

<p>Institution: Queen’s University Belfast</p>
<p>Unit of Assessment: 22 – Social Work and Social Policy</p>
<p>Title of case study: Reducing the Death and Injury of Children from Abuse and Neglect</p>
<p>1. Summary of the impact (indicative maximum 100 words)</p> <p>UNICEF estimate that over 3,500 children die annually from abuse and neglect in economically developed countries, including 100 in the UK of whom around 4 are from Northern Ireland. Although the number of deaths appears to be falling in the UK, the rate of decline is slowing. This case study describes the impact of three related pieces of research undertaken for the Northern Ireland Executive and the Northern Ireland Commissioner for Children and Young People. The aim was to identify the things that policy makers and practitioners could do differently in order to protect children better, and has led to significant improvements into how reviews are undertaken, and in the child protection policies and practices in Northern Ireland. As a result children have been better protected by child welfare professionals.</p>
<p>2. Underpinning research (indicative maximum 500 words)</p> <p>Context: Central Government is concerned with how to ensure that vulnerable children are kept safe, and that if a child dies from abuse or neglect there are opportunities to learn what could be done better for other children living in similar circumstances. Queen’s has an international reputation for research into child protection, with good links to policy makers and agencies working with children and families. The aim of the research in this case study was to provide an evaluation of whether the process of reviewing the deaths or serious injury of children could produce the type of learning that would inform the strengthening of the child protection system and keep children safer in Northern Ireland.</p> <p>Research: In 2008 the Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS) commissioned Queen’s University and the NSPCC to undertake an evaluation of the Case Management Review (CMR) process into non-accidental child deaths and serious child abuse (equivalent to Serious Case Reviews [SCR] in England) (References 1 & 2). The CMR process aims to develop a culture of critical reflection, aligned with processes for system improvement and continuing professional development in social care, health, education and criminal justice agencies.</p> <p><i>Lazenbatt</i> and <i>Devaney</i> (Reader and Senior Lecturer respectively at Queen’s) and <i>Bunting</i> (Senior Researcher at NSPCC, now at Queen’s from March 2013) interviewed and surveyed senior policy makers from a range of government departments, together with senior managers from public services about the operation of the CMR system. The research was concluded in January 2009. It identified key issues relating to: the governance of the reviews; the criteria for undertaking case management reviews; the recruitment and selection of independent chairpersons; the preparation and support of individuals involved in the review process; and the management of the review process.</p> <p>In 2011 DHSSPS commissioned Queen’s University (<i>Devaney, Lazenbatt and Hayes</i>) and the NSPCC (<i>Bunting</i>) to produce an overview of the learning from the first twenty-four CMRs and to identify ways in which the learning had led to improvements in the child protection system (Reference 3). The research was concluded in January 2013 and the overview highlighted that families are better supported when professionals get involved earlier before problems become entrenched, deliver better co-ordinated interventions, and stay involved for longer to ensure that improvements in children’s lives are consolidated. The report also highlighted that practitioners (eg social workers, health visitors, police officers and teachers) are more effective when they receive high quality supervision and line management support in organisations with robust governance processes.</p>

Impact case study (REF3b)

In 2011 the Northern Ireland Commissioner for Children and Young People commissioned Queen's University (*Devaney, Lazenbatt, Hayes, Spratt, and Davidson*) and the NSPCC (*Bunting*) to produce a focused report looking at the suicide or accidental death of eight adolescents who had died as a consequence of abuse or neglect (**References 4 & 5**). The research was concluded in 2013 and identified that these young people had been subject to multiple forms of childhood adversity over many years, impacting upon their psychological well-being and capacity for resilience. The key recommendation was that professionals needed to better understand the cumulative impact of adversity on an individual's social and emotional well-being over the life course, rather than focus solely on immediate risk. This would require significantly different ways of working with troubled young people, such as developing outreach work by Child and Adult Mental Health Services into children's residential units which is now occurring.

Collectively the three research studies have provided a strong evidence base for the importance of reviewing the cases where children have died or been seriously injured as a consequence of abuse or neglect. The research has helped policy makers in three government departments (Health, Education and the Office of the First Minister and Deputy First Minister) and professionals in social care, health, mental health, criminal justice and education to better understand the core components of an effective child protection system in Northern Ireland, and to allow for improvements to be instigated that will result in further reductions in the number of children dying or being seriously injured through abuse or neglect.

3. References to the research (indicative maximum of six references)

Reference 1: Lazenbatt, A., Devaney, J. and Bunting, L. (2009) *An Evaluation of Case Management Review Processes in Northern Ireland and Scoping of Adverse Incident Reporting and Alternative Investigative Systems*. Belfast, Department of Health, Social Services and Public Safety. Available at: <http://tinyurl.com/cjooppv>

Reference 2: Devaney, J., Lazenbatt, A. and Bunting, L. (2011) Inquiring into Non-Accidental Child Deaths – Reviewing the Review Process. *British Journal of Social Work* 41(2): 242-260.

Reference 3: Devaney, J., Lazenbatt, A., Hayes, D. and Bunting, L. (2013) *Translating Learning into Action: An overview of how the learning arising from case management reviews can influence practice*. Belfast, Department of Health, Social Services and Public Safety. (<http://bit.ly/1auP6ap>)

Reference 4: Devaney, J., Bunting, L., Davidson, G., Hayes, D., Lazenbatt, A. and Spratt, T. (2012) *The impact of early childhood experiences on adolescent suicide and accidental death*. Belfast, Northern Ireland Commissioner for Children and Young People. (<http://tinyurl.com/ctgqni2>)

Reference 5: Davidson, G., Devaney, J. and Spratt, T. (2010) The impact of adversity in childhood on outcomes in adulthood: research lessons and limitations. *Journal of Social Work* 10(4): 369-390.

4. Details of the impact (indicative maximum 750 words)

Impact on Legislation and Policy

On behalf of the Northern Ireland Association of Social Workers *Devaney* presented written (February 2010) and oral (September 2010) evidence to the NI Assembly Committee for Health, Social Services and Public Safety during consideration of the legislation on the establishment of a regional children's Safeguarding Board for Northern Ireland (SBNI). The SBNI has responsibility for CMRs. This evidence was informed by the research on the process of reviewing non-accidental child deaths, cited in the evidence presented to the Committee (**Sources 1 & 5**).

During 2010-2011 the DHSSPS invited *Devaney* to be part of the reference group developing statutory regulations to underpin new legislation on the establishment of the SBNI. The research findings informed these statutory regulations in respect of improving the governance and operation of the CMR process. (**Source 1**)

In November 2010 *Devaney* and *Lazenbatt* were invited by the Scottish Government to address a conference of policy makers and senior managers looking at ways of improving the system for reviewing non-accidental child deaths in Scotland. *Devaney* was also asked by the Welsh Assembly Government to sit on the Advisory Group for the Welsh Overview of Serious Case Reviews (2010- 2011), and by the Department of Education in London to sit on the Advisory Group for the Biennial Review of SCRs (2011-2012). In March 2011 *Devaney* and the Chief Social Services Officer for Northern Ireland attended a meeting in the Department of Education (London) to brief Professor Eileen Munro on developments in the CMR process in Northern Ireland as part of the Munro Review on Child Protection in England. **(Source 1)**.

The Safeguarding Board for Northern Ireland have now enacted several of the key recommendations from the first report **(References 1 & 2)** in relation to revising and strengthening the CMR process, such as a more robust process for the recruitment and selection of independent chairs of reviews, a programme of training for individuals involved in the review process, standardised templates for reports and stronger governance processes for ensuring that recommendations and learning are implemented **(Source 2)**.

In March 2013 the Children's Commissioner presented the 'Still Vulnerable' report to the Committee for the First Minister and Deputy First Minister at the Northern Ireland Assembly in evidence before the inquiry into a children's strategy **(Sources 3 & 6)**. The report and its conclusions have challenged established thinking about the separation of strategies looking at children's emotional and psychological well being from the strategies looking at adults.

Impact on Professional Practice

The research reported has improved the effectiveness of workplace practices. For example, the research team were asked by DHSSPS to work with the statutory Children's Improvement Board in Northern Ireland on developing actuarial tools to support the assessments by social workers of the range of adversities experienced by children. This work is strengthening the comprehensiveness of the assessment leading to more robust plans for supporting and protecting children. Additionally, CAMHS services are now being delivered to young people in care in their residential units **(Sources 1 & 3)**.

In addition during 2012-2013 *Devaney* and *Hayes* were commissioned by DHSSPS to deliver training to over 1000 professional staff (social workers, health visitors, police officers, paediatricians, midwives, mental health professionals, teachers) through a series of ten Continuing Professional Development seminars in Northern Ireland on the key learning arising from this work on child deaths. This training has now been developed into a training resource for cascade training to more professionals. **(Sources 1 & 2)**.

Impact on General Public

The research has shaped the public and political debate by challenging the way that child abuse deaths are represented in the media. In 2011 the British Association for the Study and Prevention of Child Abuse and Neglect, the NSPCC, the Northern Ireland Association of Social Workers and the National Union of Journalists involved *Devaney* in taking forward a further recommendation from the research relating to promoting communication with the local community and media to raise awareness of the positive and 'helping' work of statutory services with children, so that attention is not focused disproportionately on case management review tragedies. This has resulted in the development of jointly produced and endorsed guidance by the National Union of Journalists and the Department of Health, Social Services and Public Safety on the media reporting of child abuse and non-accidental child deaths. This was launched by the Minister for Health on 29th November 2012 (<http://www.baspcan.org.uk/northernireland/>). **(Sources 1, 2 & 4)**.

Subsequently *Devaney* was commissioned by the leading daily Northern Ireland newspaper *The Belfast Telegraph* to write opinion pieces on non-accidental child deaths, which were published on 15th April 2012 and 24th January 2013. The research team also worked with the investigative journalism website *The Detail* to disseminate findings widely (<http://tinyurl.com/k4xe2fh>). This media engagement has raised public awareness of the difficult lives some children lead.

Impact case study (REF3b)

5. Sources to corroborate the impact (indicative maximum of 10 references)

1. Chief Social Services Officer for Northern Ireland, Department of Health, Social Services and Public Safety
2. Chair, Safeguarding Board for Northern Ireland
3. Northern Ireland Commissioner for Children and Young People
4. Chief Executive, National Association for People Abused in Childhood

Documentary Sources

5. NI Assembly Research Paper *Developing New Child Protection Safeguarding Structures in Northern Ireland* Briefing Note 43/10 <http://bit.ly/HQGssT>
(Briefing paper prepared for Members of the Legislative Assembly in Northern Ireland that draws upon the first research report **Reference 1**)
6. NI Assembly: Minute of Proceedings. Committee of the Office of the First Minister and Deputy First Minister <http://www.niassembly.gov.uk/Assembly-Business/Committees/Office-of-the-First-Minister-and-deputy-First-Minister/Minutes-of-Proceedings/20-February-2013/>
(Minute of the presentation by the Children's Commissioner of the third report **Reference 4** as part of the evidence to the Assembly inquiry into a new children's strategy for Northern Ireland)
7. Safeguarding Board Act (Northern Ireland) 2011 Section 3(4)
<http://www.legislation.gov.uk/nia/2011/7/section/3>
(Legislation incorporating some of the key issues in relation to CMRs as highlighted in the first report **Reference 1**)
8. The research findings influenced the revised guidance on Serious Case Reviews in England published in December 2009 (for example section 8.54 of *Working Together to Safeguard Children (2010)* is a direct quote from pages 50-51 of the evaluation report).
9. BASPCAN, NSPCC, NIASW and NUJ (2012) *Guidance for the Media on the Reporting of Child Abuse and Non-Accidental Child Deaths*. <http://www.baspcan.org.uk/northernireland/> (Guidance for media organisations about the reporting of child deaths in order to reduce sensationalist reporting. The guidance was developed in conjunction with the National Union of Journalists and children's organisations, and cites **Reference 1** as being a key driver).