Queen's and NSPCC publish Northern Ireland's first child death and serious injury review

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The first ever review of abuse cases related to child death or serious injury in Northern Ireland will be launched at Queen's University today (24 January 2013). The review, Translating Learning into Action, was commissioned by the Department of Health, Social Services and Public Safety (DHSSPS) and was carried out by researchers at Queen's University and the NSPCC.

The Case Management Review (CMR) report – the first to be produced in Northern Ireland - analysed 24 case reviews relating to 45 children which resulted in death or serious injury in the period between 2003 – 2008. While the rate of non-accidental child deaths in Northern Ireland continues to fall as a consequence of having a strong child protection system, the findings from the review offer important opportunities for strengthening the system.

Of the 24 cases reviewed, 18 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; and eight young people who died by suicide or accident. The remaining six case reviews involved 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.

As of 31 March 2012, 2,127 children were listed on child protection

registers in Northern Ireland, a decrease of 11% (274) from 2011 (2,401) but an increase of 18% (322) since 2007.

The report drew a number of conclusions:

- The rate of non-accidental child deaths in Northern Ireland continues to fall as a consequence of having a strong child protection system;
- The majority of the 24 case reviews commented positively on the dedication and professionalism of individual staff working with the families subject to review;
- The children in these reports 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;
- There is a need for services to become involved at an earlier stage with families before problems became entrenched and harder to improve;
- Services need to stay involved for longer with some families to ensure that improvements in parenting are consolidated in the longer term;
- 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;
- Professionals should be provided with opportunities to meet together more frequently to co-ordinate assessments and interventions with children and families;
- Senior managers across organisations must take greater responsibility for ensuring that workloads of individual professionals are manageable and commensurate with their level

of experience;
- The interface between services working with children and services working with adults who are parents (for issues such as poor mental health or substance misuse) must be improved;
- Senior managers should ensure that staff receive regular support and supervision in dealing with what is often highly complex and emotional work.

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

- Improved information sharing between criminal justice and social care organisations in respect of adults who pose a serious risk of harm to children;
- Introduction of an initiative to support medical and 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.

Minister of the Department of Health, Social Services and Public Safety, Mr Edwin Poots MLA, said: "I welcome the publication of this report,

the first of its kind in Northern Ireland. It provides invaluable learnings for the protection and safeguarding of children here. This report, commissioned by my department, reflects my continued 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.

"The rate of non-accidental child deaths continues to fall. In my view, a strong child protection system has contributed positively to this reduction in numbers – and we owe it to future generations to continue to do what we do well, and to strengthen the system where it transpires we need to."

Principal Investigator, Dr John Devaney, School of Sociology, Social Policy and Social Work at Queen's University, said: "This is the first time a review like this has been carried out in Northern Ireland. The overall aim has been to provide better safeguards for children by establishing the facts of the cases where children have died or been seriously injured, establishing whether lessons can be learned, identifying what those lessons are and how they can be acted upon."

"Most of the children in these reports were already known to Health and Social Care Trusts and were not considered to be at great risk of serious harm – they were like many families known to social services. Importantly, this research, carried out by Queen's and the NSPCC, has highlighted a number of key findings from individual case management reviews have already led to improvements in the systems and processes for supporting vulnerable families and protecting children at risk."

Dr Lisa Bunting from the NSPCC, said: "The very fact of Case Management Reviews, and the production of this report, signals a real commitment to continued improvement in an already robust child protection system. There is always more to be done, and lessons that can

and should be learnt, and we welcome this opportunity to effect change.

"Examination of these cases revealed that a lack of sustained intervention with children and families was sometimes an issue. Although problems in the family had, in many cases, been evident for a number of years, agencies were sometimes particularly poor at addressing the impact of chronic neglect on children, and intervening at an early stage. We need to ensure that practitioners have access to a range of appropriate interventions and services which can prevent family problems from becoming entrenched."

More information: The full report is available online at www.qub.ac.uk/schools/Schoolof … upload,365708,en.pdf

Provided by Queen's University Belfast