TRANSLATING LEARNING INTO ACTION:

An overview of learning arising from Case Management Reviews in Northern Ireland 2003-2008

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NSPCC NORTHERN IRELAND
Cruelty to children must stop. FULL STOP

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Foreword

Most children grow up in loving and caring families that want the very best for them and who are able to provide this. Unfortunately this is not the case for all children and some are exposed to neglect or abuse that can cause physical or emotional harm and, in some tragic instances, their early death.

Over the past forty years the public, professionals and public services have become better at identifying and safeguarding children who need protection and in supporting families who need additional help. This has contributed to a dramatic decrease in the number of children dying from abuse and neglect over this period. This is an achievement which we as a society can be proud of but we can never be complacent. It is still the case that every day some children experience physical and/or psychological harm because their parents are unable or unwilling to keep them safe or care for them properly.

It is essential that we learn when things go wrong for children, particularly when the consequences for them and their families are tragic. We need to ensure that, as far as possible similar incidents are prevented for other children. That is the reason we undertake case management reviews – to learn from the past so, as far as possible, to prevent recurrences of similar tragedies in the future.

The process of case management review was first introduced in Northern Ireland in 1996 and the process has evolved over time. In 2003, Departmental Guidance, *Co-operating to Safeguard Children*, was published which updated and revised the case management review process and emphasised a focus on learning. This focus on learning is at the heart of this report.

Often incidents that trigger a case management review also trigger a police and/or disciplinary investigation, criminal or coroner's proceedings - processes which exist to determine cause of death or injury, identify who is responsible and to hold them properly to account. It is important that agencies and professionals are held to account when something goes wrong, but this is not the purpose of a case management review. The emphasis of a review is on the identification and dissemination of learning to assist practice and service improvements.

It is for this reason that the Department commissioned Queen's University and the NSPCC to produce this overview report. It brings together key learning from twenty four case management reviews completed in Northern Ireland between 2003-2008. This reflects the Department's commitment to ensuring that messages are shared with all organisations and professionals who work with children on a daily basis and who can help keep them safe. A series of seminars will support the dissemination of these messages across Northern Ireland.

The report also demonstrates the Department's ongoing commitment to openness and transparency with the wider public about the way the child protection system operates in Northern Ireland. In doing so, it is hoped there will be a better understanding of the difficult circumstances some children live with and the complexities for professionals in working with their families. It also shows how the child protection arrangements across our public bodies are open to learning and improving which will ensure the huge progress made over the past forty years is sustained and built on.

The recent establishment of the Children's Safeguarding Board for Northern Ireland (SBNI) in September 2012 is another important step forward. The SBNI is independently chaired and is a coalition of agencies across the health, social care, education, justice, voluntary and community sectors. It will promote co-ordination and co-operation between different agencies to protect and safeguard children and will do so in an open and transparent way. Case management reviews are now a function of the SBNI and for the first time in Northern Ireland these are a statutory requirement.

Any system of learning which focuses solely on when things have gone wrong is unnecessarily limited in its outlook. That is why for the first time since the establishment of a case management review process in Northern Ireland, reviews must now also be undertaken in connection with cases where there have been positive outcomes. These cases will identify positive learning where professionals and agencies have worked well either individually or in partnership and this will also help to improve safeguarding practice across the region.

I welcome this report and believe it will make a valuable contribution to improving both understanding and practice for all those involved in working with children and their families in Northern Ireland.

Séan Holland
Chief Social Services Officer
Department of Health, Social Services & Public Safety

Chapter One
Executive Summary

Even before they are born, children require parents who will provide for their physical, social and emotional needs, through the expression of love, a sense of security and the provision of care. Children, especially when they are younger, depend on parents and family to provide the stability and security required to form meaningful attachments, and to grow and develop in ways which are positive. However, we also know that not all parents provide this sense of stability and safety, either because they are unable or unwilling to do so.

Over the past twenty years there has been a much sharper focus on how to support families before a crisis arises, and on how to intervene when a child is in need of protection. There is a fine judgement to be achieved in ensuring that a child's right to be kept safe is balanced with the right of parents to bring up their child without undue interference by the State. Defining child abuse is complex as it involves an interpretation of which acts or behaviours towards a child are inappropriate, and an estimation of the amount of harm suffered by a child. There are specific criminal laws which provide a clear benchmark of what is inappropriate behaviour, such as the rape of a child. But in other instances the civil law focuses on whether the child has suffered harm as a consequence of parental behaviour (or inaction), and whether the harm is significant or not, such as when concerns exist about parental substance misuse or domestic violence. Children may be at risk of experiencing harm from a range of people, for example parents; siblings; extended family members; family friends; peers; adults in positions of trust; and strangers. Contrary to some media representations, children are at most risk from those who are known to them, rather than strangers. However, there are a very small group of individuals who pose a significant risk to any child they may have contact with, and recent improvements in the criminal justice led arrangements for monitoring and managing adults who pose a risk to children are essential in complementing the child protection system.

The United Nations Convention on the Rights of the Child explicitly places a duty on nation States to protect children from abuse and neglect (Article 3) and to uphold their right to life (Article 6). As a response to these obligations the child protection system in Northern Ireland, and elsewhere, has in recent years centred on five interlocking objectives (Devaney, 2013):

1. Reducing the prevalence and incidence of child abuse and neglect through preventative approaches;

2. Reducing the child mortality rate as a consequence of having a system for identifying and protecting children at risk of significant harm;

3. Preventing children identified as being in need of protection from experiencing repeated harm;

4. Addressing the effects of the harm experienced by children on their development, and promoting their welfare resulting in improved psychological and social functioning and improved educational attainment; and,

5. Addressing the needs of other family members so that they are in a better position to provide for the care and future protection of the child.

While we know that not all children in need of protection from abuse or neglect are referred to children's social services or the police, in the financial year 2011-2012 there were 35,516 referrals on 28,496 children made to Health & Social Care Trusts in Northern Ireland (DHSSPS, 2012). The majority of these children were never in danger of experiencing death or serious injury, however, at 31st March 2012 professionals felt it necessary to have a child protection plan in place for 2,127 children, indicating significant concerns for them.

In spite of the best efforts of those working within the child protection system, child deaths as a result of abuse and neglect remain a serious problem across nations (UNICEF, 2003). Whilst the deaths of children through illness and accidents have been closely monitored, those resulting from maltreatment are more difficult to ascertain because the perpetrators, usually parents and carers, are less likely to be forthcoming about the circumstances due to the inevitable legal consequences and public outcry. It is estimated that approximately 3,500 children under the age of 15 die annually in industrialised nations as a result of abuse. The United Nations estimate that every week two children die from abuse and neglect in Germany and the UK, three in France, four in Japan, and twenty seven in the United States. The risk of death by maltreatment is approximately three times greater for the under-ones than for those aged 1 to 4, who in turn face double the risk of those aged 5 to 14 (UNICEF, 2003). Thankfully the numbers of children dying as a result of abuse and neglect have decreased dramatically over the past forty years, although we cannot become complacent as in Northern Ireland since 1999/2000 the police have recorded that the number of homicides of children averages 2-3 per year.

The Departmental guidance *Co-operating to Safeguard Children* (DHSSPS, 2003) sets out the grounds for convening a case management review and the process to be followed whenever a child dies or is seriously injured, and abuse or neglect are believed to be contributing factors. In addition the guidance stipulates that the Department of Health, Social Services and Public Safety has a responsibility for ensuring that the learning arising from these reviews is both disseminated and used to strengthen the child protection arrangements in Northern Ireland. Specifically the Department is empowered to periodically publish an overview report of the key themes and learning arising from case management reviews. This report is the first of these overviews and presents the key learning from the first twenty-four reviews commissioned and completed between the commencement of the current process for case management reviews in 2003, up until the end of 2008.

Between January 2003 and December 2008 there were twenty four case management reviews undertaken in Northern Ireland on forty five children. The majority of the reports dealt with the death of a child – four children who died as a result of a physical or sexual assault; six infants who died unexpectedly for which there was no cause established (SUDI); and eight young people who died by suicide or accident. The other reports reviewed a range of issues including the serious injury of a child, the standard of care of children by their carers, and how professionals worked together.

The majority of the children subject to a review were living in families where parents were experiencing difficulties with their mental health, alongside misuse of alcohol or drugs, and domestic violence. These adult difficulties reduced the capacity of parents to meet their child's needs, and often resulted in children being exposed to risks as a result of lack of care and supervision, a chaotic family lifestyle and inappropriate physical and sexual behaviour towards children by adults. As a consequence of these adult difficulties most of the children were known to social services at the time of the event leading to the review. However, these children were amongst hundreds living in very similar circumstances and who were known to professionals, and the reviews concluded that it was unlikely that the children who died or were seriously injured could have been identified as being at heightened risk.

The majority of reports commented positively on the dedication and professionalism of individual staff working with the families subject to review. The reviews though did identify specific issues that could strengthen the structures and processes for supporting families and protecting children living in these complex and complicated situations, including:

- services becoming involved at an earlier stage with families before problems became entrenched and harder to ameliorate;

- services staying involved for longer with some families to ensure that improvements in parenting are consolidated in the longer term;

- ensuring that alongside providing services to reduce the risk that children may be at from physical or sexual abuse, therapeutic services to children should be provided to address the psychological harm of poor parenting;

- providing professionals with opportunities to meet together more frequently to co-ordinate assessments and interventions with children and families;

- ensuring that senior managers across organisations take greater responsibility for ensuring that workloads of individual professionals are manageable and commensurate with their level of experience;

- improving the interface between services working with children and services working with adults (for issues such as poor mental health or substance misuse) who are parents;

- ensuring that staff receive regular support and supervision in dealing with what is often highly complex and emotional work.

As a result of these reviews public agencies have made a number of significant improvements in the way that children and their families are supported, including:

- introduction of an initiative to support health professionals working in adult mental health and substance misuse services in respect of their child protection responsibilities;

- a new structure for the receipt and management of referrals in respect of children to HSC Trusts;

- a new regional framework across health and social services, education and criminal justice organisations for assessing the needs of children and their families;

- the development of Family Support Hubs to ensure that families with lower level needs are quickly put in contact with services that can meet these needs;

- improved arrangements for the supervision and support of social workers and health visitors;

- improved information sharing between criminal justice and social care organisations in respect of adults who pose a risk of harm to children.

In reviewing the first twenty four reviews a number of key learning points have emerged. Firstly, there is a need to view case management reviews as an important window into practice and an opportunity to reflect on what is working and what needs developed. However, just as a view from a building changes depending on what window is being used, so case management reviews cannot and should not be seen as providing the whole and or only view of the operation of the child protection system.

Secondly, the majority of cases subject to a case management review are very similar to many other cases known to GPs, health visitors, teachers and social workers. Therefore trying to predict which children are at greater risk of dying or suffering serious injury is ultimately a futile exercise. However, providing a wider range of families with early, sustained and co-ordinated support does reduce the likelihood of children suffering unnecessarily.

Finally, finding ways of better informing the public about the lives some children lead, the types of support services available to meet their needs, and the success of agencies in helping to improve the quality of life for children and their families is a necessary part of instilling public confidence in the child welfare system.

There is good research evidence to support the assertion that the child protection system keeps vulnerable children safe. Over the past forty years the numbers of children dying or being seriously injured as a consequence of abuse or neglect has decreased. This is due to the systems and processes currently in place, and the

preparation and ongoing training that professionals receive to support them in their work. Undertaking case management reviews is one way of ensuring that we continue to quality assure the effectiveness of the systems for supporting families and protecting children, and to make improvements that will keep future generations of children safe.

In writing this report we are very mindful that each young person who has been the subject of a case management review is someone's child, and likely is also a brother, a sister and a friend. Regrettably, too many children die or suffer abuse and neglect each year in Northern Ireland. We hope that in exploring this sensitive but important topic we are better able to provide services which can intervene early enough, and in a sustained and co-ordinated way, to reduce adversity that some, indeed many, children experience. We are also mindful that many professionals working with children who have died or who have suffered serious injury have been deeply affected by these issues. It is our hope that this report will assist in locating these events within a broader systemic perspective, rather than placing responsibility for these events on professionals who have often been delivering high quality services despite the tragic outcome.

Finally, in any reporting of the issues identified within this report we would encourage the media to have regard to the excellent guidance by the National Union of Journalists and children's organisations on the reporting of child abuse and neglect (**http://www.baspcan.org.uk/northernireland/**).

Chapter Two: Introduction

"Unexpected death during childhood is a rare occurrence in the Western world."

Sidebotham and Fleming (2007: ix)

Even before they are born, children have a need for parents who will provide for their physical, social and emotional needs, through the expression of love, a sense of security and the provision of care. Children, especially when they are younger, depend on parents and family to provide the stability and security required to form meaningful attachments, and to grow and develop in ways which are positive. However, we also know that not all parents provide this sense of stability and safety, either because they are unable or unwilling to.

Over the past twenty years there has been a much sharper focus on how to support families before a crisis arises, and on how to intervene when a child is in need of protection. There is a fine judgement to be achieved in ensuring that a child's right to be kept safe is balanced with the right of parents to bring up their child without undue interference by the State. When the public and politicians believe that the balance has been misjudged, there is an outpouring of opprobrium through the media, which can create further difficulties for professionals in responding to children's needs.

Defining child abuse is complex as it involves an interpretation of what acts or behaviours towards a child are inappropriate, and an estimation of the amount of harm suffered by a child. There are specific criminal laws which provide a clear benchmark of what is inappropriate behaviour, such as the rape of a child. But in other instances the civil law focuses on whether the child has suffered harm as a consequence of parental behaviour (or inaction), and whether the harm is significant or not, such as when concerns exist about parental substance misuse or domestic violence. Children may be at risk of experiencing harm from a range of people, for example parents; siblings; extended family members; family friends; peers; adults in positions of trust; and strangers. Contrary to some media representations, children are at most risk from those who are known to them, rather than strangers. However, there are a very small group of individuals who pose a significant risk to any child they may have contact with, and recent improvements in the criminal justice led arrangements for monitoring and managing adults who pose a risk to children are essential in complementing the child protection system.

It is always difficult to estimate the incidence and prevalence of a phenomenon such as child abuse. This is partly due to the difficulty in defining 'child abuse', but it is also related to the hidden nature of abuse and the varied forms in which it can present. Our understanding of the nature of child abuse comes from a range of sources, including statistics gathered by professionals in the course of their work, personal accounts provided by survivors of abuse and neglect, and research studies.

The most comprehensive figures on the prevalence of child abuse in the United Kingdom (UK) were collected by the NSPCC in their 2009 study of child maltreatment (Radford *et al*., 2011). This study was undertaken with a random probability sample of parents, young people and young adults from across the UK who were interviewed about their experiences of child abuse and neglect. The sample consisted of 2,160 parents or guardians of children aged less than 11 years; 2,275 young people aged 11-17 years with additional information from their parents or guardians; and 1,761 young adults aged 18-24 years. One in four of the young adults in this study reported having experienced severe maltreatment in childhood, defined as severe physical and emotional abuse by any adult, severe neglect by parents or guardians and/or contact sexual abuse by any adult or peer (Table 1).

Table 1: Rates of severe maltreatment in the UK

Maltreatment type	Under 11yrs old			11-17yrs olds			18-24yrs old		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Severe Physical	1.3% (18) *	1.0% (13)	1.2% (30)	6.7% (59)	7.1% (60)	6.9% (119)	10.2% (98)	12.9% (120)	11.5% (218)
Contact Sexual Abuse	0.2% (3)	0.8% (10)	0.5% (13)	2.6% (23)	7.0% (59)	4.8% (82)	5.1% (50)	17.8% (165)	11.3% (215)
Severe maltreatment by a parent or guardian	4.9% (64)	5.1% (64)	5.0% (128)	13.5% (119)	13.3% (112)	13.4% (231)	11.6% (112)	17.5% (163)	14.5% (275)
All severe maltreatment	5.8% (77)	6.1% (76)	5.9% (153)	18.2% (161)	19.0% (159)	18.6% (320)	20.3% (196)	30.6% (284)	25.3% (480)

* The bracketed figures are weighted frequencies (i.e. the number of children in the survey who reported this experience adjusted to take into account the UK child population numbers). The weighted frequency counts are rounded to the nearest whole number so do not always add up to the total frequency.
(Radford *et al*., 2011 p.8)

Over the past six years in the UK there has been a substantial increase in the numbers of children assessed by professionals as being at risk of experiencing harm through abuse and neglect (Table 2). Based on the evidence from prevalence research (Radford *et al*., 2011), this is more likely to reflect an increased awareness and identification of children at risk of experiencing harm rather than an increase in the numbers suffering abuse and neglect.

Table 2: Numbers of children identified by professionals as needing a child protection plan

	Children Subject to a Child Protection Plan Figures March 2006	Children Subject to a Child Protection Plan Figures March 2011	Percentage Increase
England	26400	42330	60%
Northern Ireland	1639	2401	46%
Scotland	2157	2571	19%
Wales	2165	2880	33%

Source: Table compiled by the authors from statistics gathered from Department for Children, Schools and Families (2008), Department for Education (2011), Department of Health, Social Services and Public Safety (2011), Scottish Executive (2006), Scottish Executive (2012), Welsh Assembly Government web site (http://www.statswales.wales.gov.uk/).

Whilst some people have attributed this increase to high profile child deaths, there is also a sense of a rebalancing within the child protection system as professionals have started to acknowledge that support in itself is not enough to meet the needs of some children living with adversity.

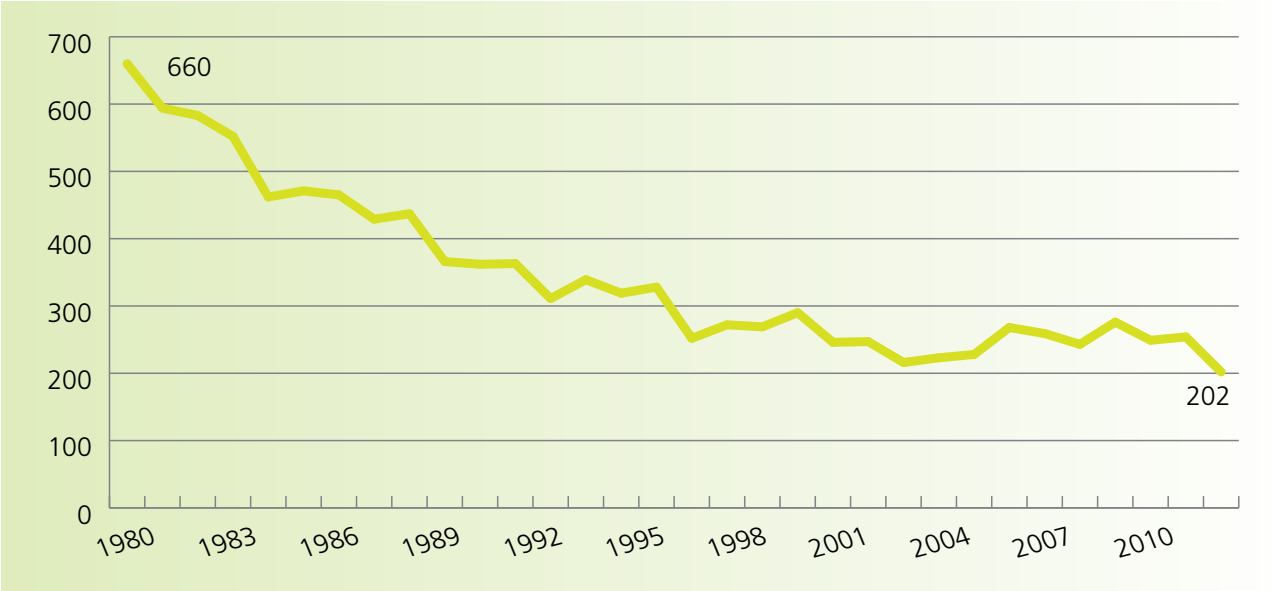
While we know that not all children in need of protection from abuse or neglect are referred to children's social services or the police, in the financial year 2011-2012 there were 35,516 referrals on 28,496 children made to Health & Social Care Trusts in Northern Ireland (NI) (DHSSPS, 2012). The majority of these children were never in danger of experiencing death or serious injury, however, at 31st March 2012 professionals felt it necessary to have a child protection plan in place for 2,127 children, indicating significant concerns for those particular children.

Childhood deaths

The death of a child may occur as a result of a life limiting condition, a sudden illness, an accident, or through maltreatment. Yet regardless of the cause, the death is a personal tragedy for the family and a loss to the wider community. Where that death results from abuse or neglect, the sense of both grief mixed with outrage is more palpable (Devaney *et al*., 2011).

Thankfully, whilst society is rightly concerned with the reasons for a child's death, childhood deaths are an increasingly rare event in Northern Ireland. In 1980, 0-15 year olds accounted for 29% of the population, and 3% of all deaths, while in 2010 0-15 year olds accounted for 21% of the population and 1% of all deaths. Therefore the rate of deaths amongst 0 -15 year olds has fallen from 124 per 100,000 in 1980, to 55 per 100,000 in 2010 (NISRA, 2011).

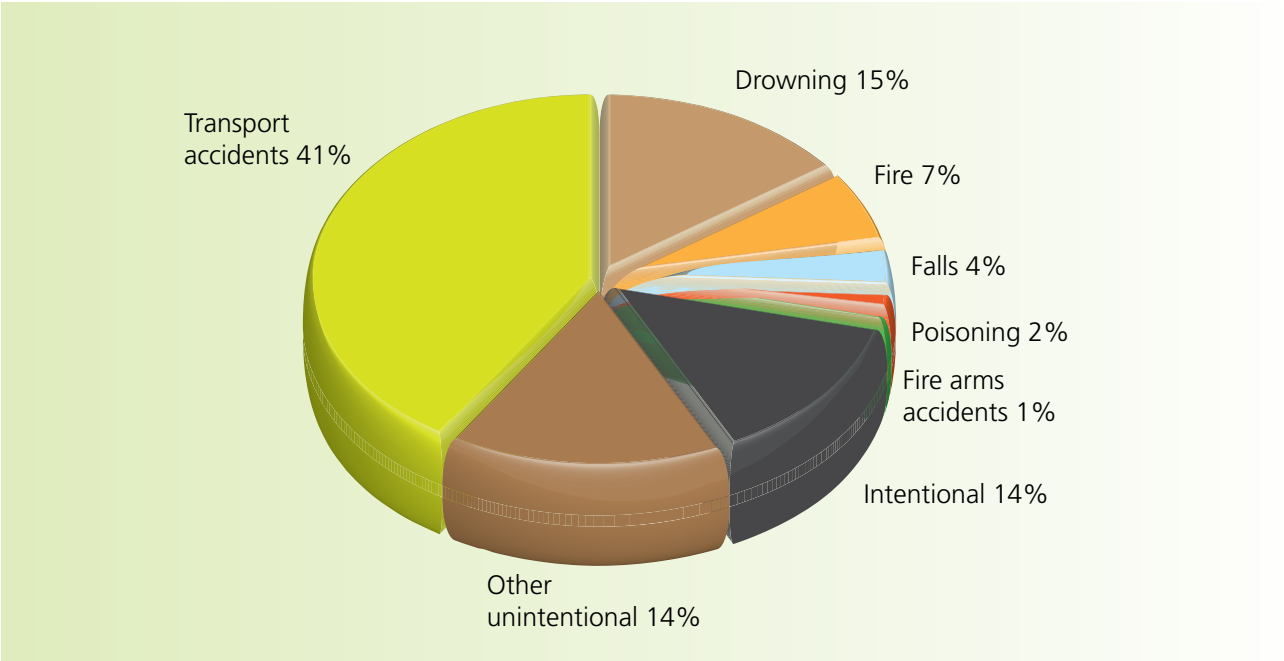
Figure 1: Number of deaths of 0-19yr olds from all causes in Northern Ireland 1980-2011



NISRA, 2012

Childhood deaths are not a homogeneous group but fall into a number of distinct and sometimes overlapping subgroups. In some cases a child's death will be anticipated due to a life limiting condition. In other instances a child may become suddenly ill through an underlying health condition or acquired infection, or suffer an unintended injury which has catastrophic consequences. In other circumstances a child may die as a result of a purposefully inflicted injury (by themselves or another) or as a consequence of a lack of care or supervision. It is estimated by UNICEF (2003) that about 14% of deaths of children that are not the result of illness or disease are the result of intentional harm being caused to the child by another child or adult (Figure 2). **It is the latter of these categories where children are seriously injured as a result of abuse or neglect, or killed intentionally with which this report is concerned.**

Figure 2: Causes of non-health related death of children in developed nations



UNICEF, 2003

Childhood deaths through maltreatment

The United Nations Convention on the Rights of the Child explicitly places a duty on nations to protect children from abuse and neglect (Article 3) and to uphold their right to life (Article 6). As a response to these obligations the child protection system in the UK, and elsewhere, has in recent years centred on five interlocking objectives (Devaney, 2013):

1. Reducing the prevalence and incidence of child abuse and neglect through preventative approaches;

2. Reducing the child mortality rate as a consequence of having a system for identifying and protecting children at risk of significant harm;

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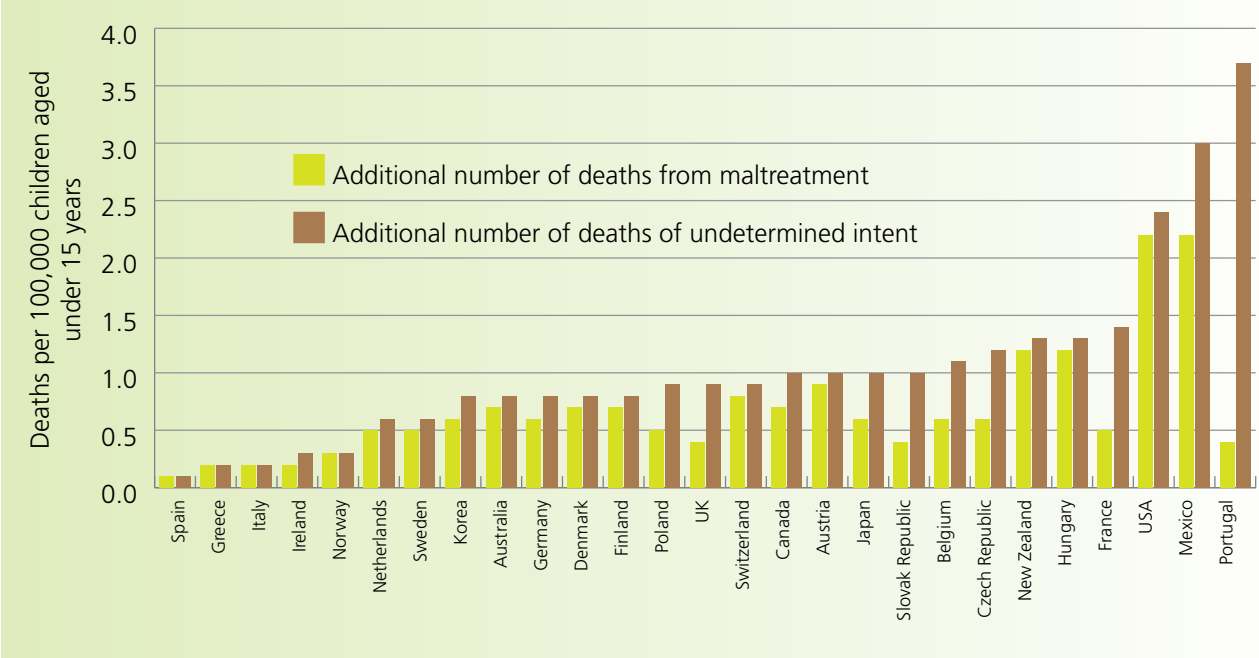
5. Addressing the needs of other family members so that they are in a better position to provide for the care and future protection of the child.

In spite of the best efforts of those working within the child protection system, child deaths as a result of abuse and neglect remain a serious problem across nations (UNICEF, 2003). Whilst the deaths of children through illness and accidents have been closely monitored, those resulting from maltreatment are more difficult to ascertain because the perpetrators, usually parents and carers, are less likely to be forthcoming about the circumstances due to the inevitable legal consequences and public outcry (Pritchard and Sharples, 2008; Pritchard and Williams, 2010). It is estimated that approximately 3,500 children under the age of 15 die annually in industrialised nations as a result of abuse. The United Nations estimate that every week two children die from abuse and neglect in Germany and the UK, three in France, four in Japan, and twenty seven in the United States (Figure 3). The risk of death by maltreatment is approximately three times greater for the under-ones than for those aged 1 to 4, who in turn face double the risk of those aged 5 to 14 (UNICEF, 2003).

Figure 3: Child deaths from maltreatment in economically developed nations



UNICEF, 2003, p.4

As noted by Frederick *et al*. (2012) whilst child protection and injury prevention policies and practices are implemented in most countries in an attempt to manage and reduce the incidence of both intentional and unintentional injuries, there is a lack of a comprehensive database on these child deaths, and limited research evidence of what makes a difference on which to develop appropriate policies. Pritchard and Williams (2010) also state that the categorisation of the cause of a child's death as due to intentional harm can be problematic, as in some cases it is "not possible for the medical or legal authorities to determine whether it was accident, self harm or assault that was the over-riding cause of death" (WHO, 1992, p.1095). In addition some deaths remain hidden, such as concealed pregnancies resulting in neonaticide. As a result the figures for child deaths by maltreatment typically include both measurements i.e. those deaths classified as being the direct consequence of an assault, and those deaths were the cause is undetermined but may be related to maltreatment. What is clear is that the chances of a child dying from abuse or neglect vary widely even amongst developed countries.

In Northern Ireland since 1999/2000, the police have recorded that the number of homicides of children averages 2-3 deaths per year (Table 3).

Table 3: Recorded Homicide[1] offences where the victim is aged under 18 (1999/2000 -2011/2012)

Year	Murder	Manslaughter	Infanticide
1999/00	1	0	0
2000/01	2	1	0
2001/02	3	0	0
2002/03	1	0	0
2003/04	2	1	1
2004/05	2	1	1
2005/06	3	0	1
2006/07	1	0	0
2007/08	6	1	0
2008/09	2	1	0
2009/10	1	1	0
2010/11	0	2	0
2011/12	0	0	0

Source: PSNI statistics branch
1 Homicide includes the offences of murder, manslaughter and infanticide

Yet despite the media coverage and public perception from such tragic cases which suggest violent child death is increasing, research published in 2008 claimed that violent child deaths in England and Wales had fallen by 70% between 1974 and 2002 (Pritchard and Sharples, 2008), and that this decline was greater than in almost all of the other major developed countries. However, many professionals working in the area of child protection feel that the published reductions in violent child deaths are not reflective of what they observe in practice. As noted by Sidebotham *et al*. (2012) these conflicting views pose some difficult questions:

- Has the rate of violent child death really fallen?
- If there has been a real decrease, what factors have led to it?
- If there has not been a real decrease, why are all of the child protection policies and procedures failing to reduce this rate?

Drawing data from the Registrar General's national mortality statistics series for England and Wales between 1974 and 2008 to address these questions, Sidebotham *et al*. (2012) concluded there was a 77% reduction in infant, child and adolescent mortality as a result of violent death from 113 to 26 deaths per 100,000 children, a very significant decrease in three decades.

Studying childhood deaths and serious injury

Traditionally, one of the most public ways of learning about child maltreatment has been through the inquiry into the death or serious injury of a child from child abuse or neglect. In the UK, as in many other countries, these inquiries have had a major influence on the way services have developed (Parton, 2004; Stanley and Manthorpe, 2004; Drakeford and Butler, 2006). The inquiry has the aim of establishing what led to the event under examination with the twin objectives of holding agencies and individuals to account for their actions, alongside identifying what can be learned to lessen the likelihood of a repeat in a similar future instance.
There is arguably a moral as well as a legal responsibility to try to understand more about the circumstances which might lead to the occurrence of a child's death or serious injury. However, there must be a greater recognition amongst politicians and the general public that child deaths from maltreatment are not entirely avoidable. Whilst it is tempting to use child deaths as a proxy for the effectiveness of the child protection system,

caution must be used in doing so. The death or serious injury of a child as a consequence of abuse or neglect is an extremely rare event, and as such we may learn something from this particular case without necessarily assuming that issues identified are indicative of the operation of the wider child welfare system. In fact, using child deaths as the sole means of reflecting upon the operation of the child protection system is likely to skew the way the system operates, a point the authors will return to later.

Case management review overview report

The Departmental guidance *Co-operating to Safeguard Children* (DHSSPS, 2003) sets out the grounds for convening a case management review and the process to be followed whenever a child dies or is seriously injured, and abuse or neglect are believed to be contributing factors. In addition the guidance stipulates that the Department of Health, Social Services and Public Safety has a responsibility for ensuring that the learning arising from these reviews is both disseminated and used to strengthen the child protection arrangements in Northern Ireland. Specifically the Department is empowered to periodically publish an overview report of the key themes and learning arising from case management reviews. This report is the first of these overviews and presents the key learning from the first 24 case management reviews commissioned and completed between the commencement of the current process for case management reviews in 2003, up until the end of 2008.

The report begins in chapter three with an introduction to the case management process, and is followed in chapter four by a summary of the key learning gained in reviewing the deaths and serious injury of children through abuse and neglect in other UK jurisdictions. Chapter five then sets out the methodology used in this review while chapter six gives an overview of the demographic profile and family circumstances of the children who were subject to a case management review in Northern Ireland during the period 2003-2008. This is followed in chapter seven by a discussion of the key themes and learning arising across the reviews undertaken. In chapter eight we then reflect on some of the data about the case management review process, before exploring what we have learnt through these reviews in the final chapter. Whilst we think the chapters are sequential and inform one another, for those wishing to get a sense of the key learning from the Northern Ireland reviews, then chapters six, seven and nine are a good place to start.

In writing this report we are very mindful that each young person who has been the subject of a case management review is someone's child, and likely is also a brother, a sister and a friend. Regrettably, too many children die or suffer abuse and neglect each year in Northern Ireland. We hope that in exploring this sensitive but important topic we are better able to provide services which can intervene early enough, and in a sustained and co-ordinated way, to reduce adversity that some, indeed many, children experience. We are also mindful that many professionals working with children who have died or who have suffered serious injury have been deeply affected by these issues. It is our hope that this report will assist in locating these events within a broader systemic perspective, rather than placing responsibility for these events on professionals who have often been delivering high quality services despite the tragic outcome.

Finally, in any reporting of the issues identified within this report we would encourage the media to have regard to the excellent guidance by the National Union of Journalists and children's organisations on the reporting of child abuse and neglect (**http://www.baspcan.org.uk/northernireland/**).

Chapter Three:
The Case Management Review Process

Introduction

When a child dies or is seriously injured, and abuse or neglect is known or suspected to be a contributing factor, it is important for professionals and their managers to ensure that other children who may be at similar risk are protected from experiencing similar harm. This may be children in the same family, children who may have on-going contact with the person believed to have caused the harm, or children living in similar circumstances but who may not be directly connected to the child who has been harmed. The first inter-agency child protection guidance issued to cover this process was published by central government in the UK in 1988 and applied to England and Wales (Department of Health and Social Security and Welsh Office, 1988). Part 9 of this guidance introduced a system of 'case reviews' which were to be undertaken by senior managers in the relevant agencies under the coordination of the Area Child Protection Committee (ACPC). This system provided a more consistent set of procedures than previous arrangements for conducting public inquiries and allowed cases to be examined in a more constructive way with greater emphasis on reflection and learning and less on apportioning blame (Hallett, 1989; Hill, 1990). The government, however, retained the power to order a public inquiry but has only done so in extreme cases, most notably following the deaths of Victoria Climbié (Laming, 2003), Jessica Chapman and Holly Wells (Bichard, 2004) and Peter Connelly (Laming, 2009).

Similar review processes were subsequently introduced in other parts of the UK (see Table 3). In Scotland they are referred to as 'Significant Case Reviews' (SCRs) and, in Northern Ireland, as 'Case Management Reviews' (CMRs). In England and Wales, subsequent revisions of the guidance provided fuller details on case reviews in section 8 and these became known as 'Part 8' or 'Chapter 8' reviews and later as 'Serious Case Reviews' (Sinclair and Bullock, 2002). Although this terminology was not actually used in official guidance in England and Wales until 2006 (HM Government, 2006; Welsh Assembly Government, 2006), the term 'Serious Case Review' (SCR) is used throughout this chapter and subsequent chapters to refer to all such reviews carried out in England and Wales under '*Working Together*' guidance.

At the time of writing, the processes for examining serious cases are being reviewed in all four jurisdictions of the UK. In England, the Munro review of child protection (Munro, 2011) recommended that Local Safeguarding Children Boards (LSCBs) use a 'systems' methodology in SCRs (Fish *et al*., 2008). The Government accepted this recommendation (Department for Education, 2011) and, on 12th June 2012, launched a consultation on revised safeguarding statutory guidance including proposed new arrangements for SCRs (Department for Education, 2012). In Wales, following a review of the arrangements for conducting SCRs and their effectiveness (Care and Social Services Inspectorate Wales, 2009) the Welsh Government launched a consultation on 9th January 2012 on proposed new Multi-Agency Child Practice Reviews to replace the current system of SCRs (Welsh Government, 2012). In Northern Ireland, inter-agency guidance is being updated following the replacement of the Regional Child Protection Committee with the Safeguarding Board for Northern Ireland (SBNI) and Local Safeguarding Panels (Devaney *et al*., 2011; Stafford *et al*., 2012), and in Scotland the current interim guidance is being updated following the recommendations of an independent short life working group commissioned by the Scottish Government to consider the process in light of recent research and practice (Multi Agency Resource Service, 2010).

Table 4: Development of case review processes across the UK

England	Wales	Scotland	Northern Ireland
Department of Health and Social Security and Welsh Office (1988). Case Reviews (Part 9)			Department of Health and Social Services (1989). Case Management Reviews (Part 10)
Home Office, Department of Health, Department of Education and Science and Welsh Office (1991). Case Reviews (Part 8)			Department of Health and Social Services (1996). Case Management Reviews (Part 12)
Department of Health, Home Office and Department for Education and Employment (1999). Case Reviews (Chapter 8)	National Assembly for Wales (2000). Case Reviews (Chapter 8)		Department of Health, Social Services and Public Safety (2003). Case Management Reviews (Chapter 10)
HM Government (2006). Serious Case Reviews (Chapter 8)	Welsh Assembly Government (2006). Serious Case Reviews (Chapter 10)	Scottish Executive (2007). Significant Case Reviews	
HM Government (2010). Serious Case Reviews (Chapter 8)			

Northern Ireland Case Management Review Process

The purpose of a Case Management Review (CMR) is to:

- establish the facts of the case;
- establish whether there are lessons to be learned from the case about the way in which professionals and statutory and/or voluntary agencies work together to safeguard children;
- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence;
- improve inter-agency working and thus provide better safeguards for children.

The primary responsibility for undertaking a case management review is vested in the Regional Child Protection Committee[1], a high level committee of senior managers from organisations with responsibilities for working with children, families and adults. The role of the Regional Child Protection Committee is to determine

1 In 2009 the Regional Child Protection Committee was established to replace the four Area Child Protection Committees as part of the Review of Public Administration in NI. The Regional Child Protection Committee was a standing committee of the HSC Board, and was chaired on behalf of the Board by the Assistant Director for Social Services (Children). Since September 2012 the Safeguarding Board for Northern Ireland has assumed responsibility for CMRs.

the strategy for safeguarding children and to develop and disseminate policies and procedures. The policy guidance for the Regional Child Protection Committee states that a case management review should always be undertaken when a child dies, including death by suicide, and abuse or neglect is known or suspected to be a factor in the child's death.

In addition, the Regional Child Protection Committee should always consider whether to undertake a CMR where:

- a child has sustained a potentially life-threatening injury through abuse (including sexual abuse) or neglect;
- a child has sustained serious and permanent impairment of health or development through abuse or neglect; and
- the case gives rise to concerns about the way in which local professionals and services worked together to safeguard children.

The policy guidance states that the review should be conducted in such a way that the process is a learning exercise. CMRs are not intended to be inquiries into how a child died, or who was culpable. Rather these are a matter for the Coroner and criminal courts respectively to determine as appropriate. The guidance states that there **must** be clarity about the interface between the different processes of investigation (including criminal investigations); ***case management***, including help for abused children and immediate measures to ensure that other children are safe; and ***review***, i.e. learning lessons from the case to lessen the likelihood of such events happening again. The processes while different should inform each other. Therefore any proposals for review should be agreed with those leading any criminal investigation to make sure that the review does not prejudice possible criminal proceedings.

The responsibility for deciding whether or not a CMR should be undertaken rests with the chairperson of the Regional Child Protection Committee. If a review is necessary the chairperson should establish a Case Management Review Panel (Review Panel) and appoint a Review Panel Chair. The guidance states that consideration should always be given to appointing a Review Panel Chair who is independent of any of the organisations that may have been involved with the child and family, and this has always been the case in Northern Ireland, a measure designed to bring greater transparency and challenge to the review of the operation of the child protection system. The chairperson of the Regional Child Protection Committee has the responsibility for drawing up the terms of reference for the Review Panel.

The Review Panel must involve, as a minimum, representatives from social services, health, education and the police. There is no automatic agency entitlement to be represented on a Review Panel, but representatives from other disciplines and agencies may be included depending on the specific nature of the issues under review. Therefore the membership must have sufficient seniority and professional child care expertise to be able to offer a professional opinion on the management and practice in a specific case. The balance of representation must be such that the Review Panel can achieve impartiality, openness, independence, and thoroughness in the review of the case. The individuals who become members of the Review Panel must not have had any line management responsibility for the specific case under consideration. The Review Panel must include members who are independent of the HSC Trusts and other agencies concerned.

Immediately upon the death or serious injury of a child known to social services, or once it is known that a case is being considered for review, each involved agency is required to immediately secure its records relating to the case to guard against contamination, loss or interference until the CMR process is complete. Where access to secured records is required by a member of staff involved in the case from any individual agency it should only occur under the supervision of an independent senior member of staff. Such access must be recorded and signed and dated by all those involved.

The Chair of the Regional Child Protection Committee should agree the scope of the review and the terms of reference with the Review Panel. Relevant issues and questions to consider should include:

- what appears to be the most important issues to address to identify learning from this specific case?
- how can the relevant information best be obtained and analysed?
- the need to bring in an outside expert at any stage, to shed light on crucial aspects of the case.
- over what time period should events be reviewed, i.e. how far back should enquiries cover, and what is the cut-off point? What family history/background information will help to better understand the recent past and present which the review should try to capture?
- which agencies and professionals should contribute to the review, and who else (e.g. playgroup leader, community/youth group leader, Chair of a Board of Governors) should be asked to submit reports or otherwise contribute?
- should family members or concerned individuals, who may have referred the case to social services, be invited to contribute to the review?
- will the case give rise to other parallel investigations of practice, for example, a mental health homicide or suicide enquiry, and if so, how can a co-ordinated review process best address all the relevant questions which need to be asked, in the most efficient and effective way?
- before (the date of the incident or concern leading to the review) was there a need to involve agencies/ professionals from other Area Child Protection Committees' areas and what are the respective roles and responsibilities of the different Area Child Protection Committees' with an interest.
- how will the review process take account of a Coroner's enquiry, and (if relevant) any criminal investigations or proceedings related to the case?
- is there a need to liaise with the Coroner and/or the Public Prosecution Service?
- who will make the link with relevant interests outside the main statutory agencies, e.g. independent professionals, independent schools, voluntary organisations?
- what is the timescale for the completion of the review?
- how should any public, family and media interest be handled, before, during and after the review?
- does the Regional Child Protection Committee need to obtain independent legal advice about any aspect of the proposed review?

CMRs will vary widely in their breadth and complexity, but in all cases the policy guidance states that lessons learned should be acted upon quickly.

Agencies involved with a child or family subject to a review should undertake an Individual Agency Review of their involvement. The aim of an Individual Agency Review is to look objectively and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about. The Individual Agency Review provides the Review Panel with a summary of agency involvement and a reflection by the agency on the standard of practice in the case under review, and an initial identification of any lessons to be drawn.

The Departmental guidance stresses the importance of remembering that the Individual Agency Reviews/CMRs are not a part of any disciplinary enquiry or process. However information that emerges in the course of a review may indicate that disciplinary action should be taken under established procedures. In some cases (e.g. alleged institutional abuse) disciplinary action may be needed urgently to safeguard other children. Therefore, the guidance states that Individual Agency Reviews/CMRs may be conducted concurrently with disciplinary action.

The Regional Child Protection Committee's Case Management Review Report should bring together and relate the information and analysis contained in the Individual Agency Reviews, together with reports commissioned from any other sources or relevant interests. It is also permissible for the Review Panel to meet with staff and family members to explore the history of a case and any wider contextual information which may be relevant.

On receiving a CMR report the Regional Child Protection Committee Chairperson should:

- ensure that contributing agencies and individuals have endorsed and agreed that the information provided is fully and fairly represented in the Case Management Review Report;
- convene a special meeting of the Regional Child Protection Committee to consider the findings from the review;
- in conjunction with the Regional Child Protection Committee translate recommendations into an Action Plan which should be endorsed and adopted at a senior level by each of the agencies involved. The plan should set out who will do what, by when, and with what intended outcome. The plan should set out by what means improvements in practice/systems will be monitored and reviewed;
- clarify to whom and when the report, or any part of it, should be made available;
- disseminate the report, or its key findings, to interested parties as agreed;
- make arrangements to provide feedback and de-briefing to staff, family members of the child whose case has been reviewed and the media as appropriate; and
- provide a copy of the case management review report, executive summary, action plan and individual agency reports to the Department of Health, Social Services and Public Safety.

The Regional Child Protection Committee should consider carefully who might have an interest in the review's outcome e.g. Board Members of HSC Trusts, the HSC Board or other involved agencies, staff, members of the child's family, the public, the media, and what information should be made available to each of these stakeholders.

There are difficult issues to balance which include the:

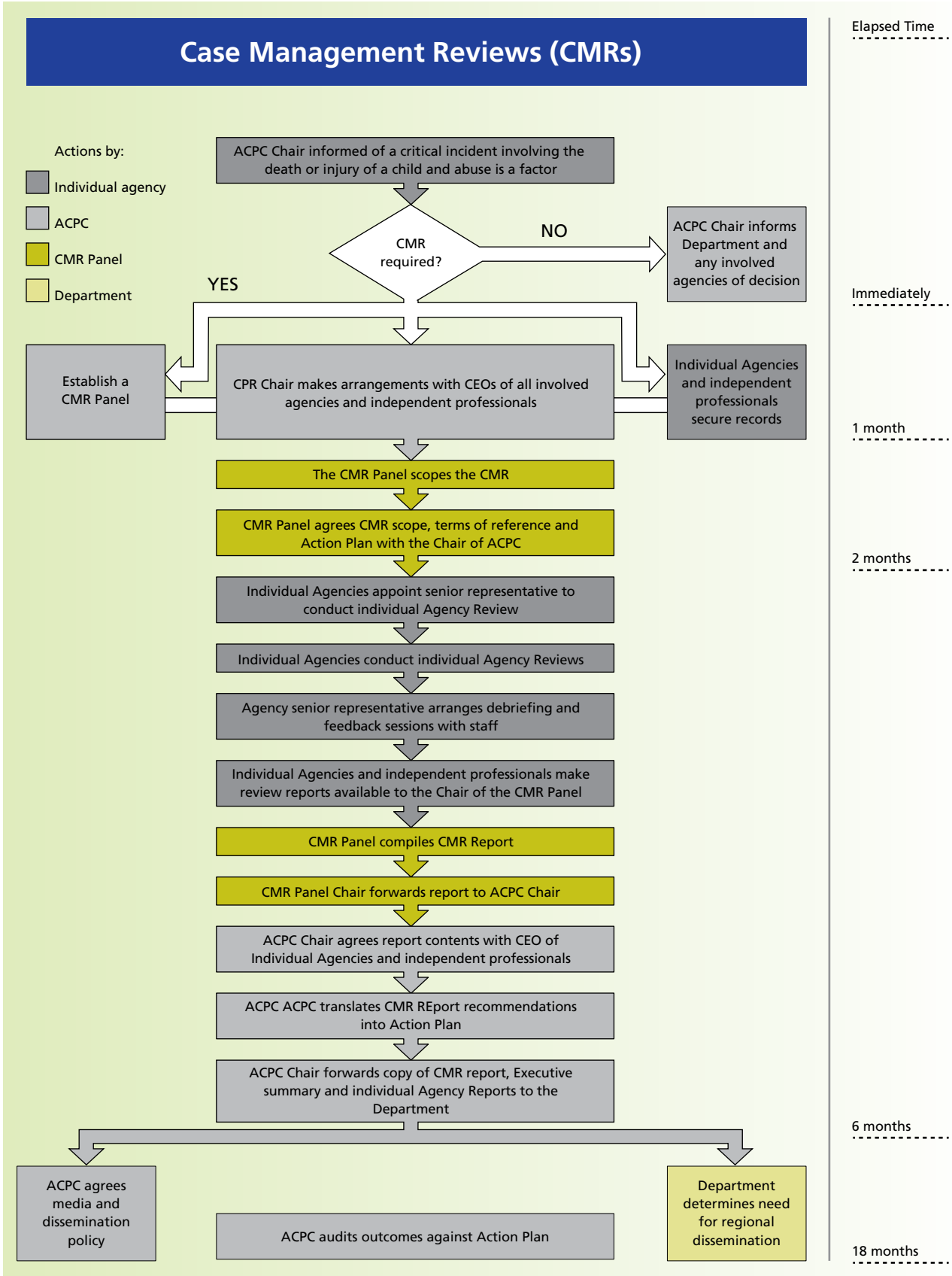
- need to maintain confidentiality in respect of personal information contained within the reports on the child, family members and others;
- need to be mindful that different family members may have very different views on the issues in the report;
- accountability of public services and the importance of maintaining public confidence in the process of internal review;
- need to secure full and open participation from the different agencies and professionals involved;
- responsibility to provide relevant information to those with a legitimate interest; and

- constraints on sharing information when criminal proceedings are outstanding, in that access to the contents of information may not be within the control of the Regional Child Protection Committee.

The Regional Child Protection Committee is required to put auditing arrangements in place to monitor action against recommendations and intended outcomes. The Regional Child Protection Committee should produce a short report approximately one year after the CMR action plan has been put in place, providing an update which demonstrates that recommendations have been acted upon and the degree to which the stated intended outcomes have been achieved. Where progress cannot be demonstrated, the report should offer an explanation and outline any further action which the RCPC considers necessary.

Finally, it is worth noting that under Article 152 of the Children (Northern Ireland) Order 1995 the Department of Health, Social Services and Public Safety may instigate local or other inquiries where it appears advisable to do so. This can include an inquiry into the functions of a HSC Trust or voluntary organisation which relate to children. An inquiry of this kind would be quite distinct from a CMR. However, it is possible that the findings of a CMR could lead to such an inquiry being convened.

Figure 4: Case Management Review process



Chapter Four:
Learning from Other Overview Processes

Learning from serious cases across the United Kingdom

The revised guidance published to govern the conduct of SCRs in England and Wales (Department of Health, Home Office and Department for Education and Employment, 1999; National Assembly for Wales, 2000) contained a commitment to commission overview reports approximately every two years, outlining the key findings of SCRs and their implications for policy and practice. These biennial analyses of SCRs published after 2001 (Brandon *et al*., 2002; 2008; 2009; 2010; 2011; Rose and Barnes, 2008; Sinclair and Bullock, 2002), together with a series of annual reports by the Office for Standards in Education, Children's Services and Skills (Ofsted) [2008; 2009; 2010; 2011a, 2011b], are the main focus of this chapter and relate primarily to cases in England. Findings from a smaller number of reports examining SCRs in Wales are also included (Brandon *et al*., 1999; Brandon *et al*., 2002; Colton *et al*., 1996; Morris *et al*., 2007). In Scotland Vincent and Petch (2012) have recently published an audit of significant case reviews undertaken between 2007-2012. There have, to date, been no regional analyses of the findings from CMRs across Northern Ireland (Lazenbatt *et al*., 2009) although some analyses of cases involving child deaths or serious injury have been undertaken. For example, the lessons from selected reviews have been presented at local seminars held by the former Area Child Protection Committees (ACPC) and more recently the Regional Child Protection Committee in Northern Ireland.

In Scotland, Vincent (2010) analysed the reports of thirteen key public inquiries or reviews into child deaths or abuse between 1975 and 2009. A number of child, family and environmental, and agency/professional practice themes were identified and these are summarised in Table 5. In relation to Significant Case Reviews, the report by the Multi Agency Resource Service (2010) recommended that the Scottish Government commission an audit and analysis of all SCRs undertaken since 2007 to provide a baseline and understanding of the relevant issues for practice since publication of the interim guidance in 2007. Fifty-six significant case reviews completed between 2007 and 2012 have subsequently been analysed (Vincent and Petch, 2012). The Multi Agency Resource Service (2010) review also recommended that on-going biennial analyses of such reviews should be commissioned in order to fulfil the commitment to national learning.

Table 5: Themes identified in reports of key public inquiries or reviews undertaken in Scotland between 1975 and 2012 (Adapted from Vincent, 2010; Vincent and Petch, 2012)

Child	Family and Environment
The following children might be more likely to die or experience serious abuse: • very young children • only or youngest child in family • children who have previously experienced neglect, physical or emotional abuse • children with special needs • hard-to-help teenagers	Children are likely to be most at risk of death or significant abuse when there is a cumulative interaction of a number of the following risk factors: • presence of a violent man in the household • poverty/financial problems • housing difficulties • frequent house moves • criminal convictions • parental/carer mental ill health • parental/carer substance misuse • parental/carer learning disability • parental conflict and/or domestic violence • young parents • social isolation/poor support networks • parental/carer experience of abuse and/or care in childhood • long-term involvement with agencies • withdrawal from contact with the outside world

Agency/Professional Practice

Key learning points regarding agency/professional practice are:

- information needs to be analysed and not simply accumulated
- assessment of risk and need should be an on-going process rather than a one-off event
- risk of harm must be managed as well as assessed
- risk assessment should form part of a wider assessment of the whole child including a child's need for care and protection
- historical information should always be sought and taken into account in the assessment process
- it is important to assess the parenting skills of fathers and significant males
- children assessed as 'children in need' may also be in need of protection
- decision-making and planning processes should be documented
- effective communication and information sharing across and between agencies is crucial
- when information is shared across and between agencies it needs to be taken into account and accurately assessed
- professionals need clear guidelines in relation to information sharing when child protection thresholds have not been met
- regular supervision is important to help professionals reflect and consider alternative points of view and also to support them in coping with the emotional impact of child protection work
- staff in universal and adult services need to be able to identify child abuse and neglect as they are often the first services to have contact with children and families
- professionals need support to work with hostile, manipulative parents and need to feel confident to challenge parents/carers when standards of care are unacceptable
- professionals from all agencies require training in communicating with children
- professionals need to see and speak to children
- working in partnership with parents is important but the needs of the child should be the main focus of intervention

Although the main focus of this chapter is on biennial analyses of SCRs and annual reports by Ofsted published after 2001, there have been a number of other overviews undertaken of cases involving child deaths or serious abuse. These can be divided into three main categories such as those that:

- analyse the reports of public inquiries (Department of Health and Social Security, 1982; Greenland, 1987; Department of Health, 1991; Reder *et al*., 1993).

- review a mixture of public inquiry and SCR reports (Munro, 1996; 1998; 1999; Corby *et al*., 1998; Fitzgerald, 2001).

- examine the reports of SCRs (James, 1994; Falkov, 1996; Colton *et al*., 1996; Sanders *et al*., 1999; Brandon *et al*., 1999; Reder and Duncan, 1999; Arthurs and Ruddick, 2001; Dale *et al*., 2002a; 2002b).

The main issues identified by the overview reports in the first two categories are summarised in Table 6. As noted by Sinclair and Bullock (2002), these issues have a tendency to recur in later studies such as the biennial analyses and Ofsted reports discussed later in this chapter.

Previous SCR Overviews (1994-2001)

A number of overviews of SCR reports have been undertaken in England and Wales which identify familiar issues to those raised by subsequent biennial analysis and Ofsted reports. James (1994) examined thirty SCR reports and produced a discussion document for the 1994 ACPC conference. He noted parental histories of abuse in just over one-third of the cases and that, in six cases children had been killed or seriously harmed as a direct result of the mental illness of a parent. The difficulties of protecting children in 'chaotic' families where there are adults in

multiple relationships, frequent changes of address, a number of pre-school children, health or disability issues, poverty or financial difficulties, domestic violence and criminal activity, were highlighted. Also highlighted were deficiencies in assessments, such as taking information given by parents at face value and non-engagement of men, as well as professional intervention in a context of inadequate resources.

Table 6: Main issues identified in overview studies of public inquiries and/or serious case reviews 1982-2001 (Adapted from Reder and Duncan, 2004)

Publication	Reports Reviewed	Main Issues/Themes Identified
Department of Health and Social Security (1982)	18 public inquiries completed between 1973 and 1981	• Difficulties in inter-agency collaboration • Difficulties in inter-agency coordination • Deficiencies in recognition of abuse and neglect • Deficiencies in assessments • Identifiable warning signs missed • Inadequate professional resources • Inadequate professional training • Inadequate use of professional authority
Greenland (1987)	35 public inquiries completed between 1972 and 1982	• Difficulties in inter-agency communication • Identifiable warning signs missed • Deficiencies in assessments
Department of Health (1991)	19 public inquiries completed between 1980 and 1989	• Difficulties in inter-professional communication • Difficulties in inter-professional coordination • Inadequate use of professional authority • Inadequate professional resources • Inadequate professional training • Inadequate professional supervision • Deficiencies in assessments • Identifiable warning signs missed
Reder *et al*. (1993)	35 public inquiries completed between 1973 and 1989	• Difficulties in inter-professional communication • Influence of parental 'care and/or control conflicts' • Relevance of the meaning of the child for the parent • Inadequate professional resources • Deficiencies in assessments (inadequate integration of information) • Identifiable warning signs missed • Inadequate professional training
Munro (1996; 1998; 1999)	45 public inquiries and Serious Case Reviews completed between 1973 and 1994	• Deficiencies in assessments (unsystematic reasoning) • Failure to revise initial assessments in light of new evidence • Difficulties in inter-professional communication
Corby *et al*. (1998)	70 public inquiries and Serious Case reviews completed between 1945 and 1997	• Difficulties in inter-agency coordination • Inadequate professional training • Inadequate professional supervision
Fitzgerald (2001)	More than 40 public inquiries and Serious Case Reviews completed by the Bridge Child Care Development Service (no dates given)	• Difficulties in inter-professional communication • Difficulties in inter-professional coordination • Deficiencies in assessments (over-emphasis on family support vs. assessment of risk) • Failure to listen to children

Falkov (1996) was invited by the Department of Health to review one hundred SCR reports in order to identify if there was an association with adult mental illness. Clear evidence of this was found in 32% of cases and, in a further 23%, there was insufficient information to form a definitive judgement. The report recommended improvements in training in mental health and child protection for relevant professionals in order to enhance the processes of recognition, referral and intervention and concluded:

> "The key finding was not an absence of agency input…but rather an absence of effective inter-agency coordination, collaboration and communication…In general a parental mental health perspective amongst child agencies was lacking and there was little emphasis on child protection and the nature of children's experiences prior to their premature deaths amongst adult services." (Falkov, 1996, p.20).

The theme of parental mental illness was again identified in a study of twenty-one SCRs carried out in Wales between 1991 and 1996 (Colton *et al*., 1996; Sanders *et al*., 1999) which found this to be an issue in close to one quarter of the cases examined. The study also identified a number of cases displaying evidence of 'chaotic' family structures as outlined by James (1994). In terms of professional practice, the authors drew attention to deficiencies in assessments, with these either not being undertaken at all or being insufficiently structured to be useful, as well as failures in inter-agency communication and information-sharing. They also queried whether, in a number of cases, parents had been afforded too much 'choice' with regards to accepting or declining support perhaps indicating an over-emphasis on 'partnership' rather than the assessment and management of risk. A further study in Wales (Brandon *et al*., 1999) examined ten SCR reports completed between 1996 and 1998. It noted:

> "Whilst there are many examples of good professional practice amongst the ten cases, a range of themes and issues emerged that indicated deficiencies…most of the themes have occurred in previous studies time and time again…These include: poor assessment of need and risk; inadequate inter-agency communication and sharing of information; over-emphasis on particular issues; the failure to consider overall patterns; poor supervision arrangements and inadequate record keeping. Throughout the reports there were instances of non-procedural adherence…" (Brandon *et al*., 1999, p.4).

Reder and Duncan (1999) analysed forty-nine SCR reports completed between 1993 and 1994 and identified a significant association between fatal child abuse and mental health problems in the parents/carers which were often accompanied by alcohol or drug misuse. The authors also concluded, in line with their earlier study of public inquiry reports (Reder *et al*., 1993), that most of the abusing parents could be described as suffering from unresolved 'care' and 'control' conflicts in which "…the parents' own childhood experiences of adverse parenting left them with unresolved tensions that spilled over into their adult relationships" (Reder and Duncan, 1999, p. 62). Younger children were considered to be especially at risk when they are most dependent and when they carry meanings for their parent(s) associated with the unresolved parental conflicts. Problematic assessment stood out as an issue above all others. This occurred in several guises, including assessments not being undertaken, new information being treated in isolation and not integrated with past concerns, warning signs not being recognised, a dissonance between assessment and action, and assessment paralysis occurring whereby professionals were unable to consider the needs of the child alongside those of the parent.

Arthurs and Ruddick (2001) analysed thirty SCR reports carried out in South-East England between 1998 and 2000. In virtually all of the cases, concerns were raised about the quality and scope of assessments with a number of issues typically being overlooked, including full family history, father's history, the potential risk posed by co-habitees, the risks to child safety and welfare in households where domestic violence is occurring, the additional risks posed to children by significant events (e.g. pregnancy within a family), a lack of reference to information from schools and primary care, and assessment of parenting capacity. Other issues identified in most reports included problems with documentation and record keeping and inter-agency collaboration which "… related not only to sharing information but also to understanding each other's roles and to respect the different perspectives" (Arthurs and Ruddick, 2001, p.18).

Finally, Dale *et al*. (2002a; 2002b) looked at seventeen SCR reports completed in the South of England during the period 1996 to 2001. They noted the presence of a number of concerning factors such as the existence of previous suspicious injuries (71%, n=12), domestic violence (23.5%, n=4), parental mental health problems (53%, n=9), and parental substance misuse (23.5%, n=4). In relation to professional practice, the authors identified the failure to follow basic, well-established procedures as a significant factor in eleven of the seventeen cases and the absence of appropriate assessments in nine cases.

Recent Findings from Biennial Analyses and Ofsted Reports (2002-Present)

The on-going accumulation of data from SCRs since 2002 has considerably aided the identification of recurring patterns over time, confirming many of the findings and difficulties documented in earlier reports. In their summary of the findings from three biennial reviews conducted between 1st April 2003 and 31st March 2009, Brandon *et al*. (2010) highlight consistency over time in the demographic characteristics of the children and families who are subject to SCRs (See Table 7 for selective overview of statistics taken from the report).

Characteristics of children and families Involved
The bulk of SCRs continue to be conducted in relation to younger children aged 5yrs and under, with those aged under one comprising the largest group. Deaths or serious injury of older young people also regularly make up a quarter of all serious case reviews; a slightly higher proportion involve boys rather than girls, with approximately three quarters being white children and less than one in ten children having a disability.

Close to three in ten were either the subject of a child protection plan at the time of the incident or had previously been subject of one with the primary abuse category being neglect, followed by physical abuse, emotional abuse and then sexual abuse. Approximately 3 in 5 incidents resulted in the death of the child although more recent analysis suggests an increase in the numbers of serious injury cases being reviewed. Although not comparable to previous reports as slightly different categorisations of the causes of child injury and death were used, the 2007-2009 analysis shows that non-accidental death was the most common cause of death, followed by suicide, sexual abuse and neglect. In 1 in 10 cases the cause of death was not yet known.

The child risk factors associated with each case also show similar consistency with roughly one in five cases involving the abuse of more than one child, 7-8% children with a serious Illness, 5-7% children with a problem with drugs or alcohol and 5-7% children with mental health problems. However, the parental risk factors show more variability, particularly those relating to domestic violence, parental mental ill health and substance misuse. It is suggested that this may reflect a change in the recording procedure rather than an actual increase in occurrence, although Brandon *et al*. (2010) also note that these risk factors are still likely to be under-recorded. Variability is also apparent in relation to increases in physical abuse and long-standing neglect being identified as key contributory factors to the death or serious injury of the child subject to the SCR.

Although based on a significantly smaller number of cases, analysis of Part 8 case reviews and administrative reviews completed in Wales show similar patterns. A majority of the 12 cases reviewed between June 2001 and May 2006 (Morris *et al*., 2007) involved children and under ones, half involved parental ill health and five involved domestic violence. Likewise, Brandon *et al*.'s (2002) earlier analysis of 10 Welsh reviews completed between 1998-2001 involved 6 children under one who died. Parental mental health problems, alcohol abuse and/or domestic violence were present in the majority of cases while child characteristics such as learning difficulties, special educational needs, developmental delay and emotional/behavioural problems were present in a smaller number of cases.

Table 7: Selected Child and Family Characteristics from Biennial Reviews of SCRs 2003-2009

	2003-05 (n=161)	2005-07 (n=189)	2007-09 (n=268)
Child Age			
< 1 year	76 (47%)	86 (46%)	119 (45%)
1-5yrs	33 (21%)	44 (23%)	59 (22%)
6-10yrs	11 (7%)	18 (10%)	25 (9)
11-15yrs	26 (16%)	20 (11%)	35 (13%)
16-17yrs	15 (9%)	21 (11%)	30 (11%)
Child Gender			
Male	88 (55%)	106 (56%)	137 (51%)
Female	73 (45%)	83 (44%)	130 (49%)
Child Ethnicity			
White	101 (74%)	125 (72%)	195 (77%)
Mixed	8 (6%)	23 (13%)	23 (9%)
Black/Black British	17 (13%)	13 (8%)	24 (9%)
Asian/Asian British	8 (6%)	8 (5%)	11 (4%)
Other Ethnic Group	2 (1%)	4 (2%)	2 (1%)
Child has Disability	14 (8%)	8 (5%)	21 (8%)
Child Protection Plan (CPP)			
Index Child had CPP at time of the incident	-	29 (17%)	42 (16%)
Index child previously had CPP	-	19 (11%)	33 (13%)
Category of index child's CPP (current or past)			
Neglect		30 (65%)	44 (59%)
Physical abuse		11 (24%)	25 (33%)
Emotional abuse		7 (15%)	21 (28%)
Sexual abuse		7 (15%)	9 (12%)
Death/Serious Injury			
Death	106 (66%)	123 (65%)	152 (57%)
Serious injury	55 (34%)	66 (35%)	116 (43%)
Incident Cause			
Non-accidental death			72 (27%)
Non-accidental injury			67 (25%)
Suicide			21 (8%)
Sexual abuse			19 (7%)
Neglect			16 (6%)
Natural causes			10 (4%)
Sudden infant death syndrome			7 (3%)
Drug / solvent misuse			5 (2%)
Self-harm			3 (1%)
Accidental injury			2 (1%)
Other			18 (7%)
Not yet known			28 (10%)

	2003-05 (n=161)	2005-07 (n=189)	2007-09 (n=268)
Parent characteristics			
Domestic Violence		49 (26%)	91 (34%)
Mental health problems- parent		32 (17%)	73 (27%)
Drug misuse – parent		28 (15%)	60 (22%)
Alcohol misuse – parent		19 (10%)	58 (22%)
Child of teenage pregnancy		18 (10%)	19 (7%)
Parent has history of being in care		9 (5%)	19 (7%)
Child characteristics:			
More than one child abused		39 (21%)	50 (19%)
Serious Illness		15 (8%)	18 (7%)
Drug or alcohol misuse - child		10 (5%)	18 (7%)
Mental health problems – child		8 (4%)	17 (6%)
Factors related to case:			
Physical abuse		58 (31%)	147 (55%)
Long-standing neglect		33 (17%)	67 (25%)
Recent neglect		31 (16%)	48 (18%)
Sexual Abuse		29 (15%)	38 (14%)
Shaken Baby Syndrome		19 (10%)	22 (8%)
Emotional abuse		15 (8%)	30 (11%)
Brandon *et al*., 2010			

Agency involvement and thresholds

The level of agency involvement is a particular focus of the 2003-2005 biennial review (Brandon *et al*., 2008) and showed that roughly half of the cases were only known to universal services at the time of the incident. Overall, families had more contact with low level and universal services than children's social care or other regulated services. The intensive review of a subset of 47 SCRs illustrated how a large array of professionals had been involved with families two years prior to the incident. The largest proportion involved health professionals such as health visitors, GPs, hospitals and A&E departments, although a range of other health, education, criminal justice and early years professionals had also provided services. The families of very young children who were physically assaulted tended to have the least, or the briefest, contact with children's social care, thus placing greater onus on universal agencies to recognise signs of harm to such children. Brandon *et al*. (2009) highlight the need for all practitioners to have a holistic understanding of children and families and to be aware of the way in which separate factors might interact to cause increased stresses in the family and increased risks of harm to the child.

In just over half of the 2003-2005 reviews there was a high level of involvement and monitoring from children's social care or from staff in other supervised settings (Brandon *et al*. 2008). Although these families tended to have been known over long periods of time only a minority of children were listed on the child protection register. Agency neglect of older adolescent children who were very difficult to help emerged as a key theme from the intensive review analysis. This points to a failure to find effective ways of responding in a sustained way to the young people's extreme distress. A number of SCRs also reflected a preoccupation with boundaries and which professional group was 'responsible' for the child, delaying the provision of services. Neglect itself also posed a particular problem in terms of meeting thresholds for child protection. Previous reviews have observed how the on-going and chronic nature of many of the neglect cases sometime results in professionals becoming immune to deteriorating conditions, basing their decisions on a threshold which 'tolerated a poor level of care of the children'(Rose and Barnes, 2006). Such cases were especially prone to a divergence of professional opinion, tending to 'drift' within the system.

Younger and older age groups

The three most recent English biennial reviews identified recurring themes about the particular vulnerability of very young children and babies, particularly those who were premature, had spent time in intensive neo-natal care, were drug addicted at birth or perceived as difficult to care for because of illness, colic or persistent crying. The major cause of death in these infant cases was fatal physical assault, usually involving non accidental head injury, although some cases also involved neglect and overlaying. A recent Ofsted (2011a) analysis of 482 SCRs pointed to an underestimation of the risks resulting from the parents' own needs, underestimation of the fragility of the baby, shortcomings in the timeliness and quality of pre-birth assessments, marginalisation of fathers and insufficient support for parents.

The deaths or serious injury of older young people have also been shown to regularly make up a quarter of all SCRs with suicide being the most common cause of death. Whilst the vulnerability of teenagers is less well recognised in earlier overview reports it is a common feature identified in various English and Welsh analyses (Sinclair and Bullock, 2002; Morris *et al*., 2007; Brandon *et al*., 2002; Reder and Duncan). In older young people cases Ofsted (2011a) observed a lack of inter agency co-ordination and a tendency to treat young people as adults and to focus on their challenging behaviour, seeing them as hard to reach or rebellious, rather than trying to understand the causes of the behaviour and the need for sustained support. This issue has also been identified in a recent analysis of young people who died by suicide in Northern Ireland (Devaney *et al*., 2012).

Family characteristics

As with earlier analyses, a range of family characteristics, in particular the 'toxic trio' of mental health problems, domestic violence and parental substance misuse were common features of the SCRs reviewed since 2003 (Brandon *et al*., 2010). As noted in a review by the Office of the Child Safety Commissioner (2012) in Victoria, Australia, these factors interfere with a parent's ability to meet and respond to their child's needs, and may increase the risk that a child is at. These three factors often co-exist and in the 2003-2005 analysis all three were found to be present in a third of cases, a further third of cases had two factors present and one in five cases one factor. Such difficulties were often compounded by poverty and frequent house moves and/or eviction and tended to be more common in cases where children had died rather than non-fatal cases (Ofsted, 2011a). However, as Brandon *et al*., (2010) observe, while 'these cumulative problems and adversities are not uncommon and present significant risks factors for children…in individual cases, they do not act as predictors for serious injury or death' (p53).

Sinclair and Bullock (2002) comment on domestic violence as a factor particularly neglected at the time of their publication. A review of Welsh cases (Brandon *et al*., 2002) noted particular examples of professionals having an unrealistic view of parenting capacity in relation to mental health as well as little consideration of the nature of alcohol use and its associated influence on family violence, mental health and parental capacity. Rose and Barnes (2008) review of 40 SCRs conducted between 2001-2003 highlights the lack of significance attributed to domestic violence and the impact this may have been having on the child or children of the family, despite the presence of violence in the home being well known to a number of agencies. In a similar vein, a recent Ofsted (2011a) report showed variation in police practice in terms of the recording of incidents of domestic violence and in identifying children at risk.

Pattern of co-operation/non-co-operation and building relationships with families

Patterns of non co-operation by families were a recurring theme, particularly in the 2003-05 and 2005-07 biennial reviews (Brandon *et al*., 2008; 2009). Patterns of hostility and lack of compliance included: deliberate deception, disguised compliance and "telling workers what they want to hear", selective engagement, and sporadic, passive or desultory compliance (Brandon *et al*., 2008). Similarly Sinclair and Bullock (2002) highlight that problematic relationships between families and professionals are common, although not universal, with nearly half of the families in their sample being seen as unco-operative. They also note that, in some cases, good parental engagement sometimes masked risks of harm to the child, describing the behaviour of some parents as 'frankly deceitful and cunning' (Sinclair and Bullock, 2002, p.30).

In the face of overt parental hostility workers often became 'frozen' and their ability to make judgments, act clearly, and follow through with referrals, assessments or plans was compromised (Stanley and Goddard, 2002). Building strong relationships with children and families is an integral element of supporting families with complex needs and reducing maltreatment. However the inherent tension between partnership and protection and trust needs to be policed with care. Brandon *et al*. (2010) recommends adopting an attitude of 'respectful uncertainty' towards families while at the same time showing an interest and curiosity in their views and experiences. Regular professional supervision is highlighted as integral to enabling practitioners to meet the emotional and intellectual challenges of working with families with complex needs.

Overwhelmed practitioners

Overwhelmed practitioners formed a theme in the 2005-07 biennial review (Brandon *et al*., 2009), where the chaos, confusion and low expectations encountered in many families were frequently mirrored in the organisational response. Many families and professionals were overwhelmed by having too many problems to face and practitioners were overwhelmed, not just by the volume of work, but also by its nature. This enmeshed interaction between overwhelmed families and overwhelmed professionals often contributed to the child being lost or unseen. Being overwhelmed limited practitioners and managers abilities to think clearly and they were often unsure about what they could, or could not do, or what information they could share despite a wealth of available procedural guidance. Lack of co-operation and hostility from families contributed to low expectations from practitioners in terms of what could be achieved with the family, particularly in cases of chronic neglect. This was exacerbated by overwhelming caseloads, high staff turnover and vacancy rates alongside high numbers of unallocated cases.

Thinking the best of families and flexible thinking

Efforts to think the best of families and reluctance to make negative professional judgements about parents were another key theme of the 2005-07 biennial review (Brandon *et al*., 2009), echoing Dingwall *et al.*'s 'rule of optimism' (Dingwall *et al*., 1983), an expression consistently referenced in review reports published since 2002 (Rose and Barnes, 2002; Brandon *et al*., 2002). The 2001-2003 biennial review (Rose and Barnes, 2008) noted professional 'over optimism', particularly about parenting capacity in difficult situations, as a common feature of serious case reviews. Likewise Brandon *et al*.'s (2002) Welsh overview identified 'over optimism' in relation to the impact of mental health on parenting capacity, confusing neglect, poverty and disability, the risks posed by partners and the level of parental co-operation.

In their overview report, Brandon *et al*. (2010) observe how professionals dealing with long-term neglect can often fall victim to the 'start again syndrome', putting aside knowledge of the past and focusing on the present and on short term thinking, their own sector, or failure to take account of how children in the household could follow the same pattern as older siblings. Brandon *et al*. (2010) also draw attention to the negative impact of rigid thinking and professional reluctance to review opinions where they conflict with the original assessment. As such, a neglect mindset could preclude the thought that the child might also be physically or sexually harmed while in other cases 'rough handling' injuries were seen as less serious acts of inconsiderate and careless parenting rather than as an indicator of much more grave underlying concerns about physical injury.

Invisible children

The invisibility of the children who were the subject of the SCRs is a common feature across review reports from the early nineties to the present day (Brandon *et al*., 2002; 2008; 2009; 2010). To address this issue in more depth Ofsted (2011b) undertook an analysis of SCRs to explore how practitioners see, observe and hear 'the voices' of the child they work with and seek to protect. Five main messages were identified:

1. The child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings;

2. Agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute;

3. Parents and carers prevented professionals from seeing and listening to the child;

4. Practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child; and

5. Agencies did not interpret their findings well enough to protect the child.

Lack of inter-agency working, inadequate information sharing and poor recording practice
Joint working and interagency co-operation are essential to effective safeguarding yet lack of co-operation, communication and information sharing is a perennial problem and one continuously highlighted throughout the overview reports. For example, Sinclair and Bullock (2002) found that 43% of SCRs expressed concerns about interagency working and information sharing (63%). Similarly, full information sharing was observed in only 10% of cases in the 2003-2005 biennial analysis, although a further 64% did manage to achieve moderate levels of information exchange (Brandon *et al*., 2008). In some cases vital information, such as the child being placed on the child protection register, was not passed on by social services, while in other cases health and medical professionals did not appropriately pass on concerns about vulnerable adults or at risk children (Brandon *et al*., 2002). Specifically Brandon *et al*. (2008) note that, where family members were in receipt of specialist services like substance misuse services and domestic violence units, there was little evidence of shared expertise, a theme also identified in the recent Australian overview report (Office of the Child Safety Commissioner, 2012). These deficits were often accompanied by inconsistent recording. In earlier overview reports this reflected very basic concerns, such as records being illegible, unsigned or lost (Brandon *et al*., 2002). While the issue of recording is much less apparent in the subsequent biennial analyses an analysis of the recommendations made in 33 SCR reports highlights improvements to recording practices and systems as common recommendations.

Poor assessment and decision-making
Superficial assessments which lack a comprehensive social history and contain limited information relating to fathers/male partners or other significant adults in the child's life are another key practice deficit routinely highlighted across overview reports (e.g. Brandon *et al*., 2002; 2010; 2011a; Ofsted, 2011). Earlier overview reports pointed to numerous examples of professionals failing to take full family histories, not undertaking any assessment beyond the bare minimum (Brandon *et al*., 2002), or not undertaking assessment at all following a referral (Sinclair and Bullock, 2002). However, Brandon *et al.'s* (2008) intensive sample analysis investigating the quantity of information collected during the assessment process suggests that concerns over assessment have changed somewhat over time, relating more to the quantity and quality of information collected rather than the absence of assessment noted in earlier reports. They conclude that the absence of information about the parent's own developmental and relationship history is likely to limit the value, usefulness and insightfulness of any assessment and in 81% of cases the ability of professionals to produce an integrated case analysis, assessment and formulation was limited. Consequently, many SCRs note the assessment process as static, providing a snapshot in time rather than a dynamic overview of the family system. Lack of adequate information and assessment, in particular inadequate risk assessment, severely limits the ability of professionals to make appropriate decisions regarding the needs of children and their families.

Summary

This chapter has summarised the key learning from overviews of case reviews undertaken across the UK over the past thirty years. Whilst there is evidence of some issues regularly being identified as recurring, there is also a sense that other issues have appeared or evolved over time.

Chapter Five:
Methodology for the Analysis of Case Management Review Reports

Aims and objectives of the study

As previously noted this is the first attempt to capture the key themes and learning arising from CMRs undertaken in Northern Ireland since the current process was established in May 2003. In common with similar studies in England and Scotland (Brandon *et al*., 2009; Brandon *et al*., 2012; Vincent and Petch, 2012) and elsewhere, this review aims to:

- provide a profile of the characteristics of the children, their families and personal situations, and professional responses, to inform our understanding of risk and protective factors;
- identify common themes and trends across review reports, drawing out the implications for policy and practice;
- compare the Northern Ireland cases and themes with those in other countries;
- profile the review process itself; and
- ensure that the learning from the study is captured so that it can feed into a longer-term project to develop systems and processes for monitoring and developing the child protection system in Northern Ireland.

Methodology

The study team had access to the full copies of all CMR reports commissioned and completed between 2003 and 2008. For convenience the reports were accessed at the Department of Health, Social Services and Public Safety. In addition to the full report, access to additional material, such as individual agency reviews, and correspondence between the Area Child Protection Committee's and Department of Health, Social Services and Public Safety was also sometimes present to read, although not routinely. As such, this additional information was not usually considered except to support the gathering of the key information required to complete the review proforma (*Appendix 2*).

Each report was reviewed independently by two members of the research team, who then compared their assessments and resolved any discrepancies. To assist in the process of review a proforma was developed to ensure that the same information was gathered from each report (*Appendix 2*). The proforma was piloted with one report which was read by all four members of the research team as part of a standardisation exercise to ensure greater consistency in the collection and interpretation of the information contained within the reports.

The proforma allowed a consistent set of data to be collected which was compiled and analysed using the Statistical Package for the Social Sciences version 16. In addition each reviewer was able to note more qualitative information about case history, issues and themes. This qualitative information was discussed between each pair of readers to ensure consistency, and then discussed amongst the four members of the research team. This structured approach to the analysis and synthesis of the themes from each report ensures that the potential for bias is minimised.

Limitations of the methodology

As noted by Hayes and Devaney (2004) using written records has certain limitations. In this review the original case records compiled by professionals involved with the child and family were not examined. The researchers also did not usually have access to the individual agency reviews that were completed as part of the review process (although more recent practice has been to share these with DHSSPS). Therefore this review has relied upon the interpretation of these other written records by the individual case management review panels undertaking each review. Nonetheless, the approach taken replicates the information typically available to members of the Regional Child Protection Committee and officials within the HSC Board and the Department of Health, Social Services and Public Safety.

Not all reviews were conducted in the same way – one report was undertaken by a single individual, whilst two of the cases also involved other review processes being completed in conjunction with the CMR process.

In common with Vincent and Petch (2012) we found that:

- There was often very little detail about parents' social history, and any implications for the issues under review;
- There was limited information about men in families;
- Information about the child and their daily experiences was sometimes limited as review teams focused solely on processes rather than considering the child's circumstances. In some cases we were unable to establish the child's or parent's ethnicity and issues relating to the disability of any family member were rarely discussed even if recorded;
- There was limited information about the family's environment, for example, whether they were working, the status of their housing and what their financial circumstances were;
- In some cases there was limited information about organisational culture, for example, a lack of analysis of the emotional impact for staff of working with non-cooperative, sometimes hostile families, in a context of staff shortages.

It is also important to stress that the number of reports analysed is small and the group of children and their individual circumstances is heterogeneous. Therefore caution should be taken in using these cases as a barometer of the wider child welfare system. Rather the analysis provides an opportunity to reflect on a very specific type of case. The learning from this review must be placed alongside the other information about the operation of the wider child protection system in Northern Ireland, such as routinely collected statistics, audits of practice and research findings, to provide a more rounded and therefore robust understanding of how children are identified as being at risk of experiencing harm, and are subsequently responded to.

Chapter Six: Case Profiles

Introduction

This chapter provides details of the characteristics of the children and their families subject to a CMR or other inquiry incorporating a case management review[2], and an analysis of the situations leading to the review being convened.

Where appropriate to do so we have included comparative data from the overview reports of serious case reviews in England for the periods 2003-2005 (n=161) (Brandon *et al*., 2008) and 2005-2007 (n=189) (Brandon *et al*., 2009).

In the presentation of the data we refer to the 24 cases, even though there may have been more than one child subject to a review in the same family or situation. For the purposes of analysis an *index child* was identified within each family i.e. this was either the child who had suffered most (e.g. the child had died); or where this was not easily discerned; was the youngest child in the family at the time of the precipitating (*index*) *event* (i.e. the event resulting in the convening of a review).

Grounds for review

Between January 2003 and December 2008 there were 24 CMRs undertaken on 45 children. The four legacy Area Child Protection Committees each convened a number of reviews (Table 8), with two reviews being shared between two of the Committees due to the family having received services in both areas.

Table 8: Area Child Protection Committee which commissioned the review (n=24)

	N	%
Eastern ACPC	10	38
Northern ACPC	4	15
Southern ACPC	6	23
Western ACPC	6	23
NB: Two CMRs were undertaken jointly by two ACPCs		

The guidance *Co-operating to Safeguard Children* (DHSSPS, 2003) sets out the grounds for the Regional Child Protection Committee (formerly the Area Child Protection Committees) convening a review, which are that:

- a CMR should always be undertaken when a child dies, including death by suicide, and abuse or neglect is known or suspected to be a factor in the child's death.

In addition, the Regional Child Protection Committee should always consider whether to undertake a CMR where:

- a child has sustained a potentially life-threatening injury through abuse (including sexual abuse) or neglect;
- a child has sustained serious and permanent impairment of health or development through abuse or neglect; and

2 For completeness two Departmental inquiries that deal with the homicide of children during this time period are also included in this analysis.

- the case gives rise to concerns about the way in which local professionals and services worked together to safeguard children.

Table 9 presents the data on the twenty four reviews, detailing the grounds for undertaking each review. Children under 1yr were most likely to be reviewed due to their death than at any other age, whereas young people aged 11yrs and over were more likely to have a review undertaken due to their death by suicide/self-harm. In total 18 of the reviews were convened on children who had died.

Table 9: Grounds for convening case management review by age of index child (n = 24)

Grounds for Convening CMR	Under 1yr	Between 1yr-5yr	Between 6yr-10yr	Between 11yr-15yr	16yrs and over	Total	
						Number	Per cent
Death of child (death not by suicide)	7	1	1	1	0	10	42
Death of child (death by suicide)	0	0	0	5	3	8	33
Inter-agency working	0	3	0	1	0	4	17
Other reason	0	0	0	1	1	2	8

When the nature of the incident leading to the CMR was explored a more varied set of circumstances became apparent (Table 10), with the two largest causes being 'sudden unexplained death in infancy' (sometimes referred to as cot death), and 'death by suicide/self-harm'. Throughout this report we will refer to this event as the index (precipitating) event; the situation or incident triggering the need for a CMR. However, as we will discuss in more depth later, the index event may be the endpoint of a lengthy period of adversity experienced by a child.

Table 10: Nature of incident leading to case management review (n=24)

Incident Type	Female	Male	Total	
			Number	Per cent
Physical assault	1	2	3	13
Sudden unexplained death in infancy	2	4	6	25
Neglect (including accidents)	1	0	1	4
Poisoning/overdose	2	0	2	8
Sexual abuse	3	0	3	13
Suicide/self-harm	3	4	7	29
Other	1	1	2	8

The two cases in the 'other' category relate to one case where allegations of poor care were made against former carers, and another case where concerns had been raised about the way that services had worked together.

Characteristics of the Children

Gender, age and ethnicity of children

In this group of CMRs the majority of reports related to girls as the index child (n=13; 54%), compared to boys (n=11; 46%). This is in contrast to England where boys (56%) have been the subject of more reviews than girls (44%) consistently since 2003 (Brandon *et al*., 2012). It may be that the small numbers of CMRs may be a reason for this anomaly. In terms of ethnicity all of the children were white, and had been born in Northern Ireland.

Table 11: Age of index child at time of index event in Northern Ireland case management reviews and comparison with Brandon *et al*. (2008)

Age at time of index event	Number	Per cent	Percentage in Brandon *et al*. 2008
Under 1yr	7	29	36
Between 1yr-5yr	4	17	29
Between 6yr-10yr	1	4	12
Between 11yr-15yr	8	33	15
16yrs and above	4	17	8
n=24			

The children subject to review varied across the full spectrum of childhood, with the youngest child dying at birth, and the oldest child making complaints about the standard of care received in foster care (Table 11). The research literature states that boys are at slightly greater risk of dying as a consequence of abuse and neglect compared to girls. In our group of cases children died in eighteen instances, split evenly between male and female children. When examined by age at death of the index child, boys were slightly more likely to die at a younger age with girls being more likely to die in adolescence (Table 12).

Table 12: Age at death of index children

Age at time of death	Female	Male	Total	
			Number	Per cent
Under 1yr	3	4	7	39
Between 1yr-5yr	0	1	1	6
Between 6yr-10yr	1	0	1	6
Between 11yr-15yr	3	3	6	33
16yrs and above	2	1	3	17
n=18				

Family Composition

Siblings

Five of the children were the only child in the family, whereas for the remainder the number of siblings ranged from one to nine (Table 13).

Table 13: Number of siblings in NI CMRS and comparison with Brandon *et al*. (2008 and 2009)

Number of siblings	Number	Per cent (%)	Brandon *et al*. 2008 (%)	Brandon *et al*. 2009 (%)
None	5	21	27	24
1	3	12	33	31
2	1	4	18	24
3	3	12.5	9	11
4	4	16.7	5	6
5	1	4.2	5	2
6 or more	6	25	4	2
Missing	1	4.2	N/A	N/A
n=24				

The cases resulting in a case management review in Northern Ireland generally involved large families (defined as three children or more). In making the comparison with England it should be noted that in Northern Ireland 21 per cent of families with dependent children had three or more children, compared with 16 per cent for the UK as a whole (National Statistics, 2007). The average number of dependent children in families in the UK is 1.8, whereas in Northern Ireland the figure is 2.2 (NISRA, 2011).

Alongside the number of children in the family, the ordinal position of the index child was examined (Table 14). Where the birth order was discernible, in 63 per cent of cases the index child was either the only child, or youngest (including the one instance of a multiple birth). Taken with the age profile of the children at the index event, this reinforces the key message that age is a significant vulnerability factor.

Table 14: Ordinal position of index child in NI CMRS and comparison with Brandon *et al*. (2009)

Ordinal Position	Frequency	Per cent (%)	Brandon *et al*. 2009 (%)
Oldest child	2	8	13
Youngest child	9	38	44
Both older and younger siblings	6	25	16
Only child	5	21	25
Multiple birth	1	4	2
Missing	1	4	N/A
n=24			

The number of siblings living with the index child at the time of the index event presented a slightly different picture, with ten of the index children being the only child (Table 15). In some instances older adult siblings no longer lived with the family, and in other instances one parent had children to a different partner, with the children now living with that parent.

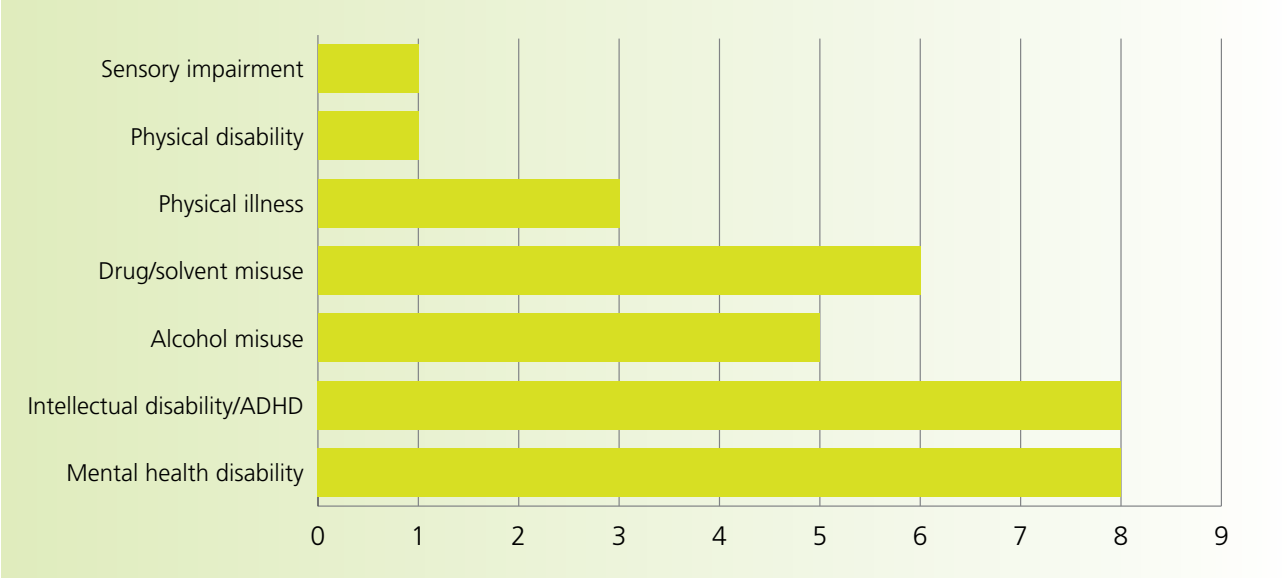
Table 15: Number of children living with index child at time of index event

Number of children living with index child	Frequency	Per cent (%)
0	10	42
1	3	12
2	3	12
3	4	17
4	1	4
5	1	4
Missing	2	8
n=24		

Illness or Disability of Index Child

Details were gathered from the reports about any illness or disability identified by professionals in relation to the index child (Figure 5). The most common disabilities were poor mental health and cognitive disabilities. In addition alcohol, solvent and drug misuse by the child were concerns in eleven of the reviews undertaken.

Figure 5: Illness or disability of index child (n=24)



As a consequence of these issues the children were often in receipt of services from a range of professionals and agencies, sometimes for many months and even years before the incident leading to the CMR.

Professional Involvement

As noted, many of the children had on-going contact with professionals as a result of their own issues or the wider family situation. Given the criteria for a case management review it is to be expected that there will have been agency involvement in the majority of instances. At the time of the index event children's social services were involved with children in 19 (79%) of the cases, with previous involvement in a further 2 cases (8%). This means that only 3 children (12%) had never been previously known to children's social services. Of the children in contact with children's social services at the time of the index event the majority were in receipt of services (Table 16).

Table 16: Stage of social services involvement with index child at time of index event

	Number	Per cent (%)
Referred but not allocated	1	4
Allocated but not assessed	3	12
In receipt of services	14	58
Pending closure	1	4
n=19		

Given that abuse or neglect was suspected as being a significant factor in the index event, the cases were examined to determine whether the index children were subject to a child protection plan at the time (Table 17). It can be seen that most of the children were not subject to child protection registration at the time of the index event, and the majority had never been assessed as needing a child protection plan, a similar profile found in serious case reviews in England during a comparable period.

However, it is of note that the four children who did have their names on the child protection register at the time of the index event were all aged 4yrs and under. When these cases were examined in more detail it was noted that two, aged 1yr and under 1yr, had both died, although the official cause was recorded as sudden unexplained death in infancy in each case.

Table 17: Index child and child protection register in Northern Ireland CMRs and comparison with Brandon *et al*. (2009) (n=24)

	Number	Per cent (%)	Brandon *et al*. 2009 (%)
On register at time of index event	4	17	17
On register previously	2	8	11
Never on register	18	75	73

This data supports the assertion by Sinclair and Bullock (2002) that children subject to a child protection plan, whilst having been identified as at high risk, are at lesser risk of being intentionally killed or seriously injured.

Nine of the index children were either looked after at the time of the index event (n=5), or had previously been looked after (n=4) with one of the young people being looked after through a series of short breaks (Table 18). The five young people were aged 14yrs and above. Four of the five children who were looked after at the time of the index event died as a result of the incident resulting in the CMR, with three of these deaths related to self-harm or suicide. Similarly, the four children who had been previously looked after were aged 13yrs and above, of whom two died through suicide or self-harm.

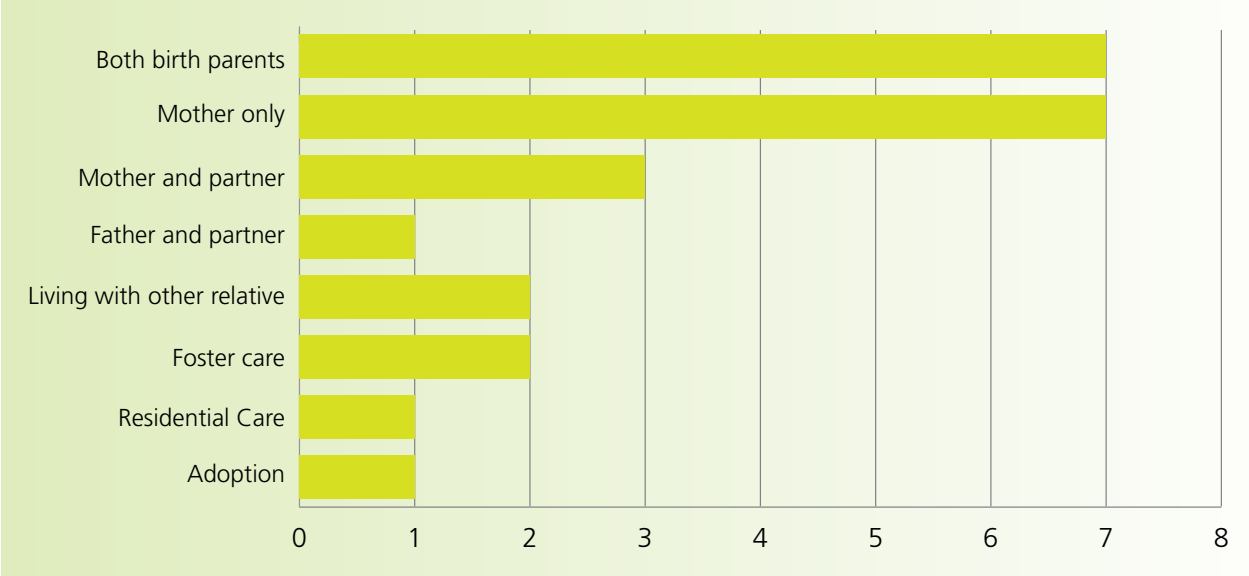
Table 18: Index child and looked after status in Northern Ireland NI CMRS (n=24)

	Number	Percent (%)
Looked after at time of index event	5	21
Previously looked after	4	17
Never looked after	15	62

Children's Residence

The majority of the children in the reports lived with their immediate birth family (75%) (Figure 6), with mothers typically caring for 71per cent of the children.

Figure 6: Child's living arrangements at time of index event (n=24)



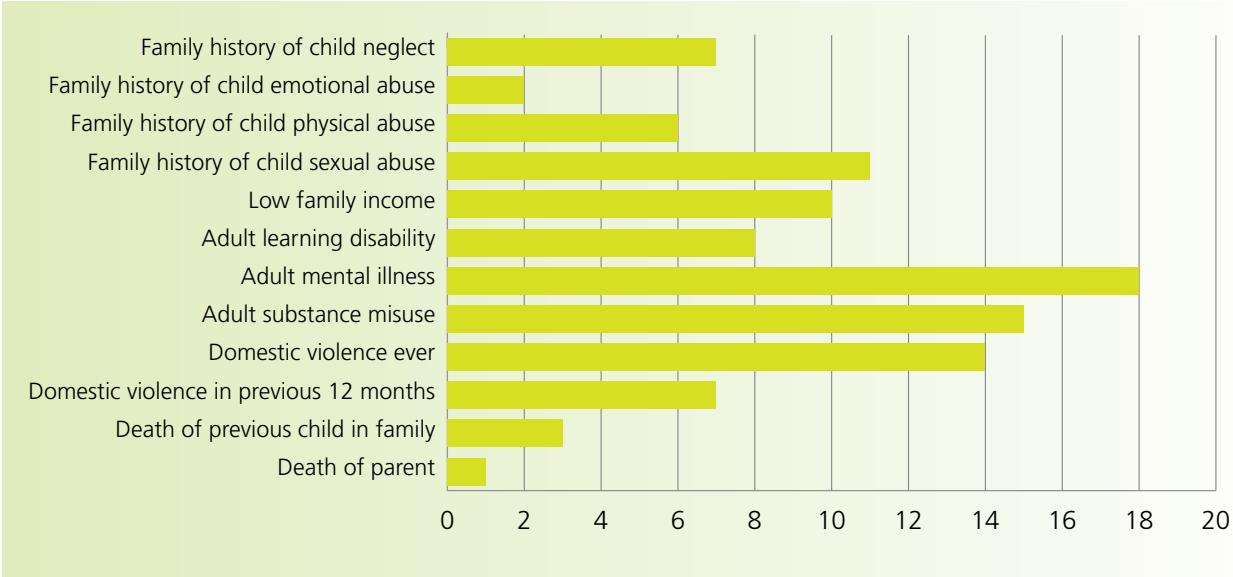
The type of housing tenure for the family was not noted in half of the CMR reports, in spite of the recognised importance of children's environment on their development. In the cases where housing type was noted, eight of the children lived in accommodation provided by the Northern Ireland Housing Executive, one child lived in privately rented accommodation and the families of three children lived in owner occupied accommodation.

The case management reports indicated that one third (8) of the families had a history of moving address frequently. Frequent moves of address are associated with poorer outcomes for children as a result of a lack of stability in children's lives, and the moves themselves are typically associated with parental issues such as disputes with neighbours and other members of the local community (including paramilitaries) and the avoidance of services. In the reports examined frequent moves had implications in some cases for the timely transfer of information between professionals such as health visitors, and in other cases in delays in the provision of services.

Indicators of Concern

The CMRs contained a considerable amount of information about the factors likely to have contributed to the incident leading to the convening of a review. Some of these issues were current at the time of the child's death or injury, whilst others were historical but important in setting a wider context. Data was collected from each CMR report on whether any of a number of specified risk factors identified from the research literature as being associated with poorer outcomes for children was present (Figure 7). Poor adult mental health, substance misuse and domestic violence were often present which is unsurprising, given the known associations with families experiencing difficulties in caring for their children (Office of the Commissioner for Child Safety, 2012; Cleaver *et al.*, 2011; Devaney, 2004). It must be borne in mind though that this is likely to be an underestimation of such issues. The reports examined may not have recorded some information, considering it irrelevant for the purposes of service involvement or the case management review, even information which the evidence base indicates is relevant, for example, low family income adding to the stress of parenting.

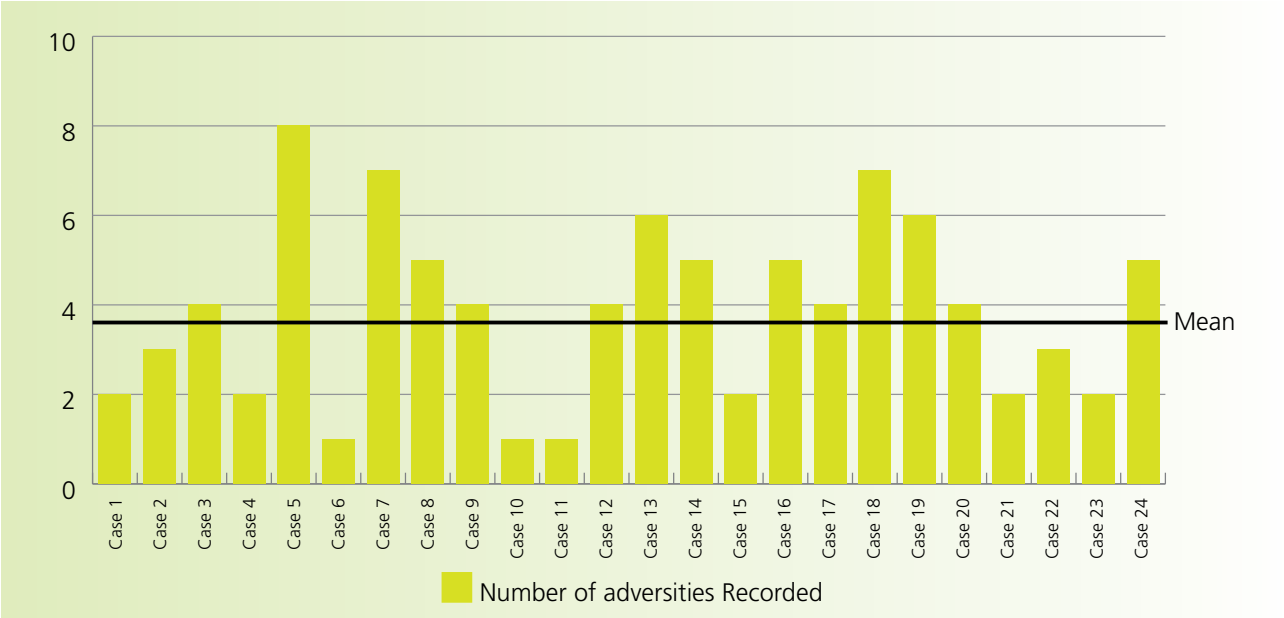
Figure 7: Indicators of concern identified for each family within each case management review report (n=24)



Note: Numbers exceed 24 as more than one issue was often present amongst individual cases

The data was examined to look at the numbers of concerns identified within each report. It is interesting to note that the mean number of concerns was 3.88, within a range of 1 – 8 (Figure 8). However, the number of concerns noted did not appear to be related to the age of the child, or the outcome of the index event.

Figure 8: Number of indicators of concern by case management review report (n=24)

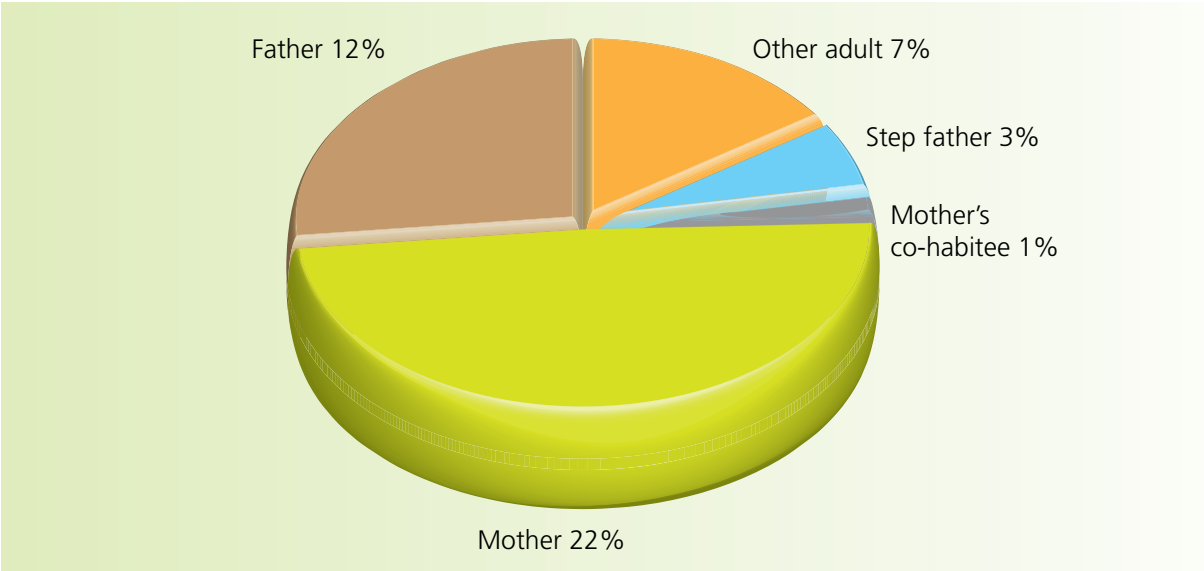


Adults with caring responsibilities towards index child

Relationship to child and age

Twenty-two of the index children were living with or had substantive contact with their mother at the time of the index event (Figure 9). Details on fathers and father figures was poor in a number of reports (a similar finding to Vincent and Petch, 2012), even allowing for the fact that some reports highlighted the lack of information on fathers and father figures in agency records.

Figure 9: Adults with caring responsibilities towards index child (n=24)



In some cases where birth parents had separated there was sometimes a high level of acrimony between parents about finances, child care arrangements such as contact and other matters, which complicated parent's abilities to retain a focus on their child's needs.

There is a widely held view that children born to teenage and young parents are more likely to have a range of poorer outcomes when compared to children of older mothers (Bunting and McAuley, 2004). The reasons, it is argued, are two-fold. Firstly, women who give birth whilst young are more likely to have pre-existing problems that both hinder their ability to parent as well as impacting directly on the children. For example, there are a higher proportion of young mothers from socially deprived and lone parent households (Lopez Turley, 2003). Secondly, as a result of giving birth at a young age, these mothers are less likely to have completed their education, to have married or to have secured a well-paid job, these factors in turn increasing the overall number of children she is likely to have. There is some evidence that teenage parents are more likely to become involved with the child welfare system in a delayed fashion, usually several years, children and occasionally partners after their teenage years finish. In our sample of CMRs the mean age of mothers was 33yrs (n=17; range 16yrs – 60yrs), 34yrs for fathers (n=9; range 16yrs – 60yrs) and 36yrs for step fathers/mother's co-habitee (n=4; range 23yrs- 44yrs).

This is a similar pattern to the recent audit of significant case reviews in Scotland, whereby the majority of parents for whom an age was recorded were aged over 30yrs (Vincent and Petch, 2012). However, in the Northern Ireland cases eight of the mothers and seven of the fathers had been parents in adolescence of either the index or another child, and this issue warrants further investigation.

Adult issues

As noted earlier the children subject to CMRs where often living with a range of adversities. The most common issues related to the health and disability of parents or other significant adults (Table 19).

Table 19: Frequency of adult health issues by relationship to index child (n=24)

	Mother	Father	Other Adult
Mental health problems	16	7	9
Learning disability	4	2	0
Physical disability	0	0	1
Physical illness	1	1	0
Sensory impairment	0	0	0

In Northern Ireland approximately 20% of the adult population have a disability. It is recognised that most parents with disabilities do not present a risk to their children, and provide their children with a loving and secure childhood. However, having a disability can in some instances have implications for parenting capacity in three distinct ways:

- parental illness can adversely affect the development and in some cases the safety of children;
- growing up with a parent suffering from a serious illness or disability can have a negative influence on the quality of that person's adjustment in adulthood, including their own transition to parenthood; and
- children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate the illness or effects of the disability of their parents.

This is particularly so when parents are dealing with a number of adversities of their own. A high proportion of the adults with caring responsibilities towards children had issues relating to alcohol and drug misuse (a finding also in Scotland and England), whilst a small but significant number had criminal convictions for offences ranging from unpaid bills to serious sexual assaults on children (Table 20). However, most of the case management reports provided very little background information on parents own childhoods, such as whether they had been known to child welfare services or been looked after in public care as children. This has been found to be a common weakness of review processes in both Scotland and England.

Table 20: Frequency of adult issues by relationship to index child (n=24)

	Mother	Father	Other Adult
Alcohol misuse	14	6	2
Drug misuse	6	2	2
Criminal record	4	5	2
Adult experience of being in care in childhood	1	0	1

Chapter Seven: The Key Themes

Alongside the collection of information on child demographics and family circumstances the detailed reading of the reports allowed themes to be identified across them. As each report was read by at least two members of the research team it was possible to discern some key themes arising both within each report and across all twenty four reports. What follows is a summary of these key themes (i.e. the issue was relevant within at least two of the reviews, and usually more). Where appropriate the findings from the Northern Ireland sample of cases are compared with previous overviews of reports completed in England to provide a broader frame of reference and discussion.

Early and sustained intervention

There is good research evidence to show the benefit to children and their families of early intervention in providing support before a crisis point is reached, and in ensuring that children's needs are met before being unduly compromised (Dolan *et al*., 2006).

Unsurprisingly many of the issues relating to early and sustained intervention identified in CMRs in Northern Ireland mirror those identified in previous overview reports. The 2003-2005 biennial review of SCRs in England demonstrated that roughly half of cases where known only to universal services at the time of the incident. Brandon *et al*. (2008) emphasise the onus this places on universal agencies to recognise signs of harm to children, echoing the view of Ofsted (2008) that the current practice of working within the Common Assessment Framework and its focus on 'children in need' makes it 'even more critical that all staff are aware of child protection issues and how to identify early indications of harm or abuse' (p25).

However, this was by no means always evident in the Northern Ireland cases reviewed for this report, with significant risk factors sometimes missed, or relevant information not shared appropriately. Similarly, few CMRs showed evidence of early recognition of significant risk factors. Indeed in some cases where a parent was known to adult services for issues relating to substance use or mental health issues, there was no consideration at all of the wider family environment or the role of the adult as a parent. The learning from CMRs reported upon in this respect has led to the development of joint training between professionals working in children's and adult services, and the establishment of protocols and joint posts to increase the opportunities for professionals to work more effectively together (Davidson *et al*., 2012). This is one example of a very positive and tangible outcome arising from the learning gained through a CMR.

In other reports, primary care professionals either did not recognise the risk factors, or where they had concerns, did not share these with children's social services or other family members who may have been able to safeguard the child. The need for child protection training for GPs and private counsellors has been identified as a key priority, along with professional bodies providing clearer guidance to their members on the limits of confidentiality where there are concerns about a child (Lazenbatt and Freeman, 2008). For example, recent guidance issued by the General Medical Council (2012) has sought to support doctors to be clearer about their professional and legal responsibilities. There is a need to ensure that professionals such as doctors undertake child protection training in order to better understand how to implement the guidance they have been provided with. Such training is usually of greater benefit to participants when undertaken on a multi-disciplinary basis (Watkins *et al*., 2009).

Where concerns were identified the response was sometimes piecemeal with a pattern of on/off engagement by social services and other agencies with families. Lack of appropriate information sharing on the part of children's social services and other agencies sometimes meant that concerns about abuse and potential risk where not identified, precluding early and sustained intervention. Lack of early intervention was particularly

apparent in cases involving adolescents, many of whom subsequently had long periods of involvement with social services as well as a range of other agencies. Although problems in the family had often been evident for some years agencies were sometimes particularly poor at addressing the impact of chronic neglect on children and intervening at an early stage to prevent problems from becoming entrenched (Devaney *et al*., 2012). Early opportunities to coordinate a multi-agency response and provide support, which may have helped to prevent the escalation of problems, were missed because of the lack of timely information sharing between agencies (Ofsted, 2010) or because of a lack of interagency working and planning (Ofsted, 2011a). For example, in one of the Northern Ireland cases the commencement of appropriate therapeutic work with one young person was seriously delayed, and in the interim the young person's emotional life became more complex and complicated by the death of a close relative, and the increasing negative influence of their peer group.

In another Northern Ireland case involving the suicide of an adolescent, the CMR report noted how early investigation of concerns in relation to neglect could have resulted in different outcomes, highlighting how a number of opportunities for multi-agency working and the provision of a support package of services were missed. In another case a large number of professionals were involved with both parents and their children over a 10 year period, including social services; residential care; family centres; health visiting; CAMHS; therapeutic services; A&E; GP; Clinical Psychology; Paediatrics; PSNI and a number of voluntary organisations. However, there was a lack of co-ordination which undermined effective planning and intervention. In this case concerns about sexually harmful and other problematic behaviours emerged early in childhood, yet, despite repeated incidents throughout childhood and early adolescence, there was no sustained effort to deal with these issues.

Equally, despite the length and array of professional involvement, there were frequent failures to respond in a sustained way to the extreme distress which manifested itself for some of the young people in their very risky behaviour. It was clear from various overview reports that behaviour exhibited by many of the perceived 'hard to help' adolescents was very challenging for the professionals involved. Several overview reports in both Northern Ireland and England identify a focus on the management and control of the young person's behaviour to the exclusion of consideration of the underlying causes as a particular practice shortcoming. In other cases from Northern Ireland it was apparent that professionals did recognise the need to support a young person to address the factors underlying their difficulties, but that the young person found it difficult to engage (Devaney *et al*, 2012). There was a tendency in some cases to refer young people to a different service, without adequately considering how they might be supported to engage rather than focusing solely on attendance. As noted in the recommendations from one CMR report this may require reconsideration of agency policies relating to non-attendance. For example, there were examples of young people being removed from waiting lists for services after failing to keep three appointments, rather than seeing non-attendance as a risk factor warranting greater efforts to engage the young person. 'Did not attend' does not equate to 'does not need'.

The importance of early, more sustained and better co-ordinated intervention, not just for younger children but older children and adolescents, is therefore stressed as being central in both reaching out to young people, but also embracing them within a service that makes them feel safe and increases the possibility of engagement.

Child neglect

Even before they are born, children have a need for parents who will provide for their physical, social and emotional needs, through the expression of love, a sense of security and the provision of care. Children, especially when they are younger, depend on parents and family to provide the stability and security required to form meaningful attachments, and to grow and develop in ways which are positive. However, we also know that not all parents provide this sense of stability and safety, either because they are unable or unwilling to.

Physical neglect and emotional neglect of children were substantial issues in most if not all of the CMRs. As noted by Burgess *et al*. (2012) neglect is extremely damaging in both the immediate and longer term, affecting a child's physical, cognitive and emotional development, with negative consequences for friendships, behaviour and opportunities. It was evident in the Northern Ireland reports that neglect was perceived as a somewhat nebulous concept, and this may in part be due to the complexity of assessing the impacts of this type of

harm from what is essentially a passive form of maltreatment characterised by omissions in care on the part of parents or carers. In many cases the level of complexity was evident, whether it was the child's everyday and extraordinary needs (including mental health issues), the family systems they lived within, the history of protective involvement from statutory services or the on-going multiple risk factors directly or indirectly associated with the phenomenon of neglect.

Many of these children experienced multiple types of neglect. In addition to other forms of maltreatment the CMRs produced evidence of the nature of significant neglect, such as parents or carers failing to supervise children or allowing them to be cared for by unreliable or unsafe adults; abandonment or desertion of children by their parents; significant neglect of children's educational or medical needs; and neglect of children's emotional or social needs. The reviews also highlighted some of the factors which contributed to parents' inability to assure their children's safety and wellbeing such as on-going parental mental illness, learning disability, living with domestic violence, substance misuse and deficits in parenting skills due to being inadequately parented themselves.

The failure of parents to recognise and understand their children's developmental and emotional needs and the impact of chronic neglect on their development was evident in many cases. Many of these children experienced significant developmental, behavioural, attachment, health and educational problems as a consequence of parental neglect. It was evident that some parents were vulnerable to emotionally neglecting or abusing their child if stresses in their lives built up, or if they were unable to manage these stresses. The CMRs highlighted specific types of social problems that were contributing to family stress (unemployment, poverty, isolation from relatives and friends, divorce, death, violence and family conflict, immature parents), health crises (illness of a family member, disability of a family member, drug and alcohol abuse within the family), and mental health problems (mental illness, depression, cognitive and learning disabilities). In several of the CMRs a number of the parents themselves had suffered trauma both as children and as adults, such as experiencing sexual abuse as children, living with domestic violence and involvement with the criminal justice system, all resulting in parental inaction, hopelessness, mental illness and on-going chaos. Some of these adult needs were recognised and appropriate counselling offered, but in other cases professionals did not appear to appreciate or understand the impact of these parental issues on the parenting role.

The CMRs illustrate that neglect is one of the most difficult forms of maltreatment for child protection agencies to address. It can occur along with other forms of abuse which, in itself, can lead to further challenges in detection. However, despite parents often being known to the health system there was little collaboration between services. Indeed, as evidenced in the CMRs, even when neglect was clearly observable, attention was sometimes focused on the risk of sexual or physical abuse rather than the actual experience of neglect. Although it is important to not underestimate the complexities inherent in identifying and treating all forms of maltreatment, abuse that equates to specific events, such as physical and sexual abuse, can be easier to assess in terms of harmful consequences compared to neglect and emotional abuse. The challenge, therefore, in working with children and families with complicated needs within a complex service system, is to better understand the child's situation so that clear actions can be taken. According to Taylor and Daniel (2005, p.12) neglected children are "*simultaneously in need and at risk*, with the risks flowing both directly from the unmet needs and indirectly from the dangers associated with lack of care and supervision." This presents a dilemma in that the "artificial divide" in child protection systems between children at *risk* and children *in need* leads to a focus on one at the expense of the other.

Thresholds for intervention

As noted in the *Family and Child Care Thresholds of Intervention* document (DHSSPS, undated, p. 3), the issues around thresholds of intervention are 'many and varied' reflecting the complexity that practitioners face on a daily basis when making decisions about the prioritisation of work and the appropriate response to the issues presented in work with children and families. Thresholds for intervention operate at different levels from referral to child protection registration, the application for court orders and children becoming looked after. A number of the reports examined in this review commented specifically on the referral stage and systems in place for the

prioritisation of referrals. Two reports, for example, highlighted a 'traffic light' system introduced in one Trust to prioritise the allocation of referrals. The review teams noted, however, that there was no clear guidance available to staff at the time of the review on how to apply this coding system thereby leading to inconsistent, and sometimes flawed, decision-making about the nature of the referral and the appropriate response.

A CMR in another Trust indicated that the categorisation of a referral as 'child care concern' had been inappropriate given the concerns expressed in the referral and led to professionals perceiving the case to be one of low level concerns that did not require the same level of communication and multi-disciplinary working as cases of a child protection nature. The social work response, in fact, was to focus on assessment of risk to the child rather than on his needs and, when it was determined that he was not at risk, to a premature closure of the case despite the child having clear needs for support. This reflects the findings of research in Northern Ireland on the social work response to child care concern referrals (Hayes and Spratt, 2009; 2012). This perception of the case led to further 'thresholding shortcomings' such as the subsequent decision to hold a case planning meeting rather than a child protection case conference despite the threshold for convening a case conference having clearly been met. Munro (2011) and others have highlighted how the initial categorisation of a referral can result in some practitioners becoming fixed in how they perceive a case, even when other information should be directing them to think about the child's situation differently.

Another report highlighted difficulties in identifying and dealing with neglect issues with the review team expressing the opinion that Social Services gave too much weight to police thresholds and pointing out the need to ensure that the threshold for prosecution does not also become a threshold for wider intervention to protect children. The forthcoming update to *The Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse* and the *ACPC Policy and Procedures* could usefully assist in this process. Legal advice was also noted to be problematic in this case in relation to whether or not the threshold for removal of the children or the initiation of legal proceedings had been met. The review team noted that it was not clear whether there was a problem with the legal advice given or with the information given to the legal adviser on the basis of which the advice was given. They noted, however, that the advice that the threshold for such action had not been met did not seem consistent with the levels of concern apparent in the case.

Communication and information sharing between professionals

Communication between professionals, and between professionals and families, is at the heart of effective child protection work. Helping parents to discuss the difficulties they are experiencing, and listening to children's accounts of family life, provide professionals with a greater opportunity to intervene in ways which are likely to be helpful. Professionals from different disciplines and different organisations need to ensure that they share the information they have on the child's situation, and to ensure that its relevance has been understood. Communication has many facets, and includes; the nature of the information sought and shared; how it is shared; whether the information, when shared, has been understood as intended; and whether individuals act upon the information they have.

As noted earlier in this report, virtually all overviews of fatal child abuse in the UK have reported evidence of failures in the communication between professionals (Reder and Duncan, 2004). This was also apparent in this overview of CMRs in Northern Ireland.

Occasionally the issue related to an absence of communication between professionals, such as in the case of a young person who died by suicide. As noted in the case management review report:

> "One consequence, which regularly shone through the review, was an unjustified optimism held by different disciplines about the work that others may be doing with the child and family.....critically, for two (services) visiting the same family, there was no evidence of collaborative working."

It is worth noting that whilst in previous decades staff had fewer means of communication (typically face-to-face meetings, telephone calls and letters), the recent increase in methods of communication (e.g. text, email, mobile

phones, instant messaging) has the potential to increase the volume of communication, whilst diluting the amount of time to think about and respond to the information communicated.

In this overview we have highlighted two different types of problems related to the way that information is both communicated and shared. In some instances there were very practical issues related to the sharing of information. For example, in one case records went missing whilst being transferred from one facility to another with a family member, and in another instance when a staff member went on a prolonged period of absence through illness, their records were not up to date, hindering other staff from having a fuller understanding of the situation of the families they were involved with. In other cases there were delays in issuing minutes from meetings, whilst other cases highlighted busy professionals missing each other's calls. In themselves most of these practical difficulties were of a minor nature and did not affect the final outcome significantly.

In the majority of cases reviewed where communication was an issue, this typically related to interpersonal issues and the meaning attached to the communication. As noted by Reder and Duncan (2003, p.84):

> "....communication is an interpersonal process, so that its psychological and interactional dimensions must be addressed before practical measures can work effectively".

They highlight the importance of understanding the meaning attached to communication between the sender and the receiver, and the factors which influence how information is understood and interpreted. In one review report dealing with the death by suicide of a young person, the author identified that professionals had been alerted by older siblings and other relatives to various incidents of physical abuse of the child and their siblings over a four year period. Professionals had dealt with each incident in isolation, not appreciating the cumulative importance of the multiple incidents. It appeared to the review panel that some professionals had a poor understanding of the concept of confidentiality and its limitations relating to children's welfare, and therefore important information known to one professional was not shared with others. In this case there was an inconsistent application of *The Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse* and the ACPC Policy and Procedures (2004) and an absence of multi-disciplinary meetings to both share information and make sense of information. The report helpfully identified that during this period there had been a 23% increase in referrals to social services in the area resulting in staffing pressures. A clear finding from this overview report is that the context within which professionals are expected to communicate has significant implications for the quality of that communication.

Across a number of reports a common issue emerged relating to the lack of opportunities for professionals to meet together to share and analyse the information held by different agencies and staff. This also had the potential to distort working relationships as individuals with more significant concerns about a child felt frustrated that their assessment was not fully understood or appreciated by the other professionals involved with a child or family. For example, in one case of an older teenager who died by suicide, referrals to social services by relatives and the young person's school were misclassified as low risk and therefore not responded to. This later resulted in the relatives asking mental health professionals not to pass on further concerns to social services as their confidence in the system had been undermined.

As Reder and Duncan (2003, p.95) note "the customary recommendation to redress communication problems within child protection networks is to adjust existing policies or to improve the mechanical aids to communication." Whilst this is sometimes necessary, this overview has highlighted the importance of recognising and understanding how wider factors relating to the environment within which practitioners work are recognised and attended to in order to facilitate more effective communication.

Recording and record keeping

Accurate recording and good record keeping are essential elements of professional practice and, as outlined in Chapter 8 of *Cooperating to Safeguard Children* (Department of Health, Social Services and Public Safety, 2003) and Chapter 11 of the *Regional Policy and Procedures* (Area Child Protection Committees, 2005), they

serve a number of beneficial functions. They provide a focus for the work of professionals, inform assessment and planning, enable work to be reviewed and reflected upon so that patterns and issues can be identified, and ensure consistency when workers are unavailable or change. They also ensure that professionals are accountable by providing a documented account of involvement which can be used by managers to monitor work or as evidence in investigations and inquiries. Despite these benefits, concerns about inadequate recording and record keeping practices have been highlighted in a number of inquiries or reviews into serious child abuse cases (Department of Health, 1999; Ofsted, 2010) and were also apparent in this overview.

General difficulties with recording and record keeping, such as records being incomplete, information being recorded in various places and not collated, records being poorly structured and, in some cases, information not being recorded at all, are noted in a number of the CMRs examined. In one report dealing with the death of a young person by suicide, for example, the review panel noted that, at interview, professionals had supplied information which was not reflected in agency reports or chronologies. They speculated that this may be because the agency held files on individual family members and that information contained within them, relevant to the young person in question, had not been considered as part of the agency's review of their involvement. In another case involving the death of a baby, inadequacies were noted in both the social worker's and the health visitor's recording. In relation to the social worker's records there were gaps in the information and, at times, the records were either not fully completed (for example, there was no record of the action taken following the family's second referral to social services) or properly signed. The review panel noted that they could not verify information given to them by the social worker at interview about a telephone conversation with the health visitor following the family's first referral to social services because '...the only recorded evidence was that the health visitor had no child protection concerns.' Research into social work practice in Northern Ireland has found that such brevity in recording of contacts with other professionals and agencies is common (Spratt, 2001; Hayes and Spratt, 2009). The health visitor's records did not follow the regionally agreed structure with the review panel stating that 'notes on various family members were made randomly on sheets.' They also contained gaps in information, especially in relation to care planning and progress reports, with the review panel noting that record keeping was '...inadequate in terms of actions taken, referrals either recorded or forwarded to other agencies.'

In other reports these types of difficulties with recording and record keeping were noted to have had a significant impact on professionals' ability to analyse information and make accurate assessments. One report, for example, notes that recording in the social work file was poor and that '...there was no analysis made of the interventions and levels of risk emerging. Records were not maintained in an orderly manner and they were not comprehensive.' Another report, involving a young person who had sexually abused one of their siblings, notes that records were often difficult to decipher and that information was missing from them. The panel found no record that two allegations made against this young person had been investigated; one of these involved inappropriate sexual activity and one involved a physical assault on a sibling. In relation to two other incidents of alleged sexual assault on other children the panel found that, whilst these had been investigated, there was no record that they were taken into account when decisions were being made about future placements for this young person or the risk they might present to children as they were not referred to in reports or minutes of subsequent multi-disciplinary meetings. The panel concluded that had this information '...been put together and analysed...it would have become clear that X posed a high risk to children and required assessment and intervention.'

One very practical and positive development arising from the learning gained through CMRs has been the introduction in 2008 by DHSSPS of the Administrative Systems Recording Policy, Standards, and Criteria; Regional Policy for Northern Ireland Health and Social Care Trusts'. This has resulted in standardised forms for the recording of contacts with children, families and other professionals across both nursing and social work services, and has the potential to support professionals to be clearer about what they record and how. There is a need to balance accurate and comprehensive recording, with the conciseness and usefulness of what is recorded.

Compliance with established policies and practice

It has been argued that one of the key reasons for the significant reduction in the number of child deaths from abuse and neglect in the UK over the past forty years has been the development of clear and robust procedures to guide professionals in their response to concerns about a child's welfare. Whilst Munro (2011) has raised concerns that the volume of procedures and guidance has become a barrier to effective practice, the growth in guidance has resulted, in part, from the learning gleaned from instances where professionals felt the need for greater direction, sometimes following a review into a child's death.

Throughout the CMR reports reviewed in Northern Ireland there was clear evidence of policies and procedures being followed in the majority of instances. However, there were also frequent incidents of established policies and procedures not being followed. Several cases were illustrative of poor communication between mental health services and children's services, and the failure of primary and secondary care professionals to implement and follow ACPC procedures. In other cases allegations made by children themselves were not investigated appropriately by social services or concerns about suspected abuse were not acted upon. In the case of one child these practice failings co-existed with the result that, despite multiple indicators of neglect early in the child's life, no action was taken and the cumulative effects were not appreciated. Later, when the child was old enough to communicate their situation, no child protection investigation followed the allegations.

Delays in activating child protection procedures or instigating joint protocol arrangements between the police and social services were also noted in a number of cases. In another case a referral concerning domestic violence which should have been acted upon immediately did not result in the instigation of child protection processes until a month later. In a separate case there were delays in joint working with police after the child's death to ensure that other children in the family were protected. Concerns were also raised with regard to adherence to joint protocol procedures with some cases inappropriately taken forward as a single agency investigation by the police when social services should have been involved, and vice versa.

Previous overview reports demonstrate how neglect can pose a particular difficulty for practitioners in terms of deciding upon the appropriate threshold for intervention. This was also apparent in the Northern Ireland CMRs and it was clear that, in complex cases with long-term professional involvement, lack of comprehensive oversight and clarity as to the direction of work contributed to less than effective decision making. However, in other cases clear signs of sexual abuse were present but did not activate child protection procedures as they should have. For example, in one case policies and procedures in relation to sexually harmful behaviour were not followed: two alleged indecent assaults failed to result in child protection case conferences as per procedures, and the issue was not adequately discussed at a child in care review. The police dismissed earlier allegations as minor and not indicative of persistent abuse, despite evidence to the contrary.

The reasons why established policies and procedures were not followed is complex and varied. Deficits in professional knowledge about the indicators of risk and abuse, organisational pressures linked to resources and staffing, lack of clarity about the circumstances under which confidentiality should be broken to protect children, difficulty in determining thresholds for intervention, lack of information sharing and in-depth assessment all played a role to varying degrees. Again these issues are common to reviews conducted across the UK over the past ten years with the result that recommendations often tend to focus on procedures and compliance with procedures (Brandon *et al*., 2011). Some authors have expressed concerns that procedurally driven recommendations minimise the role of professional judgment and do not adequately recognise the complexity of the issues being dealt with by frontline professionals or take account of organisational issues such as resources, case management and staff supervision (Brandon *et al*., 2011; Munro, 2011).

In their earlier biennial analysis, Rose and Barnes (2008) drew particular attention to a disparity between the SCR findings and recommendations which appear to reflect this procedural bias:

> 'The focus of the recommendations was surprising. The conclusions had dwelt on lessons to be learned about work with children and families and with other agencies to improve safeguarding practice. These

> conclusions were generally related to information about the case and to its analysis. The solution to enable these lessons to be learned, however, was not on improving practice by increasing knowledge and skills but on creating more procedures. The focus of the recommendations was predominantly on reviewing existing procedures or calling for new procedures.....' (p45)

Brandon *et al*. (2011) also noted the paucity of review recommendations that considered strengthening supervision and better staff support as ways of promoting professional judgment or supporting reflective practice. Likewise many of the CMRs tended towards policy focused recommendations, although recommendations around specific elements of professional training were also common to almost all reports.

Assessment and analysis of information

Effective child protection practice is built upon the gathering and sharing of information, but only in so far as that information is analysed and leads to the appropriate action being taken.

Superficial assessments lacking a comprehensive social history and containing limited information relating to significant adults in the child's life were a key practice deficit routinely highlighted across a series of overview reports completed in England and Scotland (e.g. Brandon *et al*., 2002; Brandon *et al*., 2010; Brandon *et al*., 2011; Ofsted, 2011a; Vincent and Petch, 2012). Many SCRs noted the assessment process as a static one, providing a snapshot in time rather than a dynamic overview of the family system over time. Often none of the main agencies involved had a complete picture of the child's family and a full record of concerns, severely limiting the ability of professionals to make appropriate decisions regarding the needs of children (Sinclair and Bullock, 2002). Holistic assessments of risk were not routine and agencies tended to respond reactively to each situation rather than seeing the whole context.

Likewise the CMRs reviewed as part of this study frequently pointed to a lack of in-depth assessment and analysis of the information gathered by professionals. In some cases there was no evidence of a systematic, comprehensive assessment of need being conducted at any stage in the agencies' involvement with the family, whereas in other cases a lack of multi-agency assessment meant that no one agency had the full picture of the family's needs. In one report it was noted that:

> '…there was little evidence on the social work file of an in-depth assessment of the concerns reported and even though the health visiting professionals were clearly engaged with the family, the assessment on file amounted to little more than a list of family members.'

There was also no evidence of any effort being made to engage with other key members of the family such as the child's father and background information on the mother's own family and social history were absent. Indeed, the limited availability of information relating to the child's parents and significant others apparent in a large number of case management review reports appeared indicative of inadequate assessment processes.

As a consequence, decision-making was often based on triggering events rather than cumulative knowledge. Incidents which should have generated child protection processes in relation to potential sexual and physical abuse and neglect were not always acted upon. In one case involving the suicide of a teenager, an assessment of need only took place after the case had been closed by social services, suggesting this was merely a paper exercise rather than a concerted effort to address identified concerns. Assessment was not only an issue for social services but a problem apparent across a range of disciplines and at various levels of intervention. For example, in the case of one child, despite a long parental history of mental health and alcohol related problems, psychiatric detention and involvement with mental health professionals, no comprehensive assessment of the needs of the mother or her family were ever conducted. In another case the report noted the:

> ''…consistent failure of children's social services and health visiting services to complete comprehensive assessments of the child and to share assessments in ways that can inform professional assessments.'

In particular, analysis of risk was a key feature commented upon in many CMRs. In some cases it was the considered opinion of the case management review panel that harm to the child might have been prevented if appropriate risk assessment had been conducted and episodes of concern followed up appropriately. Failure to recognise the progression and escalation of risky behaviour, whether in relation to the parents or older young people, was often a concern in cases with long-term professional involvement. Lack of recognition of the risks posed by domestic violence and sexually harmful behaviour were noted in two particular cases. Equally, the non-engagement of parents or teenagers with support services was rarely perceived as a risk to the well-being of the child or an indicator of lack of parental motivation to change behaviour; indeed, in some cases this was used as a reason for case closure with little evidence that the presenting concerns had been addressed in any meaningful way. In long-term cases the accumulation of huge amounts of information through years of on-going assessment did not necessarily result in reassessment of the situation and opportunities to identify risk were missed as result. Consequently the ability of agencies to effectively plan was seriously reduced.

As a consequence of the learning from earlier CMRs the Department of Health, Social Services and Public Safety developed and introduced a comprehensive framework for assessing children's needs across organisations working with children and their families (DHSSPS, 2008). The Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment framework was developed to:

- improve the quality of assessment of children's needs;
- assist in communicating these needs between different professionals and agencies; and,
- reduce the escalation of children's needs through an early identification of those needs and more effective intervention.

This new assessment framework was only being introduced towards the end of the period covered by this report. Findings from the Regulation and Quality Improvement Authority's recent inspection of child protection in Northern Ireland (RQIA, 2011) showed that although the UNOCINI assessment framework was becoming well established across the five HSC Trusts, there were inconsistencies in the quality of completion of assessments both within and across Trusts. In future work it will be important to evaluate if the introduction of UNOCINI has led to more timely and comprehensive assessments, and whether services to children and families are more focused and effective as a result.

Supervision, staff support and training

Child protection work is labour intensive, difficult, and emotionally stressful (Ferguson, 2011). It involves working with uncertainties and making difficult decisions and complex judgements on the basis of incomplete information in rapidly evolving, often hostile and highly stressful contexts. Leaving a child in a dangerous home or splitting a family are both potentially very damaging and mistakes are sometimes inevitable. However, the consequences of these decisions can often be enormous, and can lead to severe emotional and psychological stresses for the staff involved (Kim and Stoner, 2008; McFadden, 2012). For many practitioners involved in day-to-day work with children and families, regular and effective supervision and support is important in promoting good standards of practice and supporting individual staff members. When trained and experienced staff have access to experienced supervisors and to timely services for families, children are likely to be better supported and protected (Department of Health, Social Services and Public Safety, 2012b). However, as the CMRs illustrate, children sometimes fall through the cracks when child protection workers have unmanageable workloads, and limited support and supervision.

In order to be able to meet the demands of their role, practitioners need supervision that gives time and space to think, that addresses the emotional impact of their work, and welcomes acknowledgement of their feelings, as well as being essential for reducing the risk of errors in professionals' reasoning (Ferguson, 2011). In particular, one CMR report illustrated the need for extra support for inexperienced workers. In this case important information was not carried over from one notification of concern to the next, leading to information being

lost over time. This example highlights the need for on-going structured support for staff, whereby individuals are encouraged to think through alternative explanations about the meaning of information gathered through assessments. Key issues should be monitored and followed up, including missed appointments. Recording skills need to be supported and workers coached to be focused on what are the salient aspects of a situation. Case notes need to reflect the relevant descriptive detail and importantly the analysis and rational that lead to decisions being made. On-going supervision or co-working with a more skilled colleague could have embedded the expertise more thoroughly in this case.

The majority of the CMRs highlight the need for regular and sufficiently frequent supervision that challenges and allows for reflection across all agencies and professionals involved with child protection. In several of the reviews the problem of 'invisible children' was created by professionals, in particular psychiatrists, GPs and HVs who appeared overwhelmed by the chaotic circumstances of the families they were dealing with. They tended not to look at the whole picture and how this may affect the child's safety, but focused more on the behaviours of parents and the problems in the family in isolation. These professionals were anxious and displayed a reluctance to act and challenge parents about their behaviour. In some cases the psychiatric assessment of the parent was the prominent issue, but often senior professionals failed to identify a child who was at immediate risk of significant harm and death. In another case example, a range of services were in contact with a family but a critical appraisal of the outcomes of these services, why they were not being taken up or appropriately used, and what the implications were for the child's welfare, was never properly undertaken. When set out systematically, the pattern is a familiar one in cases of chronic neglect, and is an issue that requires strategic analysis in the context of supportive and discursive supervision meetings, which may offer considerable benefit to professionals.

Supervision has been integral to the development of social work and other helping professions from its outset (Bruce and Austin, 2001), representing a core commitment to reflective practices, and more accountable decision-making. Whilst much good supervision undoubtedly goes on, SCR overview reports also point to inadequacies in the supervisory process. Likewise RQIA's review of child protection in Northern Ireland (RQIA, 2011), whilst noting many positive examples and developments, highlighted deficits in respect of the provision and recording of supervision for social work staff. It also observed a lack of compliance within some HSC Trusts with guidelines for the assessed year in employment (AYE) undertaken by newly qualified social workers, as well as a general lack of consistency around developing a robust caseload weighting system. On a positive note, the importance of appropriately supporting and supervising all staff involved in safeguarding has been recognised and the review confirmed a drive towards establishing a supervision policy for nurses and midwives involved in safeguarding, together with a framework for supervised and supportive practice for consultant and career grade paediatricians.

Whilst there was evidence of this regular and consistent supervision within some review reports, evidence from other CMRs paints a picture of inconsistencies, interruptions, and lack of emotional support for the worker. Supervision and reflection are both important as practice relationships with children and families exist within a statutory organisational context. The organisational system also includes collegial responses and the professional team context, the provision of high-quality supervision and the training and supports needed to foster in-depth high-quality practice. Munro (2005) argues that this context is infused with overt and covert messages that influence the way in which a social worker (or other professional) might approach the work with a family. Messages about where to focus professional effort can result in a worker having to choose, for example, between seeing a child or completing paperwork. As Munro (2005, p.389) notes: "this creates dilemmas about which matters most, the child or the performance indicator". Compromising quality for quantity critically impacts on the worker's capacity to know and understand the family and the complex safety issues for the child. Munro ponders the lack of success these responses have had. She notes that while child maltreatment deaths have reduced, services in the UK and United States have become increasingly "crisis-reactive" in response to abuse allegations, concentrating resources at the risk averse front-end of the response system. This has meant fewer resources dedicated to early intervention and the needs of children who are at serious risk.

One of the positive developments arising from the learning from case management reviews has been the introduction in one HSC Trust of group supervision for clinical psychologists that focus solely on professional

development. This separates the traditional workload management function that can permeate line management supervision, from the other important aspects of supervision which allow professionals to explore the challenges and complexity of their work with colleagues.

Keeping the focus on the child

A major challenge in building a more responsive child protection system is helping a wide range of professions to work well together in order to build an accurate understanding of what is happening in the child or young person's life, so the right help can be provided. To do this well consideration must be given to listening to the child or the children involved and making their perspective more visible. As with the various overview reports examining SCRs in England and Scotland, the invisibility of the children involved was a common feature of CMRs in Northern Ireland.

In a number of cases there was a failure by professionals such as social workers, adult mental health practitioners, HVs or GPs to think beyond the immediate needs of the adult and to consider how mental health difficulties and/or problems with addiction might impact on parenting capacity and the risk posed to children. The CMR reports often described cases where health and social care professionals appeared more concerned with assessment and screening of the parent rather than placing a clear focus on the needs of the child and implications for their future health and wellbeing. Several cases highlighted the fact that professionals were often kept from seeing and talking to the child or siblings. For example, in one case, despite a long history of mental health and alcohol-related problems, psychiatric hospitalisation and involvement with mental health professionals, no assessment of the mother or her family was ever completed. Indeed, she was released from hospital after the birth of her first child with no concerns and no referral was ever made in relation to her situation. Despite frequent contact with mental health professionals no-one was aware that her first child had not resided with her from a young age. Following the death of her second child, the incident which triggered the CMR process, an interview with the eldest child revealed a history of physical abuse and neglect. Had the needs of the older child been appropriately considered and assessed it is likely that the risk posed to the second children during the mother's pregnancy would have been identified and addressed.

In considering practitioners' understanding of child development, Brandon *et al*. (2011) identify a variety of issues which prevented practitioners from paying sufficient attention to the impact of maltreatment on child and adolescent development. Key amongst these were not developing a relationship or getting to know the young person or making sense of the impact that their experiences had on their sense of themselves and on how they behaved. In one CMR report it was noted that the young person had a good relationship with their social worker and that, rather than the social worker acting as a conduit to other specialist services, it might have been more useful for the young person to have had more time with this social worker to explore the issues of concern.

Not speaking to the child and allowing the parents' voice to dominate were also common. Indeed, this is a recurring theme across all age groups and overview reports with the voice of children missing or invisible to professionals in a number of ways, including: young people who were hardly consulted or spoken with; siblings who were similarly not engaged; young people who were not seen because they were regularly out of the home or were kept out of sight; non-attendance at school; young people who ran away or went missing and children who chose not to or were unable to speak because of disability, trauma or fear.

In some Northern Ireland cases there were high levels of contact between the young person and professionals. However, in one instance the contact was mostly by mobile phone due to the chaotic lifestyle of the young person. This reduced the opportunity to have more meaningful discussions of the issues in the young person's life. Whilst new technologies can provide an additional way of maintaining contact with a young person, it should not be the main or only means of doing so. In another case the contact focused solely on discussions of presenting issues, and opportunities to explore underlying issues, such as whether the young person had been sexually abused, were not taken. Similarly, acceding to the child's wishes also can be problematic. In one local example the HSC Trust gave too much weight to the young person's wishes to have no further social

work involvement, whilst in another instance the young person's request for confidentiality resulted in some professionals not being notified about instances of self-cutting behaviour.

This theme highlights the importance of communities, families, agencies and professionals in considering how children can be supported to have a voice and for managers and policy makers to consider how processes routinely expect and facilitate this. As noted by one senior manager, the child's best interests must prevail, and establishing and maintaining the trust of children and young people should therefore be at the heart of effective child protection practice within our communities.

Organisational and staffing context

There is growing research evidence that the organisational context and philosophy of child welfare organisations vary widely and that staff who deliver services in the most positive organisational climates have better work attitudes (e.g., job satisfaction and commitment), are less likely to leave their jobs, and, most crucially, are more effective in delivering better outcomes for children (Glisson and Green, 2011).

Munro (2010) has argued for the need to place reviews of non-accidental child deaths in the wider context of how systems work to support professionals to deliver services. This raises the question of whether changes at a systems level may have greater potential for effecting the necessary changes required to impact on the factors that contribute to poor outcomes for children and families, including child deaths. As noted by Lord Laming at the time of his inquiry into the death of Victoria Climbié:

> "It is not to the handful of hapless, if sometimes inexperienced, front-line staff that I direct most criticism for the events leading up to Victoria's death. While the standard of work done by those with direct contact with her was generally of very poor quality, the greatest failure rests with the managers and senior members of the authorities whose task it was to ensure that services for children, like Victoria, were properly financed, staffed, and able to deliver good quality support to children and families."
>
> "The single most important change in the future must be the drawing of a clear line of accountability, from top to bottom, without doubt or ambiguity about who is responsible at every level for the well-being of vulnerable children."
>
> (Laming, 2003, sections 1.23/1.27)

In the current review a number of reports commented on the wider organisational context within which staff worked. One report commented on the 23% increase in referrals to social services within the HSC Trust during the preceding four years without a commensurate increase in resources. Staff vacancies had also resulted in some HSC Trusts either raising the threshold for accepting referrals or instigating a waiting list of referrals deemed 'non-urgent'. The basis for such approaches was rooted in trying to maintain manageable workloads for staff at the expense of some children and families not receiving a service. Whilst this gave the impression of workloads being managed in reality the system was not functioning correctly, and children's needs were not being met. As noted in one report:

> "The continuing high levels of staff turnover within both children's social services and health visiting services, as evidenced in this case, undermines assessment, care planning and the implementation of those plans. The demands on staff who are often at the start of their professional careers, and who are sometimes being supervised by managers new to the role, limits the prospect of staff developing advanced analytical and relational skills. Staff recruitment and retention is a continuing concern for all involved in working with vulnerable children and their families, and must be addressed by Trusts' workforce strategies."

In other instances health visiting and social work staff were effectively responsible for two or more caseloads, resulting in neither caseload getting the time and attention required. In such circumstances it was unsurprising

that agency records were incomplete or administrative tasks left uncompleted. For example, in one review a newly qualified social worker was carrying cases from three teams based in two different offices with no proper line management arrangements, resulting in a complete lack of supervision and support.

In addressing these concerns the DHSSPS set up the Reform Implementation Team in 2008. This major work stream developed policies and processes related to the factors underpinning professional practice within statutory social care, including the development of supervision standards and a workload management model. The impact of these policies should be evaluated to ascertain whether they are working as intended, and delivering the anticipated positive outcomes.

Inter and Intra agency working

On a wider level some reviews highlighted the lack of collaboration between different parts of the child protection system both within and between agencies. As previously stated, a common criticism related to the lack of joint working between children's health and social services and adult services dealing with substance use or mental health, despite being part of the same organisation. The Report of the Independent Inquiry Panel (2007) into the death of a parent and child identified communication as a central issue, highlighting that staff failed to recognise the relationship between child protection and mental health. As a result, DHSSPS funded a three-year project to pilot the recommendations of SCIE's (2009) guidance, *Think Child, Think Parent, Think* Family, as a way to improve communication across the children's services and mental health interface. While this is outside the timeframe of the CMRs examined in this study, any future analyses should consider the extent to which this may have contributed to more effective working between child care and mental health professionals.

Whilst there were clear examples of constructive and purposeful working between health and social care agencies and criminal justice agencies, there were also examples of miscommunication and a clear lack of understanding of respective roles and responsibilities, for example, in relation to adults with convictions for sexual offences. It is encouraging to note that the learning from such CMRs have informed the revised public protection arrangements introduced in Northern Ireland in 2008. Again, future analyses of CMR findings should consider the impact such guidance may have had.

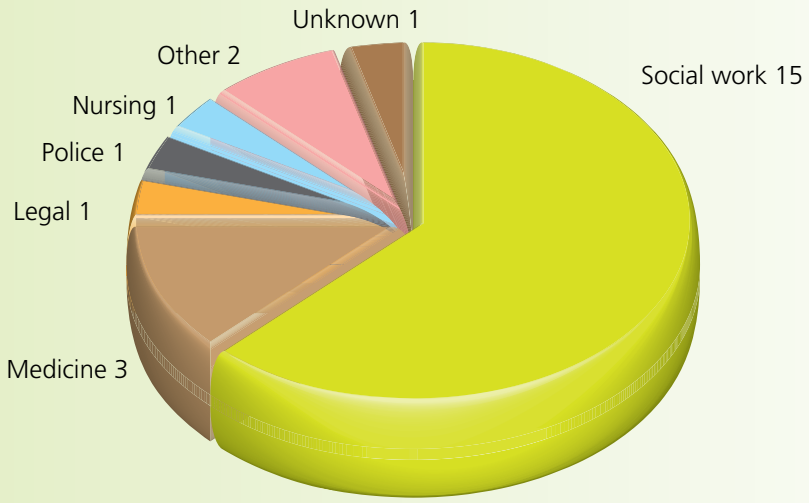
Chapter Eight:
The Process of Review

Building on our earlier work in relation to the process for reviewing non-accidental child deaths (Lazenbatt *et al.*, 2009) we used the opportunity presented in studying these twenty four CMR reports to gather some data about the review process itself.

Case Management Review Panels

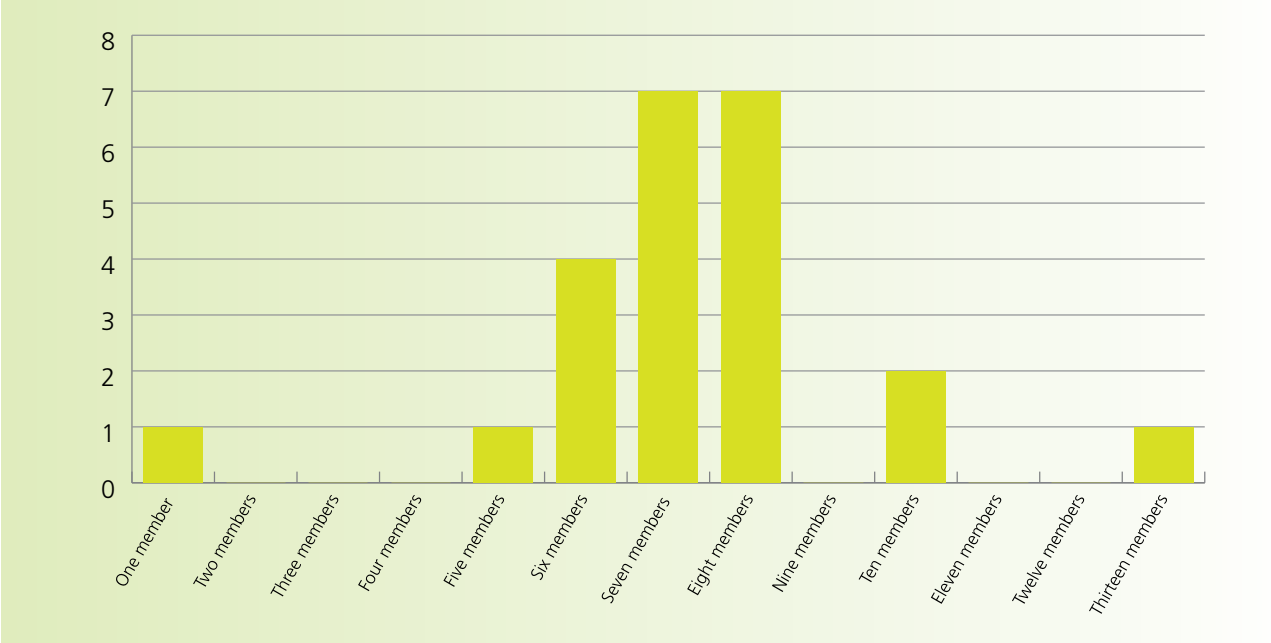
Each CMR has an independent chairperson and a panel of members to assist in the analysis of the case under review. In the twenty four reviews considered in this report fifteen were chaired by a male chairperson, with the remaining nine chaired by a female. The majority of chairpersons (62%) had a background in social work, with 12 per cent having a medical background (Figure 10).

Figure 10: Professional Background of CMR Panel Chairperson (n=24)



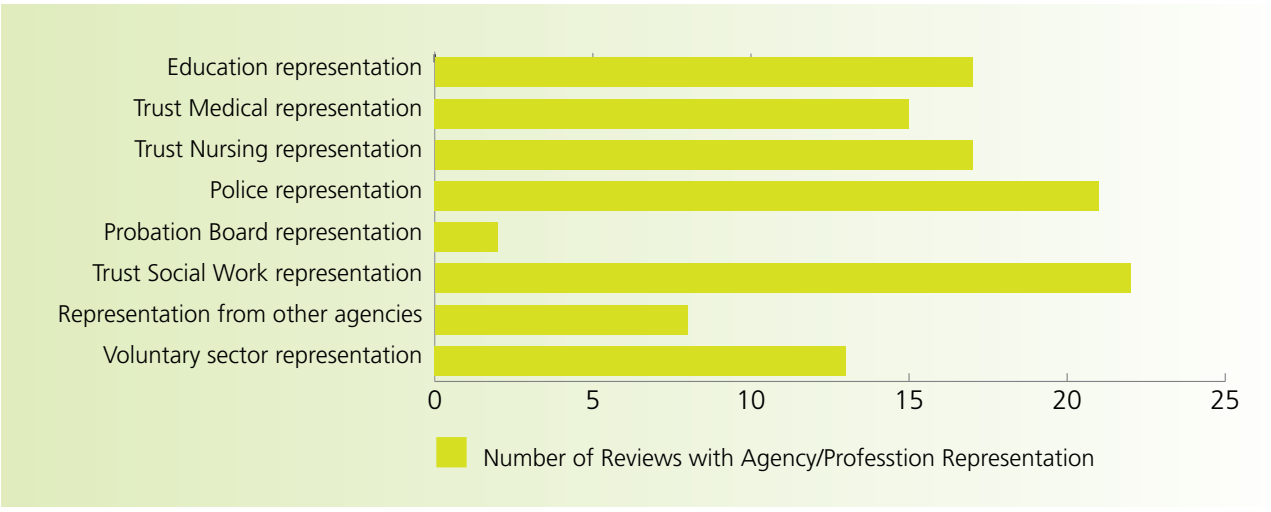
The size of panels varied, from one review undertaken by a single person, to another with thirteen members. The mean number of panel members, including the chairperson, was seven (Figure 11). The majority of panels had between 6-8 members. There did not appear to be a relationship between the size of the review panel and either the timeliness or quality of the final report, although the report undertaken by a single individual was more limited compared to reviews undertaken by a panel.

Figure 11: CMR Panel Size (n=24)



Panels varied not only in size but also composition. Given the multidisciplinary nature of child protection work it was encouraging to note that case management review panels typically had representation from a wide range of professions relevant to the particularities of the case under review (Figure 12).

Figure 12: Number of Reviews with Agency/Profession Representation (n=22*)



*n=22 cases: one report was conducted by a chairperson alone, and another report did not include details of background/ affiliation of panel members.

The most frequently represented organisations were the HSC Trust children's social work services and the police. Education and HSC Trust nursing and medical services were also represented on a majority of review panels. Given the age, characteristics and circumstances of the children under review this variation was appropriate. This was refined further, for example, through appointing a psychiatrist to cases involving issues relating to parental mental health, or a paediatrician in cases involving the sudden unexpected death of an infant. In all instances it was clear that the individuals appointed to the review panel were understood to be independent of the case under review. This independence is important in providing public confidence that the process is impartial. For example, in one case a review panel member stood down after he became aware that he had had a brief involvement with the family being reviewed a number of years previously in a prior job.

Progress of Reviews

The guidance *Co-operating to Safeguard Children* (DHSSPS, 2003) states that case management reviews should be undertaken as quickly as possible in order to ensure that other children who may be at risk are protected, and that any learning to be gained from a review is acted upon in a timely manner. The guidance states that reviews should be completed within six months (26 weeks) of the decision of the chair of the Area/Regional Child Protection Committee that the case meets the criteria for such a review.

Of the twenty-three reviews undertaken by a panel between 2003 and 2008, details were available on the number of panel meetings for fifteen. One of the very first reviews had forty-two panel meetings, considerably more than any other review. The mean number of panel meetings was 11 (range 3-42), dropping to a mean of 9 when this outlier was removed from analysis. It was possible to calculate the length of time to complete a review in thirteen of the cases examined. This ranged from 10 – 88 weeks with mean length of time between the review panel meeting for the first and last time of 36 weeks.

It was notable that whilst the time lag between the Area Child Protection Committee being notified of a case for consideration of review and the date of the first meeting of the panel was sometimes brief (in some instances 10-12 weeks), in other cases there had been a considerable delay (in one instance nearly three years). As touched upon in our previous report (Lazenbatt *et al*., 2009) there are a number of reasons for this, including staff becoming familiar with this new process following introduction in 2003, the need to gather further information in some cases to ascertain whether it met the criteria for a CMR, the need to allow other processes (such as criminal investigations) to conclude, and difficulties in recruiting suitable review panel chairs and members. In a number of CMR reports comment had been made about delays in the provision of individual agency reviews, or the need to request further information from participating agencies as contributing to delays in the process.

It is perhaps inevitable that the introduction of such a significant and important new process should experience initial difficulties whilst being introduced, and consideration will need to be given to the likely impact on timescales of any future changes in review processes. It is of note that the new Safeguarding Board for Northern Ireland is taking forward a number of the recommendations from the previous report (for example, recruiting a pool of potential chairs to call upon in advance of being notified of a potential case for review) which should facilitate more timely completion of reviews.

Review Process

The CMR process is built upon the quality of analysis undertaken by the review panel. In turn this is very dependent on the quality of information provided to the panel in the form of chronologies and individual management reviews. In more recent reviews family members and members of staff involved with the child and family have also been offered the opportunity to speak to the review panel.

The number of chronologies and individual agency reviews provided to panels varied depending on the range of involvement from other agencies. On average five chronologies (range: 1 – 10) and four individual agency reviews (range: 1 – 9) were received by CMR panels. In some CMR reports authors commented on the quality of these documents, ranging from 'very good' to 'poor'. In particular GPs tended to supply very limited information, and sometimes this had been difficult to obtain. Concern about confidentiality was often cited as the reason for cautiousness in supplying information by GPs, but not usually by other services or professionals. During the period of review it was apparent that individual agencies did become better at providing more robust and standardised information to panels. For example, the Police Service of Northern Ireland introduced a pro forma for individual agency reviews in order to improve the quality and consistency of their contribution.

Family members should routinely be notified that a case management review is being undertaken. As Morris *et al.* (2012) note involvement of family members has four main drivers: regardless of any culpability in the death or harm of a child, parents, family members and other significant people have a basic right to be involved in

contributing to a review; through involving family members the review panel can better understand the day to day experiences of the child, placing the child more at the centre of the review process; the family may hold information about what was happening in their situation and how professionals might have intervened differently; and it provides family members with an opportunity to talk about what they have been through. This is not to say that family involvement is straightforward, as family members may not agree amongst themselves, and there may be potential for practitioners and agencies to be blamed for what has happened. Family members were invited to meet with panel members in seventeen of the twenty four cases, and took up this invitation in most cases. It was apparent in some of the cases that there were high levels of acrimony between family members, resulting in decisions needing to be taken about what information could be shared with family members. Contributors to our previous report indicated that family members should receive a copy of the executive summary of the final report (Lazenbatt *et al*., 2009).

It was felt by most participants in the Lazenbatt *et al*. (2009) study that individual professionals involved with a case being reviewed should ordinarily be afforded the opportunity to contribute to the review, and should be expected to make themselves available to be interviewed for the individual agency review and/or by the CMR panel. It was acknowledged by the majority of participants that individuals could feel vulnerable and anxious about their practice being examined in this way. Whilst it could not be ruled out that the practice and conduct of an individual might warrant consideration of disciplinary procedures, it was felt that individuals should be supported to view the review as essentially a learning exercise. As such, employing agencies needed to ensure that appropriate support services were made available to staff in these circumstances. Some of the review reports acknowledged that the contribution of individual staff members had provided a much fuller and therefore more helpful account of how professionals and the wider system were operating at the time of the incident under review. As noted in the independent review into Samuel and David Briggs (DHSSPS, 2003b), consideration needs to be given to the interface with the coroners system, as this has caused individual staff and agencies some anxiety about being held accountable in different fora. This could shift the focus of case management reviews away from learning lessons, to one that is quasi judicial. Staff members were invited to meet with panel members in eighteen of the twenty four cases, and took up this invitation in most cases.

The Report and recommendations

If CMRs are to have the intended outcome of driving improvements within the system for protecting children from abuse and neglect, then it is essential that the key issues are identified and that policy makers and senior managers are supported in making any necessary improvements.

Overall the reports studied were of an appropriate standard, and did provide the level of analysis required to support system improvement. A minority of reports though were not as helpful due to:

- an overly descriptive tone which stated what happened but provided little analysis of what may have contributed to the unfolding of events, and what learning could be extrapolated;
- significant gaps in the information about family history and/or professional involvement;
- a mismatch between the issues identified within the report and the recommendations arising from the review;
- recommendations that were aspirational and lacked focus; and,
- reports with too many recommendations.

Some of these weaknesses may have been linked to the quality of the information provided to the review panel, but this was not the case in all instances.

The mean length of report was seventy one pages (range: 13-141), with a mean of eighteen recommendations per report (range: 5-63).

Conclusion

The senior managers and policy makers involved in the previous review of the CMR process identified inconsistencies in the ways in which reviews have been undertaken in Northern Ireland (Lazenbatt *et al*., 2009). Whilst this report highlights that there continues to be some inconsistencies that warrant attention, these have become less pronounced as the new system has bedded in. The taking forward of the recommendations from the earlier report will assist further in this regard. It is also important to note that the system in Northern Ireland has operated more consistently than the equivalent process in Scotland (Vincent and Petch, 2012), and therefore caution should be exercised in making any significant changes in the ways that CMRs are undertaken.

Chapter Nine: Reflections

The UNCRC places a duty on States parties to ensure that children and young people are supported during childhood in order to attain the highest standard of health and well-being, and to respond robustly where factors may be impacting on children's welfare. There is good research evidence to support the view that the current systems and processes for protecting children from abuse and neglect do work for the overwhelming majority of children who are brought to the attention of professionals. However, we also know that not all vulnerable children are identified as being in need of support or protection, and that even for those who are, the outcomes are not always positive. In some instances the death of a child through homicide may go undetected (Frederick *et al*., 2012). The reasons for this are complex, and beyond the scope of this report, but we do know that well trained professionals who are clear about their own role and responsibilities and those of other professionals, working within organisations that provide good supervision and leadership, and which have clear procedures for staff, are more likely to meet children's needs and deliver better outcomes for these children.

The death or serious injury of any child for whatever reason is a personal tragedy for the family and a loss to the wider community. Where that death or injury results from abuse or neglect, the sense of both grief mixed with outrage is more palpable. There is therefore a tendency within the policy making sphere to respond to these public and professional reactions by being seen to do something, even if it is unclear what this should be (Bunting and Reid, 2005). Case management reviews are one of a range of valuable sources of information that can inform our response to meeting children's needs. They provide a very good opportunity for professionals and agencies to reflect on how the child protection and wider child welfare systems have operated in order to identify:

- what aspects have worked as intended, and therefore can be built upon;
- what aspects have not worked as intended and need reconsidered; and,
- whether any new processes or systems need to be developed as a result of our improving understanding about children's needs.

The use of CMRs to assist in the learning process can be helpful, but one should not overestimate their ability to resolve all of the tensions and weaknesses within the child protection system. As Axford and Bullock (2005, p. 48) conclude:

> "There is some evidence of the impact of reviews on *immediate* and *intermediate* outcomes, insofar as they shape policy, guidance, training and, to some extent, practice, but benefits for *ultimate* outcomes, measured in terms of children's well-being, are less apparent."

It could be argued that the learning from a single CMR is actually very limited, and that it is only when data from a number of reviews are aggregated that we can start to spot trends. The analysis from CMRs also needs to be considered alongside routinely collected administrative data, the findings from audits and service evaluations, and the conclusions from commissioned research studies. When this information is collated it provides a fuller and more robust overview of how the child protection system is operating as a whole and whether there is a need to make refinements and improvements. It also reduces the likelihood of the system becoming skewed by one specific, albeit tragic, case.

The sense of being able to reflect on the learning from a given situation does not always sit comfortably with the need to ensure that both individuals and institutions are held to account if their actions have fallen below the

expected level. This has repercussions, though, as Olive Stevenson noted when reflecting upon her experience of sitting on inquiry panels:

> "We must at least acknowledge that the launching of an inquiry is like casting a huge stone in a pond. The ripples spread outward often involving many who did not expect it and more important, in ways that they did not anticipate. The emotional cost is very, very high and can only be justified if the inquiries appear to play a constructive part in protecting the lives of other children."
>
> Stevenson, 1979, p.3

Whilst there is a tension between using these reviews to hold individuals and agencies to account, across the UK, there has been a concerted effort to learn from the non-accidental deaths and serious injury of children through a robust process of review, leading more to learning than to blame (e.g. Brandon *et al*., 2009; 2012, Vincent and Petch, 2012). Whilst there has been a tendency for some commentators to characterise these processes as flawed, as supposedly, the same issues are identified on a recurring basis without any seeming improvement in practice (see Parton (2004) for a discussion of this issue), a more nuanced analysis indicates the benefits that such processes can bring (Lazenbatt *et al*., 2009). However, these benefits can only be realised if the process itself can command confidence from political, professional and public audiences. One small contribution to this endeavour is a report such as this.

Key Learning Points

In reviewing the first twenty four reviews undertaken since the introduction of new guidance in 2003 a number of key learning points have emerged:

1. There is a need to view CMRs as an important window into practice and an opportunity to reflect on what is working and what needs developed. However, just as a view from a building changes depending on what window is being used, so CMRs cannot and should not be seen as providing the whole or only view.

2. The majority of cases subject to a case management review are very similar to lots of other cases known to GPs, HVs, teachers and social workers. Therefore trying to predict which children are at greater risk of dying or suffering serious injury is ultimately a futile exercise. However, providing families with early, sustained and co-ordinated support does reduce the likelihood of children suffering unnecessarily.

3. Over time the quality of case management reports has improved, and progress in ensuring that reviews are more consistent in their approach should be continued, with the aim of ensuring that CMRs provide more analytical assessments.

4. The value of case management reviews is in the depth of analysis, and the opportunity to compare the findings from a single review with the other types of information that senior managers and policy makers have access to. How does it compare to what else is known, and how does it help to corroborate or challenge the strategic vision for safeguarding and child protection?

5. There is a need to ensure that reviews look at the child protection system within a number of nested levels – individual practice alongside organisational context; intra and inter- agency working; family and professional perspectives. By incorporating these different levels and perspectives a more robust understanding of what happened and what might have been done differently can start to emerge.

6. This report has identified the need to adopt public health approaches in trying to reduce the circumstances that place children at risk in both the short and longer term, such as alerting parents to the dangers of co-sleeping especially when alcohol or drugs have been consumed, and in responding earlier and more robustly to the needs of children and families before problems become entrenched in adolescence.

7. Finally, finding ways of better informing the public about the lives some children lead, the types of support services available to meet their needs, and the success of agencies in helping to improve the quality of life for children and their families is a necessary part of instilling public confidence in the child welfare system.

Over the past forty years the numbers of children dying or being seriously injured as a consequence of abuse or neglect has decreased. This is due to the systems and processes currently in place, and the preparation and ongoing training that professionals receive to support them in their work. Undertaking case management reviews is one way of ensuring that we continue to quality assure the effectiveness of the systems for supporting families and protecting children, and to make improvements that will keep future generations of children safe.

Appendix 1
CASE MANAGEMENT REVIEW REPORT FORMAT

Introduction

- Summarise the circumstances that led to a review being undertaken in this case.
- State terms of reference of review.
- List contributors to the review and the nature of their contributions (e.g. Individual Agency Review by HSC Trust, report from family general practitioner).
- List review panel members, chair and author of CMR report.

The Facts

- Prepare a genogram showing membership of family, extended family and household.
- Prepare an ecomap showing the inter-agency/professional/community involvement with the family, extended family and household.
- Compile a chronology of involvement with the child and a separate chronology of involvement with the family which shows the integrated involvement of all relevant agencies, professionals and others.
- Note specifically in the chronology each occasion on which the child was seen and the child's views and wishes sought or expressed.
- Prepare an overview which summarises what relevant information was known to each involved agency and professional about the parents/carers, any perpetrator, and the home circumstances of the specific child and other children and family members. Include additional information purposefully sought by those conducting the review to, for example, substantiate unanswered claims or to clarify a situation.

Analysis

This part of the CMR report should look at how and why events occurred, the basis for decisions, who made the decisions, the actions taken, the timeliness and appropriateness of actions taken and how all of this is reflected in case records. This is the part of the report in which reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events or outcome for the child. The analysis section is also where examples of good practice should be highlighted and commented upon.

Conclusions and Recommendations

The report should summarise what, in the opinion of the Review Panel, are the lessons to be drawn from the case and how these lessons should be translated into recommendations for action. Recommendations should include, but should not be limited to, the recommendations made in the individual reports of involved agencies. Recommendations should, where possible, be few in number, focused and specific and capable of being implemented. If there are lessons for regional as well as local policy and practice, these should be highlighted.

Appendix 2
Case Management Review Report Analysis

1.	**Case Management Review Report Reference Number**	
2.	**Analyst**	Lisa Bunting ☐ John Devaney ☐ David Hayes ☐ Anne Lazenbatt ☐
3.	**Date of Analysis**	dd/mm/yyyy
4.	**Trust Area** (tick all that apply - may involve more than one Trust area)	Armagh & Dungannon ☐ Causeway ☐ Craigavon & Banbridge ☐ Down Lisburn ☐ Foyle ☐ Homefirst ☐ Newry & Mourne ☐ North & West Belfast ☐ South & East Belfast ☐ Sperrin Lakeland ☐ Ulster Community & Hospitals ☐ Belfast ☐ Northern ☐ South Eastern ☐ Southern ☐ Western ☐

5.	**Area Child Protection Committee** (tick all that apply - may involve more than one ACPC)	Eastern ☐ Southern ☐ Northern ☐ Western ☐
6.	**Date of Incident Triggering Case Management Review (Index Event)** (If no identifiable trigger event then include brief summary of when & why CMR convened)	dd/mm/yyyy
7.	**Grounds for Case Management Review**	Death (non-suicide) ☐ Death (suicide) ☐ Serious life threatening injury ☐ Serious and permanent impairment ☐ Inter-agency working ☐ Other (please specify) ☐ _____
8.	**Incident Cause**	Physical assault ☐ Sudden infant death ☐ Overlaying ☐ Neglect (including accidents) ☐ Poisoning/overdose ☐ Sexual abuse ☐ Suicide/self harm ☐ Gone missing ☐ Other (please specify) ☐ _____ Missing ☐
9.	**Number of Children in Family at Time of Index Event** (include adult children)	☐

10.	**Number of Children Living with Index Child at Time of Index Event Leading to CMR**	☐
11.	**Family Housing Type** (where index child is living at time of index event)	Owner Occupied ☐ Social Housing (NIHE/Housing Assoc.) ☐ Privately Rented ☐ Homeless (temporary accommodation) ☐ Homeless (no fixed abode) ☐ Other (please specify) ☐ _____ _____ Not Known ☐
12.	**Family Mobility** (Did family move address frequently)	Yes ☐ No ☐ Not known ☐ Not relevant ☐
13.	**Indicators of Concern** (Tick all that apply whether suspected, alleged or confirmed)	Death of previous child in family ☐ Dom violence in previous 12mnth ☐ Dom violence ever ☐ Adult substance misuse ☐ Adult mental illness ☐ Adult learning disability ☐ Low family income ☐ History of sexual abuse ☐ History of physical abuse ☐ History of emotional abuse ☐ History of neglect ☐

Panel Proforma		
14.	**Chair of Panel**	
	Name	_____
	Gender	Female ☐
		Male ☐
	Professional Background	Social Work ☐
		Medicine ☐
		Legal ☐
		Police ☐
		Nursing ☐
		Other (specify) ☐
		_____
15.	**Number of Panel Members** (including chair)	☐
16.	**Composition of Panel** (excluding Chair) Insert number of representatives in each box	Education ☐
		Nursing ☐
		Medicine ☐
		Police ☐
		Social Work ☐
		Voluntary Sector ☐
		Probation ☐
		Other (please specify) ☐
		_____
17.	**Date of Notification of Case to ACPC**	dd/mm/yyyy
18.	**Date of Decision to Proceed to CMR**	dd/mm/yyyy
19.	**Date of Appointment of Chair**	dd/mm/yyyy
20.	**Date of First Meeting of Panel**	dd/mm/yyyy

21.	**Number of Panel Meetings**	☐
22.	**Date of Final Panel Meeting**	dd/mm/yyyy
23.	**Number of Chronologies**	☐
24.	**Number of Individual Agency Reviews**	Requested ☐ Submitted ☐
25.	**Agencies Contributing Individual Agency Reviews** (tick all that apply)	HSS/HSC Trust ☐ Police ☐ Education ☐ Probation ☐ Youth Justice Agency ☐ NSPCC ☐ GP ☐ Other (please specify) ☐ _____
26.	**Were Professionals Invited to Meet With Panel?**	Yes ☐ (provide details below) No ☐ Details (eg who; how many times they met) _____ _____
27.	**Were family members invited to meet with Panel?**	Yes ☐ (provide details below) No ☐ Details (eg who; how many times they met) _____ _____

28.	**Length of Final Report**	☐ pages
29.	**Number of Recommendations**	☐
Child Profroma (for each child in family subject to CMR)		
30.	**Is this Proforma on the Index Child** (The index child is the one who was either the most seriously affected, or if more than one child in this category, the youngest)	Yes ☐ No ☐ If 'Yes': Most seriously injured/affected ☐ Or Youngest child involved ☐
31.	**Date of birth**	dd/mm/yyyy
32.	**Gender**	Female ☐ Male ☐
33.	**Ethnicity**	Bangladeshi ☐ Black African ☐ Black Carribean ☐ Black other ☐ Chinese ☐ Indian ☐ Pakistani ☐ White ☐ Irish Traveller ☐ Other (please specify) ☐ _____ _____ Missing ☐

34.	**Number of Siblings** Half sibling – blood tie Step sibling – child of a legal relationship between birth parent and another adult, or living in same hosuehold	Full Siblings ☐ Half Siblings ☐ Step Siblings ☐ Number living with index child: Full Siblings ☐ Half Siblings ☐ Step Siblings ☐
35.	**Ordinal Position**	Eldest child ☐ Youngest child ☐ Both older and younger siblings ☐ Only child ☐ Multiple birth ☐ Not known ☐
36.	**Who Child was Living With at Time of Index Event**	Both birth parents ☐ Mother only ☐ Father only ☐ Mother & partner ☐ Father & partner ☐ Mother & other adult relative ☐ Father & other adult relative ☐ Living with other relative ☐ Foster Care ☐ Residential Care ☐ Adoption ☐ Living independently ☐ Not known ☐

37.	**Illness or Disability of Child (Tick all that apply)**	Mental health disability ☐ Learning disability (ADHD) ☐ Physical disability ☐ Child born prematurely ☐ Physical illness ☐ Sensory impairment ☐ Alcohol misuse ☐ Drug misuse (Solvent abuse) ☐
38.	**Outcome for Child of Index Event**	Death ☐ Permanent impairment or disability ☐ Neither of the above ☐
39.	**Known to Social Services**	At time of index event: Yes ☐ (go to question 40) No ☐ On previous occasions: Yes ☐ (go to question 41) No ☐ (go to question 41)
40.	**Stage of Social Services Involvement**	Referred but not allocated ☐ Allocated but not assessed ☐ Initial assessment completed ☐ In receipt of services ☐ Pending closure ☐
41.	**Child Protection (tick one only)**	On register at time of index event ☐ On register previously ☐ Never on register ☐ Not known ☐

42.	**Looked After (tick one only)**	Looked after at time of index event ☐ Previously looked after ☐ Never looked after ☐ Not known ☐
43.	**Indicators of Exposure to Adversity**	Domestic violence ☐ Parental substance misuse ☐ Parental imprisonment ☐ Parental mental ill health ☐ Sexual abuse ☐ Physical abuse ☐ Emotional abuse ☐ Neglect ☐
Adult Proforma (for each adult considered in report)		
44.	**Relationship to Index Child(ren)**	Mother ☐ Father ☐ Step-father ☐ Step-mother ☐ Mother's Cohabitee ☐ Father's Cohabitee ☐ Other (specify) ☐
45.	**Gender**	Female ☐ Male ☐
46.	**Age**	Yrs

47.	**Ethnicity**	Bangladeshi ☐ Black African ☐ Black Carribean ☐ Black other ☐ Chinese ☐ Indian ☐ Pakistani ☐ White ☐ Irish Traveller ☐ Other (please specify) ☐ _____ Missing ☐
48.	**Living with Index Child(ren) at time of Index Event**	Yes ☐ No ☐
49.	**Illness & Disability** (Tick all that apply)	Mental health disability ☐ Learning disability ☐ Physical disability ☐ Physical illness ☐ Sensory impairment ☐ Alcohol misuse ☐ Drug misuse ☐

50.	**Employment**	Full-time employment ☐ Part-time employment ☐ Education ☐ Training ☐ Not in employment (caring responsibilities) ☐ Not in employment (long-term illness or disability) ☐ Not in employment (seeking work) ☐ Not in employment (not seeking work) ☐ Not in employment (reason not known) ☐ Not known ☐
51.	**Parent in Adolescence**	Yes ☐ No ☐
52.	**Adult Experience of Care**	Yes ☐ No ☐ Not known ☐ Brief Details: _____ _____
53.	**A Care Leaver within three years of index event**	Yes ☐ No ☐ Not known ☐ Not applicable ☐

54.	**Parental Criminal Record**	Yes ☐ No ☐ Not known ☐ Brief Details: _____ _____

Thematic Analysis of Case Management Review Reports

Please identify the key issues and themes identified within the report and your analysis as to whether other issues appear to be relevant:

Thematic Analysis of Case Management Review
Please identify the key issues and themes identified within the recommendations and your analysis as to whether other issues appear to be relevant:

Did the report highlight any examples of positive or good practice? If so, please specify.

Was the report critical of the professionals involved (non-critical is classified as a clear statement to the effect that professional were not at fault or could not have predicted the critical incident)

Yes ☐

No ☐

If yes, which professional groups were criticised:

Education ☐

Nursing ☐

Medicine ☐

Police ☐

Social Work ☐

Voluntary Sector ☐

Probation ☐

Other (please specify) ☐

Was there evidence of a conflict in opinion between professional groups in relation to the risks posed to the child/ren?

Yes ☐

No ☐

If yes – please specify

Was there evidence of a conflict in opinion between professionals and family members/neighbours in relation to the risks posed to the child/ren?

Yes ☐

No ☐

If yes – please specify

What assessment was there of the interaction between the family and primary health care services?

What assessment was there of the interaction between the family and social services?

General Comments and Observations
Please list any other issues that you would like to discuss

Appendix 3
Members of Reference Group

Health & Social Care Board	Tony Rodgers
HSC Trust	Paul Morgan
Police	Anne Marks
Nursing	Deirdre Webb
Education	Pamela Woods
Medicine	Daphne Primrose
Voluntary Sector	Paul McConville
DHSSPS	Fergal Bradley

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