention are factors impeding the delivery of a safe, stable, therapeutic model of care for children in residential care
- the HSCB and HSCTs, in collaboration with DoH, to consider how best to ensure that the application of Signs of Safety is effectively integrated into residential child care practice and aligned to LAC guidance and risk management processes consideration should be given as how best to address the shortage of social work staff in the context of the Work Force Review commenced by the DoH in 2020, in collaboration with HSCB and HSC Trusts. With the specific issue in mind of recruitment and reliance on agency workers in delivering a social work service to children with complex needs in residential care.

In respect of physical abuse:

- the Education Authority to consult with the Department of Education recommending the implementation of a policy and system for all educational settings that ensures electronic recording and monitoring of safeguarding (wellbeing and pastoral) issues
- the Education Authority Child Protection Support Service should develop a key set of principles and a checklist of actions, to strengthen child protection practice and culture in schools, and ensure designated teachers, principals and boards of governors are trained in its implementation
- the Education Authority to consult with the Department of Education recommending updated regional Safeguarding Guidance in Schools to include

advice to governors and school leadership of the need for dedicated time and resources for designated teachers to effectively implement school procedures

- the HSCB in conjunction with GP representatives should consider and agree an appropriate process to ensure Public Health Nursing is notified of new NI entrant pre-school children, who attend a GP and do not immediately complete GP registration
- the HSCB should oversee the development and dissemination of an electronic CHS 8 form through the CH Regional User Advisory Group
- the SBNI should consider developing guidance, resources and training focussed on professional curiosity
- a task and finish group to review the current information sharing arrangements between the HSCB and PSNI (PDU and PPD) in order to redress current gaps. To provide policy and procedural guidance with inter-agency training to ensure that staff are fully conversant with the parameters of the various checks available to them. This should include a central repository and processes to ensure that all concerned are working from the same current ISA
- a review will be undertaken of the ISF form by the task and finish group to provide social workers with prompts to assist them in specifying the information they are seeking from the PSNI in instances of fostering/adoption extraneous to Access NI ECRC applications
- the HSCB to consider implementation of policy and procedures accompanied by guidance for staff and training to ensure that checks are completed through the appropriate process if a potential carer is, or has been, a serving member of the armed forces
- regional fostering and adoption services to develop the regional training pathway to include remote learning (Skills to Foster and Core Issues Training) that can be delivered to kinship foster carers including those across jurisdictions. This will support kinship

In respect of harmful sexual behaviour

- the statutory partners and signatories to the Protocol for the Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse NI to revise the protocol to provide detailed guidance on decision making on single vis a vis joint investigation with particular reference to LAC
- the Education Authority Welfare Service to review the practice of routine case closure of Year 12 young people to ensure that closure of statutory involvement is sufficiently flexible to allow the needs of the service user to be met
- Police College NI to review the training provided to officers and staff on children and young people who display harmful sexual behaviours and, where gaps are identified, a training plan should be developed and delivered within an identified timeframe.

Improvements made as a result of CMR' s

All CMRs by their very nature generate recommendations for improvement. These CMRs are followed up by comprehensive action plans by member agencies to ensure all recommendations are given due consideration and appropriate implementation.

Highlighted below are some completed and ongoing reforms, noted in the Evaluation Report, which have come about as a result of CMR reports.

- Greater understanding in relation to the thresholds for referrals relating to child protection and neglect and an increased awareness in schools of the role of the Education Authority (EA) Child Protection Support Service.
- The timeliness of responses to referrals and the need for Initial Assessments to be holistic and include all family members.
- Greater liaison with the PSNI Public Protection Branch and other agencies involved in cases where a child has died and the death is unexplained or suspicious.

- The Health and Social Care Board reviewed the timescales in initial responses to cases referred to the HSCTs, where those cases involved indicators of neglect combined with physical harm to children.
- The need for and subsequent development of a consistent and co-ordinated multi-agency approach in Northern Ireland, in relation to young people who display Harmful Sexual Behaviours and to individuals who cause concern in the context of families.
- Commissioning of expert reports to be subject to agreed standards and governance processes.
- Development of Guidance on the Resolution and Escalation of concerns and information sharing developed.
- Development of a policy to establish the role and responsibilities of staff in universal services when parents refuse to engage with the child health service.
- The revised Information Sharing Agreement between PSNI and HSCT's (2019) has been further revised.
- Closer collaboration in relation to individuals who are a cause for concern.
- On-going consideration of legislative changes and the development of guidance in relation to children on Care Orders who reside in a different Trust area.
- Development of a regional data base and guidance in respect of children living in kinship care placements
- A review of the Protocol for the Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse (NI) to include arrangements for oversight by management and support for children who find it difficult to make a complaint.
- The Pre-Mobile Baby Protocol for bruising/marks has been further revised and published in the Core Policy and Procedures manual.
- The PSNI data base has been updated to ensure that alerts in respect of Children who are subject to a Child Protection Plan are available to Police Officers at all times.
- Development of new Guidance on the transfer of cases between Health and Social Care Trusts is under development.

- Development of Guidance to staff regarding children/young people who are subject to paramilitary threat has been developed and disseminated to all member agencies.
- Increased awareness for staff regarding parental mental health and its impact on children and young people.
- A Regional Multi-Agency Protocol for Sudden Unexplained Death in Infancy for Northern Ireland is being developed. This will improve how this area of exceptionally difficult work with families is undertaken to strengthen protection for children.
- Increased awareness for staff regarding the devastating impact of neglect on children and how work on this particular area of concern can be improved to help address its impact on children's lives.

Dissemination of Key Messages/Learning from CMR' s

The focus of the CMR is on learning, that is: 'learning from what has worked well and then build upon it; and what has not worked well and determine how this should be prevented in the future.' DOH guidance 2012 (revised 2014)

All completed CMR reports, including identified learning and recommendations, are shared with the organisations involved. Copies of all reports are provided to appropriate and relevant organisations to ensure regional learning within specific sectors.

In addition, dissemination of learning from all CMRs is on-going with regional and local events regularly held across Northern Ireland. This sharing of learning is co-ordinated and undertaken jointly by the CMR Panel and the Safeguarding Panels. All CMRs completed in the preceding year are discussed. The events in 2021 -2022 were held via virtual platform which enabled a wider group of professionals to attend than may have been able to attend if the sessions were delivered in person.

During 2021 - 2022, 7 dissemination of learning events were undertaken by SBNI.

The first event was a local event for the Western Area Safeguarding Panel which had been postponed during the previous business year as a consequence of Covid and workforce pressures.

The remaining 6 events focussed on the thematic learning from the CMR Evaluation 2020 as well as three reviews which were completed in the previous business year.

A regional event for senior managers and cross departmental colleagues was delivered in December 2021 with five local Safeguarding Panel events then delivered in the final quarter of the business year.

These events were attended by in excess of 700 professionals inclusive of managers and practitioners from across the multi-disciplinary and agency spectrum.

As in previous years these events were extremely well evaluated.