SBNI

Safeguarding Board for Northern Ireland

Learning from CMR'S

2022 -2023

Case Management Review Learning 2022 -2023

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

The CMR Panel is required to meet at least four times per year and is independently chaired and includes membership from senior representatives of agencies represented on the Board.

In 2022 -2023 the panel met on nine occasions.

The panel's role is to consider notifications in respect of serious incidents involving children and young people to identify;

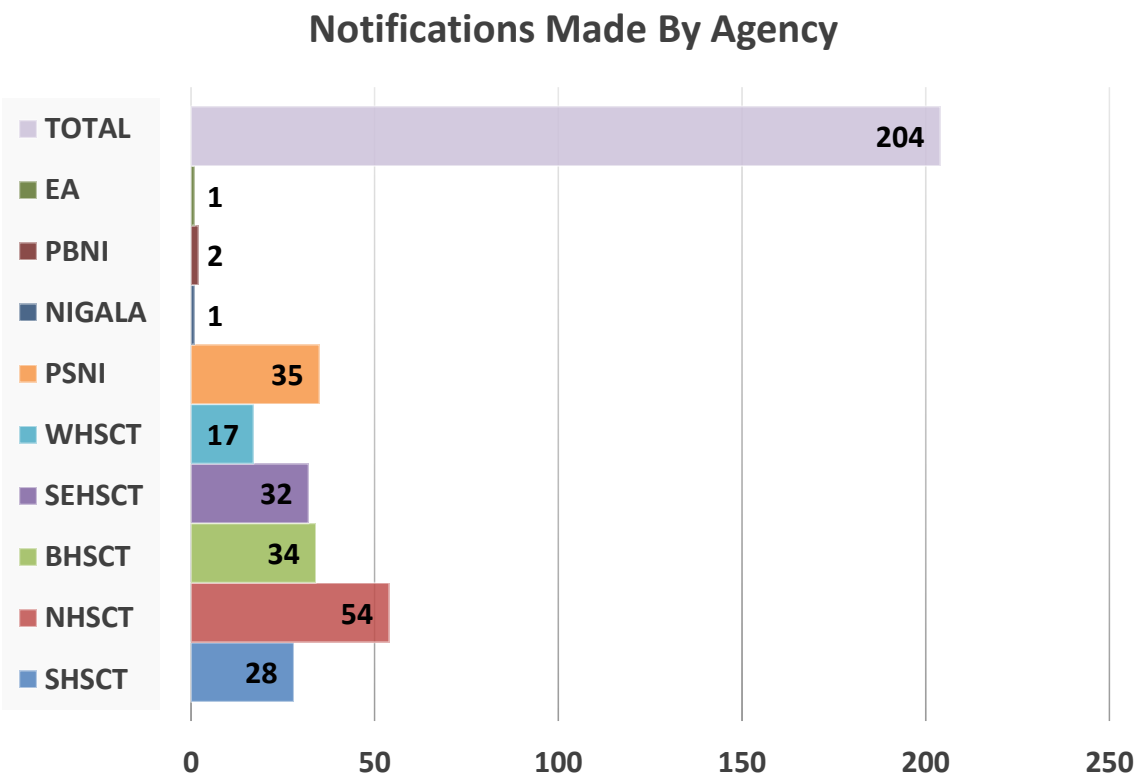
- where there have been positive outcomes for children and young people or
- where things have not gone well and there is significant learning,

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 makes the decision whether or not a CMR should be undertaken.

CMR Notifications received since 2012

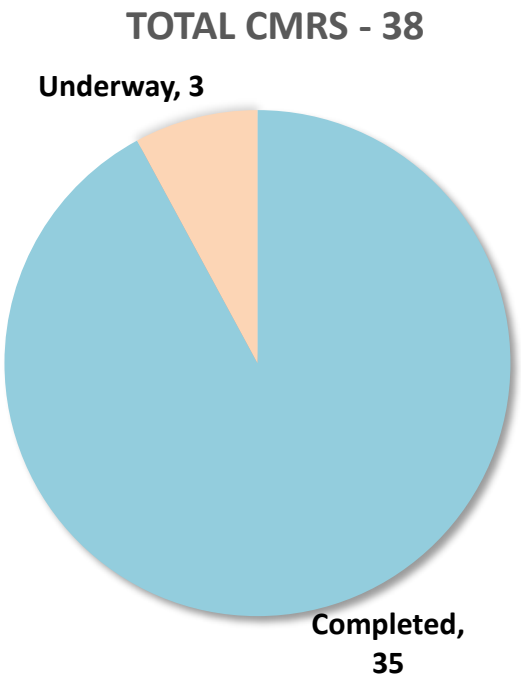
Since 2012 the SBNI has received 204 notifications (including two from RCPC and duplicate referrals)

Summary of notifying agencies since 2012



CMR's Competed since 2012

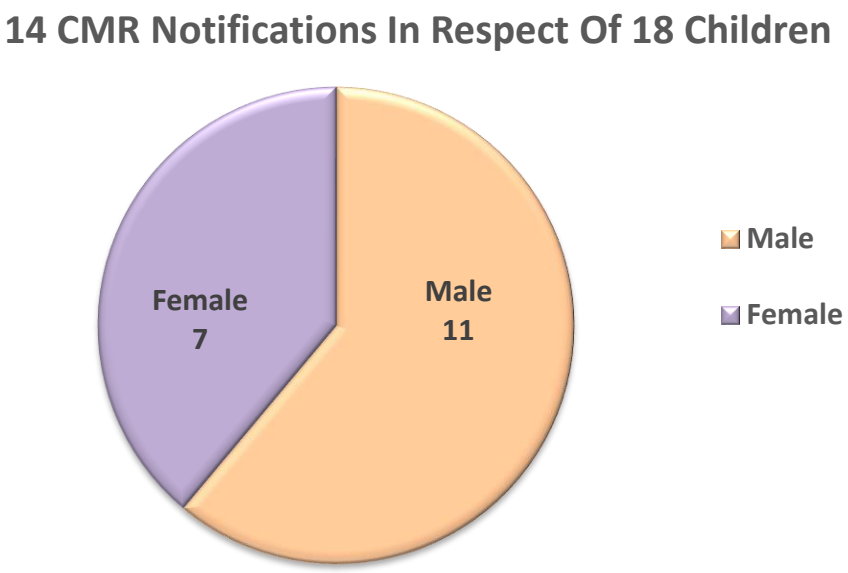
At 31 March 2023, the total number of CMR's completed is 35; 3 CMR' s are underway.



CMR Notifications received during 2022-2023

During 2022-2023, 14 CMR notifications in respect of 18 children were received by the SBNI. Of these notifications, 1 Case Management Review was commissioned in respect of 1 female child.

The notifications related to 18 children of which 11 were male and 7 were female.



Gender of children subject to CMR Notification

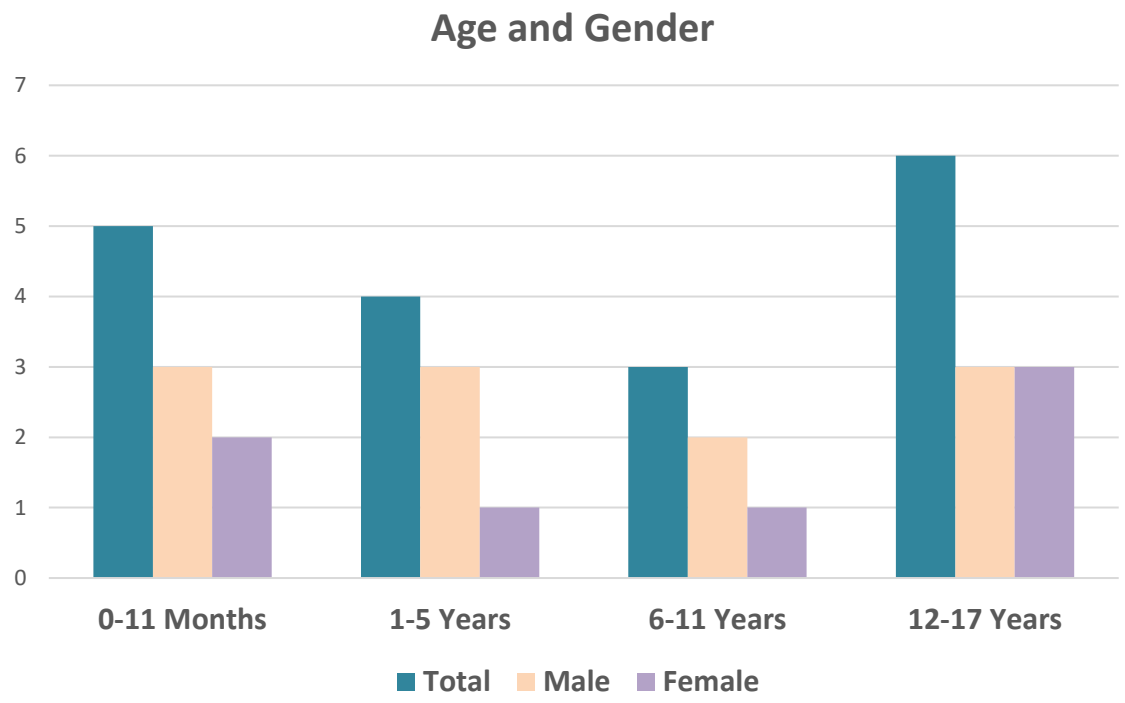
The age range of these children who were notified to SBNI were as follows

0 – 11 Months - 5 children (3 male & 2 female)

1 Year – 5 Years - 4 children (3 male & 1 female)

6 – 11 Years - 3 children (2 male & 1 female)

12 – 17 Years - 6 children (3 male & 3 female)



Age range of children subject to CMR Notification

12 of the 14 notifications received were considered by the Board in 2022-2023. Of these notifications;

- 4 were received in the last quarter of business year 2021-2022.
- 8 notifications were received ‘in-year’

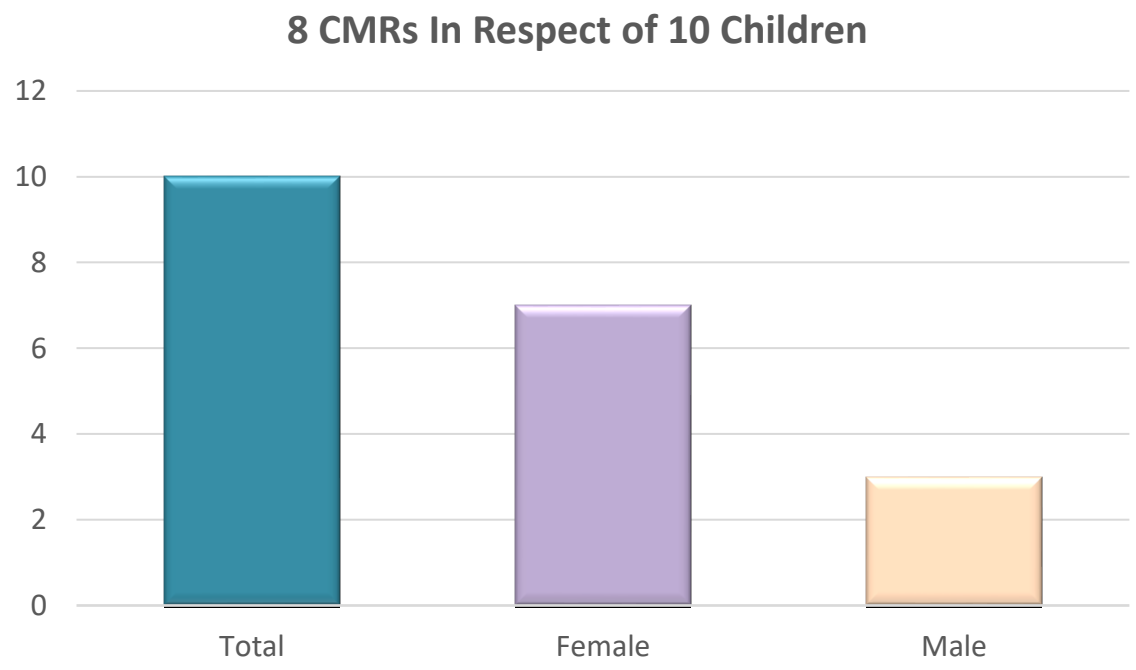
Of the12 notifications considered 1 proceeded to CMR.

6 notifications received in the latter part of business year 2022-2023 will be considered by the Board in the forthcoming business year 2023-2024

A number of notifications involved the death of children by natural causes. Their circumstances were considered by the Board as they met the notification criteria as currently defined in statute however abuse or neglect were not deemed to be causal factors[1];

Completed Case Management Reviews

During 2022–2023, 8 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

[1] 1 https://www.health-ni.gov.uk/publications/guidance-safeguarding-board-northern-ireland-0

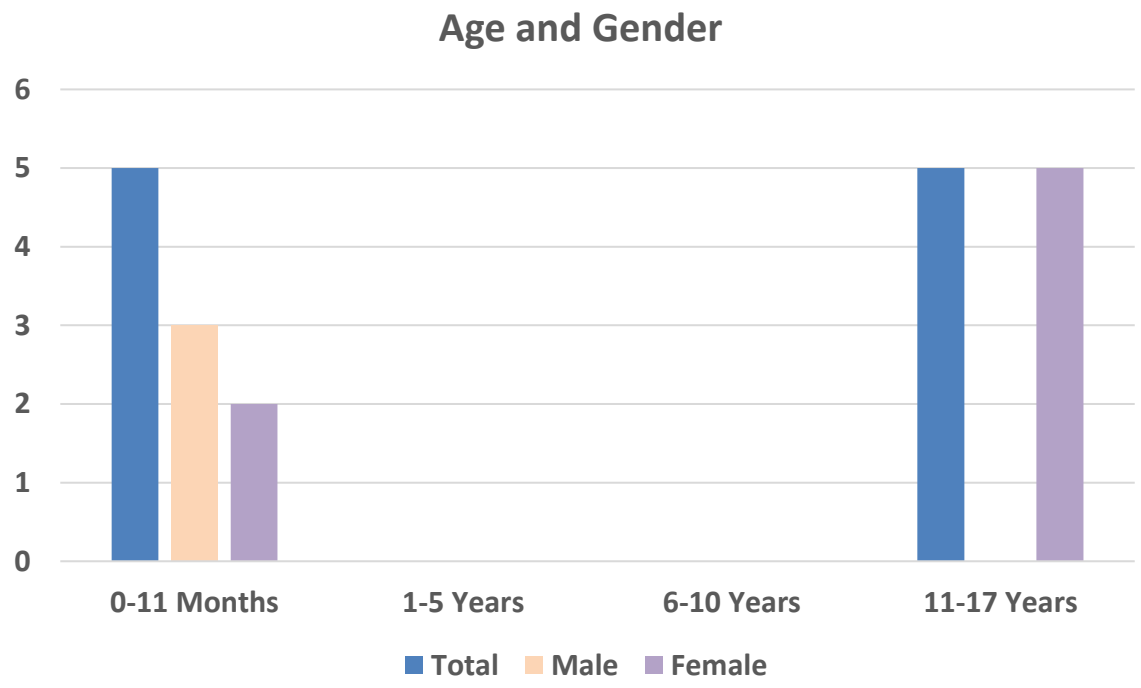
The age range of these children were as follows

0 – 11 months – 5 children (3 male & 2 female)

1 – 5 years - 0

6 – 10 years - 0

11 – 17 years – 5 (5 female)



Age range of children involved in completed Reviews

Completion Times for CMR's

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 lockdowns and circuit breakers in 2020 – 2021. Work in undertaking 6 of the 8 reviews presented to the SBNI Board in 2022-2023 experienced delay due to the

- 'Pausing' of work in the early stages of the pandemic
- Subsequent circuit breakers
- Authors requiring to 'shield'

- The unavailability of staff members from member agencies to complete Individual Agency Reviews (IAR's) as a consequence of both Covid and workforce pressure
- During one review the author was required to replace their entire team due to long term ill health and team members moving post. This required the team to recommence the review process

In addition, further delays in respect of two of the CMR's presented in-year to the Board, were attributable to delays in the recruitment processes for authors. This impacted on the completion of both reviews by 4 months.

Despite these interruptions and difficulties, staff endeavoured to ensure as timely a response to the completion of reviews as was possible in the difficult and uncharted circumstances.

All CMR's which commenced immediately before the pandemic, in the early stages of the pandemic and during the pandemic are now complete.

The average time of completion of the 8 reviews presented to the Board in 2022-2023 was 15.6 months.

It is anticipated during the next business year the timeliness for the completion of reviews shall improve.

Summary of learning and improvements arising from these Reviews

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

There were 53 recommendations associated with the completion of the 8 reviews in 2022-2023.

Learning across the reviews focussed on

- Child Sexual Exploitation

- Adolescent Self harm
- Physical Abuse
- Sudden Infant Death and
- A still born child.

Summary of learning and improvements arising from Case Management Reviews

CMRs by their very nature generate recommendations for improvement. Learning across the reviews primarily focused on:

- Physical Abuse
- Adult Mental Health interface with Children Services and
- HSCT interface with PSNI

Physical abuse

- The SBNI Policy and Procedures Committee are further developing the SBNI Policies and Procedures Manual in respect of 'The Child Protection Register', Point 8; 'Children/ Young People and Families Who Move', which provides guidance in respect of the transfer of child protection cases, to include pre-birth child protection cases, across the HSCT's and across jurisdictions. This transfer guidance will provide clarity with regard to the roles and responsibilities of all professionals involved with parents, and families, including the parents of unborn children, in terms of information sharing and escalation of concerns in order to promote collaborative working.
- The SPPG and PSNI are working together to review current guidance, procedure and practice in respect of the interface between HSCTs and PSNI, specifically in respect of Domestic Abuse referrals. It is anticipated that any revisions to the current guidance emerging from this exercise will be reflected in an appropriate suite of training events and resources.
- The PSNI have undertaken to audit samples of police officer's communication and interviews with victims of Domestic Abuse.

- The PSNI have undertaken to review the training made available to officers and supervisors in respect of circumstances where it is necessary to escalate concerns in respect of children and young people at risk of significant harm.
- The HSCT's are ensuring the 'Encompass' Information system will be built to ensure necessary domains exist to enable;
    - early identification of adults associated with a child;
    - and whether interpreting services for a family are required.
- SPPG are working alongside the 'Signs of Safety' Principal Practitioners cohort to develop a robust and consistent approach to Safety Planning across the Region. Within the context of this work, opportunities will be realised to share learning and practice developments with relevant agencies including the Regional Emergency Social Work Service.
- The SPPG and PSNI are developing improved awareness raising for practitioners working in Child Protection on the Public Protection Arrangements Northern Ireland (PPANI).
- All HSCT's have promoted further awareness raising across their Children's Services Social Work staff teams in respect of the Protocol Between Northern Ireland and Ireland for Handling Inter-jurisdictional Children's Cases.
- All HSCT's have undertaken to raise awareness of 'Guidance on Information Sharing for Child Protection Purposes' (August 2021, reviewed in 2024).

Dissemination of Key Messages and 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 CMRs is delivered via 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 2022 -2023 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 2022 - 2023, 7 dissemination of learning events were undertaken by the SBNI. These comprised of a regional event for senior managers and cross departmental colleagues, five local Safeguarding Panel events and a bespoke CMR learning event for the Children's Court Guardian Agency for Northern Ireland (Formerly NIGALA).

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, however member agencies are keen to explore how the SBNI can better disseminate and embed the learning extrapolated from the completed reviews.