A Review of the Safeguarding Board for Northern Ireland (SBNI)

February 2016

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Preface

This Review was commissioned by the Department for Health, Social Services and Public Safety. Its remit is included as an appendix. We interviewed over 50 people, some on more than one occasion. We read public and confidential minutes of the SBNI Board, the Safeguarding Panels and the Committees, from 2012 to 2015. We attended several meetings of the SBNI Board and two Development Days, as well as meetings of the five Safeguarding Panels. We met two groups of young people, in Belfast and Ballymena, organised by Include Youth. We also talked to people with an overview of safeguarding in England, Scotland and Wales.

*In the recommendations we have concentrated on the key issues which we considered should be the highest priority for change and improvement. These are listed at the end of the report. Throughout the report we identified many other significant points which need to be addressed if multi-agency child protection is to be more effective in the future. These are marked in the text as *points of note*. Paragraphs containing 'points of note' are indexed in an appendix, for ease of reference.*

We would like to thank everyone involved for their help and co-operation, and particularly the staff of DHSSPS who were assigned to support us in this Review.

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Table of Contents

Executive Summary

The Safeguarding Board for Northern Ireland (SBNI) has been operational for over three years, with its first meeting in October 2012. Its first Chair resigned in October 2014 and was replaced by an Interim Chair in January 2015. At the time of writing she continues in that capacity until June 2016.

From the outset, the Board spent too much time on the wrong issues, and failed to deliver on its main statutory responsibilities concerning improved protection of children. There were also tensions between various elements of the Board's activities, such as the Board, the Safeguarding Panels, the Committees, the staff team and the CMR Panel, which were not addressed. Relations between the sponsoring Department, the Department of Health, Social Services and Public Safety, and the Board were reported by both Chairs to have been 'tense'.

Both the Board and the Safeguarding Panels had the statutory function of communication with children and young people. Whilst some consultation exercises had been carried out, and funding identified for this purpose, little progress had been made. This should be rectified in 2016, with the emphasis on local engagement.

Perhaps the most troubling concern was the lack of structured focus on the multi-agency aspects of child protection. The Board now needs to restate its core role of ensuring that work to protect children is properly coordinated. One way of addressing this would be to put formal arrangements in place for a child protection sub-committee in each of the Safeguarding Panels, though the Board would continue to set the strategic direction for this work. Each Board meeting could also be structured in two parts, with one part devoted exclusively to child protection.

There were differences of interpretation amongst members about the purpose of the Board and several governance matters. These included membership, quoracy, voting, conflicts of interests, and the question of independence. The focus on these over an extended period of time by the Board distracted it from its core business, leading to much frustration and polarised opinion. The Thematic Review of 22 CSE cases, which the Board undertook on Ministerial Direction, was seen by the majority of Board members as the key event, which 'blew the Board off course'. This occurred at an early stage in the Board's development. However, it was not the Thematic Review in itself which distracted the Board, but the way in which the members collectively chose to handle it. Some of these difficulties were related to the prescriptive nature of the Regulations and Guidance which the Board had to follow. These should be revisited and simplified.

Despite some recent progress, important functions set out in the Act and the statutory Regulations had not been delivered.

There were a number of statutory and non-statutory Board Committees, Panels and sub-groups, which some member bodies with limited staff resources found hard to support.

The Case Management Review Panel, whilst attended by a range of people with considerable expertise, had been unable to deliver its primary purpose of ensuring that learning from serious incidents was widely disseminated across Northern Ireland. Reviews took too long to complete. Partly this was due to the variable quality of the commissioned reports.

There is broad support in Northern Ireland for the commencement of the child death review function and establishment of the Child Death Overview Panel. However, we recommend that a phased approach is adopted with themed reviews initially and progression to individual reviews once the system is working effectively.

The relationship between the local Safeguarding Panels and the Board has been problematic. They appeared to operate in a disconnected way. Communication with the Panels by the Board had been poor, but latterly was improving.

Some of the SBNI members considered there was too much overlap and duplication of membership and function of different parts of the safeguarding system. These included reporting arrangements for Serious Adverse Incidents, the Children's Services Improvement Board, and the Children and Young People's Strategic Partnership.

Despite the areas of weakness identified above, nearly all of those interviewed were keen to see the retention of a region-wide body, with an Independent Chair, which fulfilled the overall intention of the legislation but with simplified Regulations and Guidance. Most members wished the local Panels to be empowered to get on with local matters.

The Board was well resourced, and should have been able to operate effectively within its budget. It was surprising that in a staff team of nine, there was a lack of clarity about roles and line management. There was insufficient oversight of business plan financial priorities, expenditure and procurement. There needed to be improvement in the governance of finance within the Board overall.

The roles and grades of senior staff should be reviewed, to make sure they fully support the Strategic and Business Plans of the Board. In the absence of an identified alternative, the hosting arrangements by the Public Health Agency should continue, but the agreed review mechanisms described in the Memorandum of Understanding should be implemented.

In a section comparing the systems of safeguarding and child protection in the UK, many aspects of the objective and requirements of the SBNI emerge as broadly consistent with the other nations. The key difference was the organisational context where local authorities in the other countries had a leading operational role in safeguarding and child protection. It was worth noting that governments in England, Wales and Scotland are all intending to make significant changes to their systems of safeguarding in 2016.

In the course of the present Review, the Minister for Health, Social Services and Public Safety announced it was his intention to abolish the Health and Social Services Board. The details of this are not yet known, but there are likely to be implications for the SBNI.

The present Review considered the future options for the improved delivery of the statutory functions of safeguarding now assigned to the Board. The first was the status quo, with little or no change, except for improving the current ways of working. We concluded that correcting identified shortcomings, whilst necessary, would not in itself be sufficient. Fundamental change in priorities, governance, CMR systems and Safeguarding Panels was needed if the considerable merits of a regional body were to be fully realised.

A more radical option would be to separate safeguarding from child protection. This could involve the creation of a statutory Child Protection Partnership, with an Independent Chair, in place of the current Board. The wider safeguarding agenda could then become the responsibility of an overarching Children and Young People's Strategic Partnership.

The immediate overriding priority, however, must be to refocus the work of the Board and its resources to demonstrably improve the protection of children in Northern Ireland.

1. Context

1.1 Many of the developments in safeguarding children in Northern Ireland paralleled arrangements and policy in England. This meant a gradual shift from the specific focus on child protection to the wider concept of seeing vulnerable children within the general system of child welfare and family support.

1.2 The key difference between safeguarding and child protection is that safeguarding is the activity in its widest sense to prevent children suffering any harm and being able to grow up being kept safe. Child protection is the process of taking action to protect individual children from significant harm (or risk of harm) as a result of abuse and neglect. This was the shift in focus from the previous Regional Child Protection Committee (RCPC) to the SBNI.

1.3 The SBNI was established in 2012 following the enactment of the Safeguarding Board (Northern Ireland) Act (2011). There was all party support for the legislation which created the SBNI.

1.4 The Minister for Health, Social Services and Public Safety at that time commented that the previous Child Protection Committees had been criticised for lacking focus, a strategic perspective and a legislative basis. The processes were also seen as too much dominated by Social Services and the Police. The proposals for change were 'overwhelmingly endorsed' from the consultation on the Bill.

1.5 The statutory objective of the Safeguarding Board is to co-ordinate and ensure the effectiveness of what is done by each person or body represented on the Board (by virtue of section 1(2)(b) and (4)) for the purposes of safeguarding and promoting the welfare of children.

1.6 The statutory functions of the SBNI include the following:

a) develop policies and procedures for safeguarding and promoting the welfare of children and young people;

b) promote an awareness of the need to safeguard children and young people;

c) keep under review the effectiveness of what is done by each person or body represented on the Board to safeguard children and young people;

d) undertake Case Management Reviews in cases where a child has died or been significantly harmed, or where there has been multi-agency involvement, and to learn from them; and

e) promote communications between the Board and children and young people.

1.7 The Board is obliged to submit to the Department an Annual Report, a copy of which must be laid before the Assembly.

1.8 The SBNI began its work in late 2012. The intention was that it should have responsibilities for strategic matters, and that five (local) Safeguarding Panels would have a coordination and implementation role. These Panels are statutory

and replaced four Area Child Protection Committees.

1.9 The legislation and the Regulations require the Board to undertake Case Management Reviews (CMRs) in accordance with the Guidance issued to the SBNI, and to establish a Case Management Review Panel.

1.10 It was also required to establish a Child Death Overview Panel, though this has not yet been commenced.

1.11 The first Chair was in place from 1 July 2011 to November 2014. An Interim Chair took up post in January 2015; her contract will extend to June 2016. There was a staff team of nine people to support the work of the Board. It was led by a Director of Operations. This post became vacant in November 2015.

1.12 The Minister for Health, Social Services and Public Safety recently announced significant changes to the organisation of health and social care and the current scheme of delegation which exists between the DHSSPS, the Health and Social Care Board (HSCB) and Health and Social Care (HSC) Trusts. The detail and timing of these changes are not yet known.

1.13 The terms of reference for the present Review are given in Appendix 1. Chapter 10 of the report gives a summary of recommendations, and in Appendix 2 there is a list of 'points of note' which need to be addressed in order to improve multi-agency working. A chart showing the structure of the SBNI is provided in Appendix 3.

2. Organisational Arrangements

Some tensions were evident in the sponsorship and hosting arrangements for the SBNI, and these should be resolved. Further debate about practical arrangements should not be allowed to divert attention from more pressing concerns the SBNI faced in discharging its statutory functions. The Memorandum of Understanding between the Department, the Public Health Agency and the SBNI should be reviewed regularly and should include a mechanism to resolve any operational difficulties.

There were several issues within the staff team which needed to be addressed. A review of senior staff roles should be undertaken, with particular attention to banding and the need for a Business Manager. Despite having to achieve savings in line with public sector organisations, the Board was well funded and benefited from secure funding from the Department year on year. Greater attention should be paid to delivering business plan priorities from within existing resources, including the resources held by partner agencies as well as the SBNI's direct allocation.

In the short term, the work of the Board should be more strongly focused on child protection. In the longer term, the creation of a statutory Child Protection Partnership should be considered as a replacement for the SBNI, with wider safeguarding sitting within an overarching Children and Young People's Strategic Partnership.

Sponsorship

2.1 The SBNI is an unincorporated statutory body, sponsored by the DHSSPS. The Department exercised oversight of the SBNI on a continuing basis.

2.2 The SBNI was required to provide regular performance reports and documentation demonstrating progress against Departmental priorities, and provide assurance as to the effectiveness of the SBNI systems. This included twice-yearly meetings between the DHSSPS Deputy Secretary and the SBNI Chair. An accountability meeting with the Interim Chair took place in December 2015 and other meetings had been held on specific issues.

2.3 There were some strong voices of opposition to the DHSSPS being the sponsor for the Board. Concerns were expressed about this during Assembly scrutiny of the draft legislation; this and related matters regarding the independence of the Board had given rise to much debate within the Board. The significance of these to some Board members is referred to later.

2.4 There were tensions between the Department and the Board during the tenure of the first Chair and the Interim Chair, reported by both incumbents. In 2013-2014 these tensions crystallised in how the Thematic Review into child sexual exploitation (CSE) was handled. The former Chair reported enjoying a very positive relationship with the senior official with whom he worked most closely. The Interim Chair referred to more routine concerns, such as the Board not being consulted on some relevant matters, and being advised of key decisions late on in

the process.

2.5 At the time of writing, the 2015 Annual Report had still to be finalised and laid before the Assembly.

2.6 The Interim Chair was of the view that it would be more appropriate for the Department of the First Minister/Deputy First Minister to sponsor the Board. That Department already held the remit for children's policy and also for the sponsorship of the Northern Ireland Commissioner for Children and Young People.

2.7 It would be impossible for any statute and related guidance to define the relationship between a Board and its sponsor Department in such detail that every eventuality was anticipated. More important is the way in which the Department exercised this responsibility on a range of matters and the willingness of the SBNI to work collaboratively with its sponsor Department to achieve mutually agreed objectives.

2.8 The present Review considered that the DHSSPS was an obvious location for sponsorship of the SBNI. More debate about this was likely to divert attention further from the core business of the SBNI and the many concerns that required more immediate attention.

Hosting arrangements

2.9 The Public Health Agency (PHA) acted as corporate host to the SBNI, discharging functions primarily relating to Regulations made under section1(5)(c)[1] of the 2011 Act. The PHA was accountable to the Department for its corporate host obligations to the SBNI but was not accountable for how the SBNI discharged its statutory objective, functions and duties.

2.10 The hosting arrangement was intended to enable the Board to function effectively within the resources made available to it by the Department. The PHA secured a number of functions including Human Resources, IT and Equality from the Business Services Organisation (BSO) under a service level agreement. Financial support was secured through a service level agreement between the PHA and the Health and Social Care Board (HSCB).

2.11 In September 2012, a Memorandum of Understanding (MOU) was agreed between the Department, the Public Health Agency, and the SBNI. It specified the roles, responsibilities and obligations of the three parties. The last paragraph of the document stated that the Memorandum would be reviewed after one year and every three years thereafter. A number of meetings had taken place but to date no formal review had been held. This should be rectified and reviews put on a regular, formal footing.

[1] Provision as to the staff, premises and expenses of the Safeguarding Board.

2.12 The MOU stated that the details of the SBNI expenditure would be reported within the PHA annual accounts. This aspect of the agreement should be reviewed, to clarify the level of detail to be reported.

2.13 The former Chair reported a range of difficulties associated with the hosting arrangement and considered that it led to the Board being organisationally quite isolated.

2.14 The former Director of Operations had strong views about the hosting arrangement with PHA, which she found to be 'very bureaucratic'. Areas that were most problematic included Human Resources, IT, Procurement and Equality. There was also duplication because SBNI had to go through the PHA to access services provided by the Business Services Organisation. She thought the SBNI should be able to deal directly with the BSO without the involvement of the PHA.

2.15 The MOU stated that the hosting arrangement would allow the SBNI to take advantage of the relationship the PHA had with the Business Services Organisation and the Health and Social Care Board and therefore minimise the administrative apparatus necessary to support the SBNI.

2.16 In a submission to the Review, the former Director of Operations observed that the SBNI had received advice, but no direct assistance in respect of functions such as equality impact assessments, development of business cases, single tender actions, procurement and many other areas.

2.17 The PHA advised the present Review that the provision of direct assistance in areas such as preparation of business cases and procurement was not within the scope of the hosting arrangement. It considered that the Operations Directorate had provided the SBNI with at least as much support and guidance as it would to any other Directorate within the PHA. It did not have a central corporate unit to develop business cases or do single tender actions. More widely, in areas not covered by the hosting arrangement, such as risk management and information governance, the PHA had shared its own documents and processes to assist the SBNI develop and manage its own systems.

2.18 The PHA did not have its own equality unit, but secured equality services from the Business Services Organisation, through the PHA service level agreement. The SBNI contributed an amount to this service level agreement, to secure support on equality matters.

2.19 It was evident from the above that there were different expectations between the SBNI, the PHA and the BSO about the level of support to be provided to the SBNI. This needed to be clarified in order to support the smooth operational running of the SBNI, and should be addressed at an early stage. ***This is a point of note*.**

2.20 During the present Review, we met with the Chief Executive and senior managers in the PHA, including the Chief Accountant whose team was responsible for providing financial support to the SBNI. They confirmed that the SBNI sat within

the reporting structure of the PHA for accounting purposes and was supported by the HSCB Finance Directorate.

2.21 The SBNI received monthly budget and expenditure reports as with other budget holders. There were regular review meetings with finance staff regarding budget setting, projected financial position and financial governance. Despite reported difficulties, the present Review was satisfied that the SBNI had received an appropriate level of support from the finance team.

2.22 Issues of financial management and reporting within the SBNI are covered in Chapter 3.

2.23 The SBNI was required to conform to PHA financial regulations and procurement rules. Two significant procurement issues had arisen, concerning the Thematic Review and the appointment of an Interim Independent Chair.

2.24 Despite the dissatisfaction expressed by the SBNI about the hosting arrangement, there was no obvious alternative given the planned restructuring of health and social care. When reviewing the MOU, it would be helpful to reconsider operational liaison arrangements, so that any practical difficulties could be resolved more speedily.

Membership and Attendance

2.25 The membership of the SBNI is prescribed. The draft 2015 Annual Report indicated it had 29 members, and gave information about attendance in 2014/15:

% attendance	Number	Agencies / Representatives
92%	6	Chair, Lay Members (2), Children in Northern Ireland, Designated Doctor, BHSCT
81%	15	NSPCC, CMR Chair, WHSCT, Banbridge District Council, Youth Justice Agency, Belfast ELB, HSCB, Children's Law Centre, Lay Member (1), Probation Board, Action for Children, SEHSCT, NHSCT, Designated Nurse, Barnardo's NI,
55%	4	PSNI, Director of Nursing, SHSCT, Include Youth
40%	2	Newtownards Council, Director of Public Health
30%	2	General Practice, Prison Service

Board and staff roles

2.26 In May and September 2014, the Board held two workshops. The second of these focused on governance and implications for different roles. The report of this workshop referred to the view that the structure created tensions between certain roles and gave examples of these:

- Chair and Director of Operations
- Director of Operations and the 5 Area Safeguarding Panels

- Panels and the SBNI Board/Chair
- Chair of CMR and Chair of the SBNI
- Director of Operations and Committees of the Board.

The Staff Team

2.27 The staff team were employees of the PHA. The Team comprised a Director of Operations (vacant from November 2015), two professional officers, an office manager, a part-time manager for the Child Death Overview Panel, and four administrative staff.

2.28 Low staff morale was identified in the 2015 mid-year Assurance Statement and the SBNI risk register, and attributed to anxiety amongst staff about the present Review. However, from interviews with staff members and others, it was clear that staff morale issues predated the commissioning of the present Review. Some staff members raised concerns with us about leadership and the sense of a blame culture. Some expressed frustration at the lack of clarity on reporting lines and were unsure what their job was. Generally, we considered that the staff team would benefit from improved leadership and more consistent support.

2.29 The professional officers worked with Committees, but their roles went beyond professional advice. At times they were required to operate in an administrative 'servicing' role or became involved in project development. These responsibilities did not require input at such a senior professional level.

2.30 Several Board members referred to the need for the staffing to be reviewed, in particular the role of Director of Operations and the professional officers. This was not to suggest they did not do valuable work, but rather raised the question of whether their current work fitted the Board's objective and priorities.

2.31 Amongst HSC Trust Directors, there was a strong view that the hosting and the staff team should be lodged with one of the larger partner agencies, rather than the PHA, as this would make them feel less 'isolated', and improve relations with the Trusts. They also thought the staff team should support the work of the Safeguarding Panels.

2.32 In 2014, a Service Review of the structures, processes and working practices of the staff team was carried out by the Health and Social Care Leadership Centre, at the request of the Director of Operations. Whilst it was noted that staff generally worked well together, the Service Review report identified some areas for improvement pertinent to staff roles. These included concerns about banding, role clarity and lack of induction and training.

2.33 A number of staff commented on the grading structure and the significant gap between grades at the senior level of the organisation and others. This had at times resulted in a reluctance to engage in new tasks. The level of administrative support to the Chair was an area of ambiguity, as was the role of the communications operation. There also appeared to be a conflict between the

administrative staff and the senior staff about the level of secretarial support provided.

2.34 Staff at all levels commented that new people did not receive adequate induction, and this was exacerbated by the absence of written processes and procedures. This was particularly relevant to the administrative staff team where there had been a high level of turnover. The Service Review thought this might explain the dissatisfaction of professional staff with the quality of some of reports and minutes, although it was not clear that their expectations had ever been fully explained to business support staff.

2.35 The Service Review painted a picture overall of a busy group of people who were not provided with the necessary leadership to resolve some basic system and process concerns. We were told that the findings of the Service Review were implemented. However, similar concerns were repeated to the present Review in 2015, suggesting they had not been fully addressed.

2.36 Both the former Chair and the Interim Chair held the view that the role and grading of the Director of Operations should be reviewed. There was agreement that it would be more appropriate for the post to be a Business Support Manager, with remuneration reflecting that role. This required further consideration, and would require a change in the Regulations.

2.37 The present Review also identified banding as needing to be addressed. From figures provided by the Director of Operations, we calculated that taken together the 4 most senior posts in the staff team, equivalent to 3.6 full time posts, accounted for 32% of the core financial allocation.

2.38 The present Review considered that the process whereby staff grades were decided was not sufficiently transparent. Although appointments were made in line with PHA procedures there was a lack of input by the Board into decisions which had financial consequences.

Recommendation 1

A review of senior staff roles and grades should be undertaken quickly. The role of the Director of Operations, whose appointment is prescribed in Regulations, should be refocused to one of Business Manager, and the number and grades of professional officers and the Business Manager (CDOP) should be revisited. The establishment and grading of posts should require the approval of the Board or one of its Committees.

Funding

2.39 In the 14/15 financial year, the SBNI received £1,030,424. The draft 2015 Annual Report gave the following details of income and expenditure:

SBNI INCOME AND EXPENDITURE 2014/2015

INCOME	£	£
DHSSPS – Recurrent Funding	777,767	
Health & Social Care Board (CMRs)	71,645	
DHSSPS - Thematic Review	133,000	
DHSSPS – Preventative Education	48,012	
Total	**1,030,424**	
EXPENDITURE		
Independent Chairs & Lay Members		111,534
SBNI Staff		436,022
GP Fees		4,390
Thematic Review (K9SB02)		159,040
CSE Advertising Campaign (K9SB03)		36,514
CMR (K9SB04)		12,405*
CSE Preventative Education (K9SB06)		47,290
SBNI Committees (K9SB05)		21,711
Sundries (K9SB01)		129,045**[2]
Rent		45,393
BSO re-charge		13,954
Total Expenditure		**1,017,298**
Underspend	**13,126**	

2.40 In line with reductions in public funding, savings of 5% had to be achieved in its 2015/16 budget. Options had been submitted to the Department on the 2016/17 budget and a decision was awaited.

2.41 The present Review considered that the SBNI was well funded. In contrast to Safeguarding Boards in England, it benefited from secure funding from the Department year on year. We noted statements that additional funding would be needed to progress work on business plan priorities. For example it was recorded in a minute of the Chair's Business Group that no further work would be carried out on safeguarding children with a disability because there was no funding available for it. This was not a helpful approach. The SBNI needed to promote partnership working across member agencies in order to ensure best use of resources to deliver agreed priorities.

[2] * The cost centre for CMRs was only created in the final quarter 2014/2015 Financial Year. All other CMR expenditure prior to that period was included in the ** Sundries spend.

Future Options

2.42 The present Review considered future options for the improved delivery of the statutory functions of safeguarding now assigned to the Board. The first option was the status quo, with little or no change, except for improving the current ways of working. We concluded that correcting identified shortcomings, whilst necessary, would not in itself be sufficient.

2.43 The second option involved more fundamental changes in priorities, governance, the CMR system and the Safeguarding Panels. These would all be essential if the considerable merits of a regional body were to be properly realised. In Chapter 8, we suggest that at a minimum, the Board should convene annual meetings for the sole purpose of securing sufficient focus on protecting children in Northern Ireland, on a multi-agency basis. This would be a short term, interim measure only.

2.44 A more radical option would be to reconfigure the various regional bodies concerned with safeguarding, child well-being and child protection This could include the creation of a statutory Child Protection Partnership, with an Independent Chair, as one of its components, in place of the current Board. Its membership should be drawn from those agencies with statutory responsibilities to protect children. The wider safeguarding agenda could then become the responsibility of the revised overarching Children and Young People's Strategic Partnership. In this way, safeguarding and the promotion of children's welfare might more appropriately be undertaken by other parts of the system.

Recommendation 2

In the longer term, consideration should be given to rationalising the various regional bodies concerned with safeguarding, child well-being and child protection, including the creation of a statutory Child Protection Partnership, with an Independent Chair. The wider safeguarding agenda could sit within the revised overarching Children and Young People's Strategic Partnership**.**

3. Planning, Improvement and Partnerships

The Board's Strategic Plan set five top-level priorities for the plan period. The Business Plan for 2015/16 did not include performance targets and budget information and the planning process required development.

There was insufficient transparency around decision making about budgets and procurement. Action had been taken recently to address these problems.

Work had been done on learning and improvement, but the Board did not yet have an agreed performance framework. There was a range of partnership activity, although this could be strengthened. A second round of Section 12 audits had been completed, using an online system.

3 year Strategic Plan

3.1 Section 5.2 of the SBNI Guidance requires a draft 3-year strategic plan, supported by an annual Business Plan, to be submitted to the Department for approval. Section 5.5 of the Guidance requires the SBNI to produce an annual report which the Department must lay before the Assembly. (Section 6(1) and section 6(2) of the SBNI Act).

3.2 The Strategic Plan was finalised in January 2014. It covered the period from September 2013 to March 2017. In the text itself, the period was stated to be from April 2013 to March 2016. The Plan was subject to wide consultation and an equality impact assessment.

3.3 The first Strategic Plan listed five top-level priorities:

a) working in partnership to ensure children and young people are living in safety and with stability;

b) protect and safeguard children by responding to new and emerging concerns;

c) providing leadership and setting direction;

d) driving improvements in the current child protection system;

e) building the capacity of the Safeguarding Board in the medium term.

3.4 The Plan discussed a list of priorities. These included children who experience multiple adversities, children who display sexually harmful behaviours, children with a disability, looked after children, children who are victims or at risk of sexual exploitation and the emerging theme of children at risk because of digital technology. These were converted to a list of actions under the five headings. Perhaps understandably so early in the life of the SBNI, there was an emphasis on processes, procedures, strategy development and learning. It was not possible to tell from the Plan what difference the SBNI hoped to make to children's lives.

Annual Business Plan

3.5 The annual Business Plan should support the implementation of the 3-year Strategic Plan. The Guidance states that it should include key actions, supported by performance targets and indicators, to be undertaken in the year ahead. It should also include budget information.

3.6 The second Business Plan covered the year to March 2016. It went to the Board for approval at the end of May 2015.

3.7 The Interim Chair had taken action to bring forward the preparation of next year's plan so that it was ready to be approved before the start of the new financial year. A Board Development Day, held in October 2015, was the start of the 2016/17 planning process.

3.8 The planning process was still in the early stages of development. The rationale for including some issues in the Business Plan and omitting others was not clear. The current plan did not comply with the Guidance in relation to performance targets and indicators. It did not contain budget information or a financial plan, which would be considered good practice.

3.9 The recent Development Day received a presentation from the Director of Operations on 'what had been achieved' by the Business Plan, and what had been carried forward.

3.10 At the same Development Day, the Interim Chair proposed a themed approach in the next Business Plan. There was consensus that this should be 'Neglect'. It was not clear what activities would underpin this theme and how this would affect existing and future Business Plan priorities.

Financial planning and management

3.11 The SBNI operated within approved PHA financial and procurement procedures. However, the PHA had no role in determining the SBNI Business Plan priorities, which were a matter for agreement between the sponsor Department and the SBNI.

3.12 Several members of the SBNI Board had requested regular financial reports, but these required improvement. Expenditure was reported inconsistently. There was no clear statement of the approved budget, spend to date and projected year-end expenditure.

3.13 The process for deciding the allocation of funding to Business Plan priorities was not transparent.

3.14 Some monies that had been 'earmarked' in the 2015/16 budget for business plan priorities were not spent in the current financial year. This could have been anticipated and part-year expenditure planned for. Underspends were being used to balance the budget bottom line.

3.15 As indicated earlier, the present Review was satisfied that an appropriate, and indeed substantial, amount of financial support had been provided to the SBNI by the PHA/HSCB Finance Team. We were advised that lack of progress on improvements such as aligning cost centres to Business Plan priorities was the result of the SBNI not providing the Finance Team with the necessary information in a timely manner.

3.16 A significant amount of work was outsourced, without a clear rationale or explicit approval for this. Accountability for procurement decisions was blurred and there was no clear trail of approval linked to the level of proposed spend. ***This is a point of note*.***

3.17 In the course of the present Review, we brought concerns about finance and procurement to the attention of the Interim Chair, who initiated a review of the SBNI financial systems. She also advised that procurement activity was being reviewed.

3.18 The Interim Chair was in the process of introducing a more robust system for financial reporting. When implemented, this would satisfy compliance with good practice in terms of accountability for public funds.

3.19 In chapter 7, we include a recommendation about the SBNI establishing arrangements for oversight of finance and audit.

Partnerships

3.20 The present Review heard that the SBNI had been superimposed upon what was already a complex set of partnership arrangements. This resulted in a lack of clarity over whether the SBNI should deliver certain activities itself, as opposed to what member bodies should deliver in the course of discharging their statutory functions.

3.21 There was no clarity about responsibility for producing guidance and procedures – for example, the HSCB and the Police had recently produced Missing Children Procedures but the SBNI produced CSE procedures.

3.22 Many believed that locating the SBNI within the Health and Social Care Board with an Independent Chair would have strengthened partnership working and facilitated closer links between the SBNI and the Children and Young People's Strategic Partnership (CYPSP). Others were strongly opposed to this because of fears about independence being eroded. In any event, this debate had been overtaken by the recent announcement about the restructuring of health and social care. Assuming that the CYPSP continues in the new configuration of health and social care, there would be considerable merit in closer alignment of the two partnerships.

3.23 The Children and Young People's Strategic Partnership and the SBNI had a Memorandum of Understanding (MOU) covering the period April 2015 – March 2016. There had also been an MOU in place covering the previous year. It set out

their distinctive functions and areas for joint working.

3.24 The SBNI had worked with the CYPSP and the HSCB in developing its draft Effective Practice and Improvement Model, which took as its starting point data which was already being collected.

3.25 The SBNI had good links to the public protection arrangements (PPANI). The former Director of Operations attended its strategic management group. There was crossover between them on the Sexual Violence Strategy, the Domestic Violence Review, and the Children and Young People's Strategic Partnership. There had been joint work on a PPANI Serious Case Review.

3.26 There was a large degree of overlap between membership of Local Area Public Protection Panels and local Safeguarding Panels, but their functions were quite different, with the former focusing on the management of individual offenders.

3.27 No close links existed between the SBNI and the Northern Ireland Safeguarding Adults Partnership (NIASP), which sat under the HSCB. The Partnership had one full time coordinator with secretarial support. It worked largely through dedicated adult safeguarding specialists based in each of the HSC Trusts. The Chair and coordinator considered this was a very effective mechanism to get things done. They thought that safeguarding adults was much higher on the agenda than it was before NIASP was set up, and that tangible improvements had been made. The DHSSPS had introduced a new policy on adult safeguarding in 2015.

3.28 The reported success of NIASP in raising the profile of safeguarding and bringing about improvements in practice raised the question of whether lessons could be learned from this model. This would involve the SBNI developing stronger links with Assistant Directors who hold the lead for children's safeguarding in the HSC Trusts.

3.29 The SBNI had in place a number of other MOUs, although some had not been formally signed off at the time the present Review was conducted. MOUs included agreements with the Northern Ireland Social Care Council, the Regulation and Quality Improvement Authority (RQIA) and, in respect of the Thematic Review, an agreement with the Police Service of Northern Ireland (PSNI) and the Public Prosecution Service. The MOUs were not reviewed annually, as stated in some of the agreements. A less frequent review schedule might be less onerous.

3.30 A major gap was that an MOU with the Police and the Public Prosecution Service had not been put in place, in respect of CMRs/IARs. We return to this later.

Learning and Improvement

3.31 In 2014, the SBNI identified the need to develop a multi-agency framework that would enable it to understand the effectiveness of safeguarding arrangements and promote shared learning and improvement priorities across Northern Ireland. Work was commissioned and undertaken to develop an Effective Practice Improvement Model. The proposed model emphasised the importance of shared

knowledge, reflection and shared understanding to bring about learning and improvement.

3.32 A report 'A Journey towards Monitoring Effectiveness and Making Improvements in Children's Safeguarding in Northern Ireland' was approved as a consultative draft in March 2015. The report proposed an information framework (quantitative and qualitative), based largely on data sets and other information currently held by the CYPSP and HSCB information staff.

3.33 This was a positive initiative. In response to consultation, it had been decided to phase in key areas as a starting point. This work had not been completed. In its absence, the Board did not yet have an agreed performance framework, and needed to clarify responsibility for driving this forward. ***This is a point of note*.**

3.34 In the proposed framework, data on CSE/Missing Children was identified as requiring significant regional dialogue. No qualitative data sources were identified, although regular case audits could have been suggested. Improving information about CSE was an outstanding recommendation of the Marshall Report, which needed to be progressed by the SBNI.

3.35 At the time of the present Review, CSE monitoring appeared to be carried out by Children's Services and the Police. The lack of structured input from Education was a major gap. Although CSE was a standing item in the confidential section of all Panel meetings, reporting was mainly in the form of verbal reports. By comparison with some Safeguarding Boards in England, the SBNI did not appear to have effective multi-agency mechanisms for measuring, monitoring and reporting the scale of CSE across Northern Ireland. ***This is a point of note*.**

3.36 Alongside the work on the learning and improvement framework, the NSPCC led a review of effective safeguarding practice and improvement in multi-agency working, based on a study of 12 Local Safeguarding Children's Board (LSCBs) in England and Wales, where performance was judged to be good. This was a helpful piece of work that captured learning to inform system improvement in Northern Ireland. It found that the SBNI shared the same challenges as LSCBs and could learn from LSCBs which were performing well.

Assurance and Accountability

3.37 Assurance arrangements are set out elsewhere in this report.

3.38 There were some issues with the content of the most recent draft assurance statement presented to the Board in September 2015. The Interim Chair resolved these before the statement was submitted. The statement highlighted internal control problems and issues of staff morale.

3.39 There was some criticism from member bodies about the Section 12 audits that SBNI conducted annually as stipulated in the Guidance. In 2015 a system was developed to allow the audits to be completed online. The SBNI lead professional officer reported that the new system had brought about improvements, which had

been welcomed by member bodies. However, it was going to take a large amount of officer time to analyse the audits and prepare feedback. This was deferred following the departure of the Director of Operations. The Interim Chair had plans to streamline the process with the possibility of repeating the Audit every two years.

3.40 The SBNI had not yet reached the stage of being able to report on its own effectiveness or the effectiveness of member bodies. In a foreword to the 2015 draft Annual Report, the Interim Chair acknowledged that the report was mainly about activities and progress made. Things that needed to be done better included evidencing that the Board was effective in having an oversight of the performance of all agencies, and also evidencing that the work of the Board made a difference.

4. Case Management Reviews

The Case Management Review Panel was working well but was let down by the system and processes underpinning its work. It was chaired effectively. The Panel is one of the strengths on which the SBNI could build improvement.

CMRs were the source of widespread frustration and criticism. The current CMR and IAR[3] review processes were resource intensive. There were concerns about duplication and delays. As a consequence, learning from CMRs had not been shared across the region. There was a large measure of consensus over what needed to improve. Most of the improvements could be brought about by the SBNI, although a small number of changes required review of the Regulations and/or Departmental Guidance.

The Case Management Review Panel, working with the local Safeguarding Panels, should be given lead responsibility for disseminating regional learning and monitoring implementation.

Purpose of CMRs

4.1 One of the statutory functions of the SBNI is to undertake CMRs. The Regulations prescribe the circumstances when a CMR must be notified and undertaken. The Regulations were amended in 2014[4], and revised Guidance was issued by DHSSPS in May 2014.

4.2 The Guidance was clear about the purpose of CMRs, the approach to be adopted and the principles that should govern case management reviews. Although the Guidance emphasised that CMRs were about learning and not about blame, the perception that CMRs were about attributing blame was deeply rooted.

4.3 Many of those interviewed told us that there were hopes that the establishment of the SBNI would lead to new approaches to learning from case management reviews. The lack of change led to frustration and disappointment.

SBNI Guidance on the CMR Process

4.4 At the time of the present Review, the SBNI had not put in place an effective CMR handling procedure, as the Guidance required. A draft was prepared in 2013, but publication was delayed because of changes in the Regulations that took effect in May 2014, coupled with clarification that the full SBNI rather than the Chair had to deal with recommendations from the Panel.

4.5 Revised CMR Process Practice Guidance was completed late in 2014, but consultation was delayed because the incoming Interim Chair had some reservations about the CMR process. It was eventually put out for consultation in June 2015. At the end of the consultation period, the Interim Chair decided that

[3]CMR = Case Management Review; IAR = Individual Agency Review, carried out by each agency involved in the case and fed into the Case Management Review.

[4] Section 17(2)(d) was added to include significant learning from the case as a criterion for CMRs.

the Practice Guidance should be 'paused', pending the outcome of the present Review.

4.6 The draft Practice Guidance was generally welcomed. It required some further work and amendment in order to make sure that examples of 'significant harm' were consistent with the DHSSPS Guidance, particularly concerning notifications; to give a clear statement about early dissemination of learning to the five local Safeguarding Panels; and to avoid unrealistic timescales.

CMR Register

4.7 Departmental Guidance requires the SBNI to maintain a CMR register, which must include the details of each CMR undertaken; the learning identified; the method of disseminating learning from each CMR; the actions agreed to implement the learning; and any follow-up action taken by the SBNI to ensure that learning has been applied.

4.8 The SBNI maintained information about CMRs on a series of spreadsheets but there was no CMR register. This should be developed in an accessible format and shared with local Safeguarding Panels to assist the flow of communication.

The CMR Panel

4.9 The CMR Panel met monthly, was regularly attended and had a stable membership. As required, it had an Independent Chair who was also a member of the SBNI. There were many positive comments on the Chair's performance, both from members of the CMR Panel and more widely. The Chair was highly regarded because of his expertise in CMRs, child protection and safeguarding. He had an excellent understanding of the complex issues involved in carrying out case management reviews.

4.10 Panel members had relevant experience, knowledge and seniority and were capable of taking complex decisions about child protection. The present Review considered the Panel to be a strength on which improvement could be built.

4.11 The CMR Panel did however face many challenges in relation to decision-making, delays in the system and dissemination of learning.

4.12 The Chair of the CMR Panel identified important strengths in the CMR process, compared to arrangements under the former Area Child Protection Committees and the Regional Child Protection Committee (RCPC), of which he had direct experience. These included greater transparency, inclusiveness, good buy-in from different agencies, and better recognition of the benefits of challenge. Others interviewed had a different view and considered that things had worked better under the former arrangements.

Notifications

4.13 The Guidance explicitly states that in considering whether cases met the criteria of

Regulation 17(2), the **only** consideration for member bodies is whether elements 17(2)(a) – child had died or been significantly harmed; **and** 17(2)(b) – abuse/neglect suspected **or** child or sibling on child protection register **or** child or sibling is/has been looked after were present.

4.14 Despite the clarity of the Guidance, the decision about whether or not to notify was sometimes problematic. There were examples of discussions at Safeguarding Panels straying into areas covered by other parts of the Regulations, in particular 17(2)(c) (effectiveness) and 17(2)(d) (significant learning). These were not matters to be considered in the notification of cases.

4.15 Excluding legacy cases, 27 notifications had been received by the SBNI. There was one notification in 2012; 11 in 2013; 11 in 2014 and only 5 by early December 2015. The drop in notifications in 2015 had been discussed at the CMR Panel and the Board's Development Day, and the CMR Chair was alert to the need to monitor trends and explore possible reasons.

4.16 A small number of interviewees (who held senior positions in their own agency) suggested that adolescents who met the CMR criteria were less likely to be notified than younger children. There was confusion about whether the death or significant harm of a looked after teenager would be dealt with through the Serious Adverse Incident procedure rather than the CMR process. There had been three notifications in respect of adolescents to the SBNI (two went to CMR and one did not).

4.17 A Health and Social Care Board Procedure, dated October 2013, routed the deaths of looked after children and children on the child protection register through the Serious Adverse Incident process. It referred to 2010 guidance issued to HSC Trusts on 'Untoward Events relating to Children in Need and Looked after Children'.

4.18 The HSBC 2013 procedure made no reference to the statutory duty to notify the SBNI under section 17(2)(a) and 17(2)(b) of the Regulations, as set out above. This was a major omission and should be rectified without delay. ***This is a point of note*.**

4.19 Notifications because of suicide or self-harm of looked after children were fewer than those received by the former RCPC. The reasons for this had not been explored and merited scrutiny by the SBNI and member bodies to make sure that all deaths were notified.

4.20 The former Director of Operations stated that work was ongoing to examine cases reported under the Serious Adverse Incident procedures that met CMR criteria but had not been notified. This work did not appear to have been followed through.

Recommendation 3

All agencies must make sure that the SBNI is notified of all deaths and significant harm to looked after children and those on the child protection register, so that these cases

can be dealt with through statutory CMR procedures.

Decision making about CMRs

4.21 Once a notification is received, the task of the CMR Panel is to consider whether the case meets Regulation 17(c) (concerns about the effectiveness of agencies involved) **and** Regulation 17(d) (significant learning from the case). A recommendation then goes to the SBNI, which takes the final decision.

4.22 Until May 2014, decisions were taken by the Chair of the SBNI, acting on a recommendation from the CMR Panel. There was evidence of scrutiny and challenge by the SBNI Chair in exercising this responsibility.

4.23 It was then clarified that there was no provision in the Regulations for decisions to be remitted to the Chair. Instead, recommendations needed to be considered by the full SBNI Board.

4.24 Apart from the difficulties created by having to obtain retrospective approvals from the SBNI, this became contentious for two reasons. Firstly, it introduced delays into the process; and secondly, there was a widespread perception that some members of the SBNI Board lacked knowledge and experience of child protection. The requirement for the full SBNI Board to take the decision, as opposed to the Chair deciding on a recommendation from the CMR Panel, did not make sense to many professionals involved in child protection.

4.25 Some commented that there was a reluctance to hold CMRs and that HSC Trust representatives on the Panel would find it difficult to take opposing views on a case. However, the Chair of the Panel considered that over time, agencies had been able to move from a defensive position.

4.26 These are not problems unique to Northern Ireland. In England the panel of independent experts found "a deep reluctance in some instances to conduct Serious Case Reviews (SCR)"[5].

4.27 From our observations, the members of the CMR Panel took their responsibilities seriously and there was robust challenge within the Panel when contentious issues had to be dealt with.

4.28 Recommendations and decisions about CMRs were taken by voting. A few people had a perception that some agencies would always vote against a CMR, but it was difficult to establish evidence for this.

4.29 The legislation requires the SBNI to take decisions by voting. However, the present Review considered that consensual decision-making would be a more appropriate way to take decisions on matters involving deaths or significant harm to children. Majority voting had the effect of obscuring accountability.

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[5] First Annual Report of the National Panel of Independent Experts on SCRs (July 14).

4.30 There was no mechanism for multi-agency learning in cases which met the criteria for notification but where the decision was that the case did not meet the criteria for a CMR. Particularly in cases where opinion was divided, the CMR Panel should have the option of remitting a case to the respective Safeguarding Panels for inter-agency discussion and learning. The CMR Panel would receive the Panel's findings and assume responsibility for disseminating any learning across the region.

4.31 The Interim Chair favoured greater involvement of the Safeguarding Panels including the identification of peer IAR authors.

Conduct of Reviews

4.32 Virtually no one was satisfied with the conduct of reviews. Concerns included lack of consistency, delays, and duplication between IARs and the CMRs. IARs often did not fit well with the Terms of Reference, and the latter needed to focus more on critical events. Sometimes staff were interviewed by the IAR team and by the CMR team, which was not helpful.

4.33 CMRs and IARs were resource intensive processes. They were added on to the normal duties of senior managers/professionals.

4.34 Independent Chairs experienced great difficulty when they had to both chair and minute CMR Team meetings. They needed additional support to ensure a full record was kept of each Team meeting, and this should be possible within the resources of local agencies. ***This is a point of note*.**

4.35 The Guidance is not prescriptive about the methodology to be adopted in case reviews. There was general dissatisfaction that the historic methodology for CMRs had survived unchanged in the transition to the SBNI, and there was consensus that new approaches should be tried out with a view to delivering quicker, relevant learning.

4.36 The CMR Panel Chair considered that the key components of any case review system were:

a) clarity about the terms of reference;

b) a capable reviewer/author (the CMR Team Chair);

c) good quality information to inform the review;

d) a clear brief on what the end product should look like; and

e) agreement on what the review and CMR report were intended to achieve.

4.37 Along with the CMR Panel, he favoured having options for reviews, ranging from an in-depth review, akin to the current CMR, to a limited number of other processes for lighter touch and quicker reviews.

Quality of CMR reports

4.38 The Independent Chair of the CMR Panel gave his considered opinion on the

quality of CMR reports compared to those produced by the former Area and Regional Child Protection Committees. He had extensive experience of reviewing CMR reports[6] and learning in other parts of the UK and elsewhere, and also direct experience of working with the former Area Child Protection Committees.

4.39 He considered that the quality of reports had improved under the SBNI. Reports were more consistent and over time they were developing a common style. He recognised that there were still many matters to be addressed through training, guidance and support. Overall he thought that CMR reports were better than under the previous system.

4.40 Notwithstanding the historic comparison, there were real concerns within the SBNI about the quality of CMR reports, both those completed and those in progress. Reports were considered to be too long, repetitive and lacking in SMART[7] recommendations. Poor quality reports were cited as a major reason for the delay in concluding the reviews.

4.41 Recent findings in England[8] about the quality of SCRs were applicable. Reports were criticised for having too much detail, whilst failing to present clear findings. What was needed was "a report which succinctly and clearly encapsulates what happened, why and what should be done to prevent a recurrence".

4.42 The present Review examined the process of providing comments on draft CMR reports. It required overhaul. Far too many people commented on the draft and the process of collating comments delayed the process still further. Moderation of content and quality should be restricted to the CMR Panel Chair and one professional officer. We were advised that improvements had been put in place in December 2015. In instances where draft CMRs were of poor quality, the moderation process should aim to have a positive influence on future performance. ***This is a point of note*.**

4.43 The CMR Panel Chair's comments on draft reports were helpful and proportionate.

4.44 We read four signed-off CMRs and two that had reached draft stage. Most were too long and repetitive. The template for CMRs was being revised to reduce the tendency towards repetition.

4.45 The quality of analysis in the four completed reports was variable. In one case, the analysis was excellent and covered all the relevant points, although the report was long and repetitive. In some reports the quality of assessments was weak and some salient points appeared to have been missed or glossed over.

4.46 The number of recommendations made in the four completed cases ranged from 19 to 4. Recommendations tended to be general, and about processes and

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[6] Translating Learning into Action: An overview of learning arising from Case Management Reviews in Northern Ireland 2003 – 2008 (January 2013).
[7] SMART = Specific, Measurable, Achievable, Realistic and Timely.
[8] Second Annual Report of the National Panel of Independent Experts on SCRs (November 2015).

procedures, rather than action that would support practice improvement.

4.47 There was agreement that CMRs would have more impact on learning if recommendations could be kept to a manageable number of key issues.

4.48 Recent findings[9] suggest caution in insisting that recommendations must meet SMART criteria. In the past, English SCRs have led to action plans with large numbers of SMART recommendations. These appeared to have encouraged an overly simplistic and mechanistic approach to change. Recommendations needed to be forward looking, less concerned with planning and process and more focused on providing Safeguarding Boards with strategic challenge and reflection.

4.49 In advance of the CMR findings being disseminated, implementation of IAR recommendations were usually driven forward. IARs developed by the local HSC Trust were reviewed at Safeguarding Panel meetings, but there was no agreed mechanism for the Panels to review and monitor IARs produced by other agencies.

4.50 A number of recommendations in CMR reports were addressed to the SBNI. With the exception of co-sleeping, which had been actioned, it was not clear that the SBNI had any mechanism to action or monitor CMR recommendations. The present Review was advised that staff were working on this.

Chairs of CMR Teams

4.51 In 2013, the SBNI recruited a pool of seven independent people to lead and produce CMRs. At the time of the external Review, five were engaged in CMR work.

4.52 The Team Chairs, in conjunction with the Chair of the CMR Panel, performed well on engaging with families during the CMR process.

4.53 The SBNI draft CMR Process Practice Guidance stated that Team Chairs would sign a contract for a period of three years and would be subject to satisfactory performance as determined by the SBNI Chair and CMR Panel Chair. This was too vague a statement. The Board should be specific about what constituted satisfactory performance, how it would be assessed and whether Chairs would have a right of appeal. It is important to avoid any suggestion that Chairs might be penalised for exercising their independence

4.54 In many parts of England, separate report authors assisted Independent Chairs of SCRs. The SBNI could consider adopting this approach. ***This is a point of note*.**

CMR Timescales

4.55 The Guidance states that CMRs must be completed as soon as practicable and as a general rule within nine months of the decision to undertake a review.

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[9] ADCS Virtual Staff College work on Serious Case Reviews.

4.56 The SBNI Annual Report should record the total number of CMRs completed in the reporting period, and the average time taken to complete reports. Annual Reports did not include any information about time taken.

4.57 To date, nine CMRs had been undertaken. In the three years to December 2015, the SBNI had signed off four CMRs, including 2 legacy cases where there had been long delays (2yrs 9 months in the first case, 1 year 9 months in the second) prior to transfer from the RCPC to the SBNI. Both legacy cases took just over 2 years to complete after notification to the SBNI. The other five CMRs were in varying stages of completion.

4.58 The time taken between the event, notification and a decision was 3 months or less in most cases. A small number of cases were significantly delayed at this stage, but it was apparent that this was because cases were deferred to obtain more information, rather than through administrative delays.

4.59 The table below shows time taken between decision to hold a CMR and sign-off by the SBNI. No cases had been completed within the nine-month timescale.

Case No	SBNI decision	Sign-off by the SBNI	Time taken (to December 2015)
1	December 2012	June 2015	2 years 6m
2	April 2013	June 2014	1 year 2m
3	September 2013	2 years 3m to date (sign off expected December 2015)	
4	February 2014	Not signed off – 1 year 10m to date	
5	February 2014	1 year 10 m to date (sign off expected January 2016)	
6	April 2014	Not signed off – 1 year 8m to date	
7	December 2014	Not signed off – 1 year to date	

4.60 It was not possible to compare the performance of the SBNI with the RCPC since five of the seven SBNI cases (excluding legacy cases) had still to be finished.

4.61 The average time taken by the RCPC to sign off 26 reviews was 19 months. 27% were completed in less than a year; 38% between 1 - 2 years; 31% between 2 - 3 years; and 1 case took 3 years 4 months.

4.62 A number of challenges intrinsic to the CMR process had been managed appropriately. These included a shortage of skilled and experienced staff to input to IARs/CMRs; timescales for IARs having to be extended because of the complexity of cases; and the time taken to engage with families at the beginning and end of the process.

Dissemination of Learning

4.63 Learning from the findings of three CMRs had been disseminated, but only to the respective local Safeguarding Panels involved in the case.

4.64 There was no mechanism for sharing the learning across all the Safeguarding Panels. This was a serious weakness, since learning from CMRs was one of the SBNI's core functions. Safeguarding Panels had a statutory duty to implement arrangements for sharing the findings of CMRs, and for this reason the SBNI should have passed CMR findings to all the Panels as soon as it had approved the CMR report. The SBNI stated that reports were not circulated to the Panels until summaries were published. This was not an acceptable practice as it introduced unnecessary delay.

4.65 Whilst not required by the Guidance, the SBNI had a policy of publishing executive summaries of CMRs, suitably anonymised. None had yet been published, although work was ongoing on a publication strategy for two completed reports. Publication was not possible in all cases, for example because of criminal proceedings.

4.66 The public protection arrangements (PPANI) had a system of publicising learning from Serious Case Reviews in the form of a series of practice notes placed in a secure area of their website. Practice notes were anonymised (or not case specific). The emphasis was on getting learning from reviews out to front line managers and staff as quickly as possible. Practice notes could be updated easily, as learning developed in individual cases. The SBNI should implement a similar system. ***This is a point of note*.**

Training and Support

4.67 Insufficient training and guidance for those leading and involved in CMRs and IARs were key issues raised throughout the present Review.

4.68 The SBNI organised 3-day training in 2013, drawing on the SCIE 'Working Together' model. It was very well attended. Many perceived this to be the start of a process to streamline and improve the CMR process. There was much criticism of the SBNI's failure to follow through on this initiative.

4.69 Training on CMRs was scheduled to take place early in 2016. Training on IARs was held in November 2015. Learning from the IAR training day, and the areas identified for improvement, echoed many of the findings outlined in this report.

4.70 The SBNI had agreed to purchase Chronolator software, which was expected to impact positively on the production of chronologies.

4.71 Within the HSC Trusts, there already existed mechanisms for facilitated learning events for practitioners. We understood that there was scope to broaden these events to include other agencies, and to focus on multi-agency learning from CMRs and serious case reviews in other parts of the UK.

Collaboration with other agencies

4.72 We refer earlier to agreements with other agencies. A Memorandum of Understanding (MOU) was in place between the SBNI and the NI Commissioner for Children and Young People. A time-limited agreement had been reached with the PSNI and the Public Prosecution Service in respect of the Thematic Review; however, progress had not been made on a wider agreement on CMRs, which should be a priority. ***This is a point of note*.**

4.73 At least one CMR contained findings and recommendations about a registered service but there was not appropriate communication from the SBNI to the Regulation and Quality Improvement Authority (RQIA). A draft MOU was signed off as the present Review was nearing completion. Liaison with the RQIA needed to be strengthened. ***This is a point of note*.**

Improvements to CMRs

4.74 Towards the end of the present Review, we met with the Interim Chair of the SBNI, the Chair of the CMR Panel, the former Director of Operations, one of the SBNI professional officers and two members of the CMR Panel, specifically to look at areas for change and improvement in the handling of CMRs. There was broad consensus about a number of actions for improvement and agreement that the changes described below would increase professional confidence in CMRs.

Streamline CMR and IAR processes and eliminate duplication

4.75 This was agreed by all to be a high priority.

Shorten timescales for completing CMRs and IARs and introduce a more flexible range of review models.

4.76 The focus should be on critical events rather than the whole case history. Reviews must be proportionate to the likely learning from the case. Greater flexibility is already possible within the existing Departmental Guidance.

4.77 The SBNI should have access to a 'toolbox' of different models. This would allow the CMR Panel to make judgements on a case by case basis, to determine the approach most likely to maximise timely and effective learning. There was scope to customise some models being utilised in other parts of the UK and Ireland.[10]

4.78 There is a growing body of evidence[11] about ways in which learning from case

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[10] The ADCS Virtual College material referred to earlier contains a helpful overview of different systems models which are currently being used in England and Wales.

[11] For example, Translating Learning into Action: An overview of learning arising from Case Management Reviews in Northern Ireland 2003 – 2008 (January 2013); DoE "Barriers to Learning" July 2014; Association of Directors of Children's Services Virtual Staff College Report "Serious Case Reviews (July 2015).

reviews can be improved. A shared understanding of these findings across the SBNI, its CMR Panel and local Safeguarding Panels could contribute to a common sense of purpose.

4.79 There is, as yet, no clear evidence base for which models work best for effective independent reviewing.

Involve the Safeguarding Panels, and recognise their expertise

4.80 Some reviews could be allocated to Local Safeguarding Panels to lead, for example, on cases which fell short of the criteria for a CMR but which could contribute to multi-agency learning. The findings would then be fed back to the CMR Panel for regional dissemination.

Speed up the dissemination of learning

4.81 The CMR Panel had detailed knowledge of each case, and the Panel was well placed to lead on the dissemination of learning. If this is agreed, the CMR Panel should work closely with local Safeguarding Panels.

Recommendation 4

The SBNI, working through the CMR Panel, should act to streamline the CMR process, and introduce some other review options. Reviews must be proportionate to learning, and able to be completed within the timescale of about 9 months or less. Learning must be disseminated more quickly. This should be tasked to the CMR Panel, acting in conjunction with the five Safeguarding Panels.

Improvements requiring changes to Regulations/Guidance

4.82 There would be merit in exploring whether the CMR author and the independent CMR Team Chair should be different people (as happens in England).

4.83 In relation to decision-making, the emphasis should be on consensus. Accountability for CMR recommendations/ decisions should rest with a named individual, either the Chair of the CMR Panel or the Chair of the SBNI. Majority voting on CMRs should be ended, as it is not an appropriate way to make decisions about the deaths of children or significant harm to them.

4.84 If delegation of decision-making can be agreed, the respective roles of the CMR Panel Chair and the Chair of the SBNI should be more clearly defined.

4.85 The present Review affirms that an independent CMR Panel Chair was a strength in the current system. Equally, it is important for there to be clarity about the role of the SBNI Chair in decision making about CMRs. This could be accommodated if the Chair of the Panel held delegated authority to make recommendations (in the light of Panel discussions) and the Chair of the SBNI had delegated authority to approve recommendations without recourse to the full SBNI, as was the practice until 2014.

4.86 Minutes of the CMR Panel and the SBNI should always contain a clear record of the reasons for CMR decisions, in terms of the criteria specified in the Regulations. Minutes should also record dissent, again in terms of the specified criteria.

Recommendation 5

The SBNI and DHSSPS should discuss possible changes to the Regulations and Guidance, in order to strengthen arrangements for CMR chairing and report authoring, and to delegate authority for CMR decisions.

5. The Safeguarding Panels

The Safeguarding Panels were chaired effectively but they had not been able to make sufficient progress in delivering their statutory functions. To a large extent, this was because the SBNI itself had not made enough progress in key areas such as completing case management reviews, and finalising policies and procedures. Progress on matters such as these would have assisted the Panels to deliver on their core functions. In line with the future development of a regional child protection partnership, the responsibility of local Panels for child protection should be restated and clearly defined.

Although there were some inconsistencies in performance, the Panels had a sound operational focus and showed evidence of good information sharing and cooperation. Some engaged well with front-line staff. However, there was variation in agencies' contributions to individual Panels. Engagement with children and young people did not appear to have progressed at local level. The Board should work in partnership with the Panels to empower and assist them to deliver their statutory responsibilities.

5.1 The Act makes provision for a prescribed number of Safeguarding Panels. The Regulations established five Panels, corresponding to each of the Health and Social Care Trust areas. The Regulations also defined the functions and membership of the Panels.

5.2 As required, the Safeguarding Panels were independently chaired. Membership of each Panel was drawn from statutory agencies, the NSPCC, voluntary organisations and the Local Medical Committee of the British Medical Association.

5.3 All the Panels met regularly (and more frequently than the prescribed four meetings per year). The present Review observed that meetings were chaired effectively, and most Panels appeared to operate cohesively. However, some variation in the quality of contributions and discussions was noted. It appeared that understanding of multi-agency working on child protection and safeguarding was excellent in some Panels, but not all. We observed the Independent Chairs to exercise a challenge role, where appropriate.

5.4 The arrangement whereby local HSC Trusts provided administrative support to the Panels appeared to be working well.

5.5 The Regulations prescribe the functions of the Safeguarding Panels as follows:

a) coordinating the implementation of the SBNI's Strategic Plan for safeguarding and promoting the welfare of children;

b) monitoring the implementation of the SBNI policies and procedures;

c) promoting awareness of safeguarding;

d) implementing arrangements for sharing the findings of CMRs; and

e) promoting communication between the Safeguarding Panel and children and young people.

5.6 Regulation 30 requires the Safeguarding Panels, in respect of each financial year, to prepare and send to the SBNI a report on the exercise of their functions. This should review the year's activities, give details about the objectives and priorities which have been agreed by the Board and report the achievements of the Panel in respect of them. The report should also include comment on the effectiveness of what has been done by each of the bodies represented on the Panel to safeguard and promote the welfare of children.

5.7 The requirement for the Panels to produce an annual report was not mentioned in the Guidance and did not appear to have been implemented. Instead, Panels prepared a description of their activities for inclusion in the SBNI Annual Report.

5.8 It appeared to the present Review that there would be merit in the Guidance making explicit the requirement for the Panels to produce an annual report, to assist them to focus on their statutory functions. ***This is a point of note*.**

5.9 The Guidance specifies that Safeguarding Panels will play a key role in assisting the SBNI to deliver its functions, and that the SBNI will work with each Panel to ensure that action plans reflect the delivery of the Panel's statutory functions. This part of the Guidance had not been well implemented. Many we spoke to, both locally and centrally, commented on the disconnection between the SBNI and the Panels.

5.10 Almost all the Safeguarding Panel members whom we met, many of whom were senior managers in their own organisations, supported the need for a regional structure for safeguarding and child protection.

5.11 Early in the life of the SBNI, the Panels established sub-groups to deal with CMRs, Training, and Engagement with Young People. In 2013, the Panels received a directive from the Chair of the SBNI that sub-groups (with the exception of those dealing with CMRs) were to be 'paused'. The SBNI minutes showed that there was a consensus amongst Board members about this decision. There was a strong reaction against this decision within the Panels, because the lack of sub-groups prevented them making progress.

5.12 As a consequence of the slow pace of progress made by the Board in key areas such as completing case management reviews, and finalising policies and procedures, the Panels had not been able to make progress in delivering their related statutory functions. Additionally, work on communication with children and young people at a local level did not appear to have progressed to any great extent. We have noted elsewhere that engagement primarily needs to be led locally. Engagement should become a priority for the Panels, and this should be supported by the Board.

5.13 At the beginning, there were problems with governance in some of the Panels, especially around recruitment of voluntary and community representatives and confidential business. The Panel Chairs recognised the need for transparency

and wanted an agreed procedure for recruiting voluntary and community representatives. We comment on this later.

5.14 The Panels focused on some matters relevant to child protection and appeared to impact positively on information sharing and co-operation. Some agencies, particularly those that did not have operational responsibility for child protection, said they would welcome greater flexibility about attendance, so that they could attend relevant parts of meetings as required by the agenda.

5.15 In line with the future development of a regional child protection partnership, the responsibility of the Panels for child protection should be restated and clearly defined, so that multi-agency work on protecting children is effectively coordinated at a local level.

5.16 Business discussed at Panels included child protection statistics; child sexual exploitation and initiatives to raise awareness about it; public protection arrangements; domestic violence and harmful sexual behaviour. Some Panels received presentations about local and national projects, such as the Northern Ireland Childline and 'The Real Story' – a handbook and DVD produced jointly by Barnardo's and the Public Health Agency, covering relationships and sexuality education.

5.17 A small number of initiatives originated in one Panel and were extended more widely. These included a protocol on bruising in pre-mobile babies, and an audit of child protection case conferences, monitoring attendance and whether agencies provided reports. This latter work showed that much more needed to be done to improve multi-agency working on child protection. Some agency representatives, particularly Education, appeared to have had a variable input to the Panels.

5.18 Members of the Panels felt disconnected from the Board. There was a strong perception of a 'top down' approach. The matters that caused the greatest frustration were the delay in completing CMRs, lack of communication about them, and the 'pausing' of sub-groups.

5.19 There was a perception that communication between the Board and the Panels needed to be improved. The Board did not communicate directly with the Panels, but expected the Trust Directors to relay decisions through their representatives on the Panels. There was a view that communication came from 'on high' and was directive, rather than consultative in nature. During the present Review communication seemed to be improving.

5.20 The Interim Chair of the Board had initiated a programme of visits to the Panels and had taken action to address some of their concerns. This included taking a more flexible approach to Panel work plans, to allow these to reflect local priorities as well as the SBNI plans. Representatives from the Panels were invited to attend a Business Planning Development Day in October 2015, and this was welcomed.

5.21 Communication about CMRs was being improved. The Chair of the CMR Panel

and the two Panel Chairs had agreed that the Panels would receive regular updates on progress on case management reviews. This would increase local ownership.

5.22 We met a group comprising three out of the five Directors of the HSC Trusts and a manager from the Health and Social Care Board. They thought there was a lack of connection between the Panels and the SBNI. They considered that clarifying the role of the Panels was the most important issue facing the Board. They considered that the HSC Trusts should chair the Panels rather than having Independent Chairs. They believed this would increase local ownership.

5.23 The present Review considered that Independent Chairs brought transparency to the Panels and added value to multi-agency working.

5.24 Our overall findings in respect of Safeguarding Panels were that they had in the main a committed, knowledgeable and skilled membership; that they had not been able to make enough progress in achieving their statutory functions; and that they were viewed by some Board members as peripheral rather than central to the work of the Board – a perception that needed to change.

5.25 The SBNI should empower the Panels to discharge their statutory responsibilities. Their authority would be enhanced if the Independent Chairs were members of the SBNI rather than merely in attendance. We commend this suggestion to the DHSSPS and the SBNI. ***This is a point of note*.**

6. Child Death Reviews

Under the legislation[12], the SBNI was required to establish a Child Death Overview Panel (CDOP). The child death review function had not yet commenced.

There was broad support for the enactment of child death reviews. However, existing processes for reporting and learning from child deaths were undergoing change and duplication should be avoided. It was not clear that the SBNI currently had the capacity to fully implement child death reviews and there would be merit in considering the Public Health Agency as a possible location. A phased approach should be adopted, with themed reviews initially, and progression to individual reviews when the first phase had been successfully introduced.

6.1 The Guidance states that commencement of the Child Death Review function of the SBNI would be deferred until one year after its establishment. In 2015, it was deferred again, pending the completion of the present Review.

6.2 Systematic approaches to reviewing child deaths have been introduced in many countries, including most of the USA, Canada, Australia and New Zealand.

6.3 Statutory child death reviews were implemented in England in 2008. In 2013, 3857 child death reviews were completed in England, where the primary purpose was to review individual deaths, to identify modifiable causes and to learn lessons and put the lessons into practice to prevent future deaths.

6.4 The English CDOP system was reviewed in 2013. Recommendations were made to improve data collection and shared learning. A forthcoming review of Local Children's Safeguarding Boards in England will include the effectiveness and location of CDOPs.

6.5 Child death reviews were piloted in Wales in 2009-10, and following a successful independent evaluation, a programme of reviews was implemented. From April 2014, this became part of core activity within Public Health Wales.

6.6 The emphasis in Wales is on themed reviews. The Child Death Review programme aims to identify patterns and causes of child death including any trends, and to recommend actions to reduce the risk of avoidable factors.

6.7 In Scotland, a report into CDOPs was completed in 2014 and it is anticipated that CDOPs will be implemented in the near future.

Thematic Review of Infant Deaths

6.8 In advance of the enactment of the child death review function, a thematic review of infant deaths was undertaken by a partnership between Queen's University Belfast, the PHA, the SBNI and the Northern Ireland Coroner's Service.

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[12] Section 7(1)(b) and section 3(5) of the Safeguarding Board (Northern Ireland) Act 2011

6.9 The report was presented to the SBNI in September 2015. It addressed important gaps in knowledge about infant deaths in Northern Ireland. It highlighted risk factors associated with sudden unexpected death in infancy (SUDI), the dangers of co-sleeping and the importance of good information for health professionals and families. The report was well received by the SBNI. Board members saw it as a positive sign that the Board's attention was now shifting away from internal processes and towards the safety and protection of children.

6.10 We were told that there was no regional multi-agency SUDI protocol in Northern Ireland. This should be addressed. ***This is a point of note*.**

Young People Vulnerable to Suicides and Accidental Death

6.11 Northern Ireland has high rates of suicide. The NI Commissioner for Children and Young People initiated work on the deaths of children by suicide[13], which was reported in 2012. All agencies were called on to reflect on their responsibilities in safeguarding children and young people vulnerable to suicide and accidental death and to carefully consider how arrangements could be strengthened. The SBNI could demonstrate leadership of multi-agency activity on child suicide prevention. This was being discussed in the preparation of the 2016/17 Business Plan.

Support for Implementing CDOP in Northern Ireland

6.12 There was strong support for the implementation of child death reviews in Northern Ireland. This came from a range of interests, including members of the SBNI, the NI Commissioner for Children and Young People, the Royal College of Paediatrics and Child Health and the National Children's Bureau Northern Ireland.

6.13 In 2012, 155 children died in Northern Ireland. 60% of deaths occurred in children aged less than one year, and 20% occurred in young people aged between 14 and 18 years. It was estimated that just over 20% of these deaths involved modifiable factors, which if addressed could prevent deaths in the future.

6.14 The development of proposals to implement CDOP was worked on intensively by the Director of Operations and colleagues from the PHA. The former Chair considered that this was undoubtedly the most effective example of joint working with the host agency.

6.15 In 2014, the SBNI submitted proposals to implement CDOP to the Department. The SBNI and the PHA recruited a Business Manager to work part time on CDOP and part time on collecting and analysing data on maternal and child health[14]. The SBNI share of costs for this post was met from within its current level of funding

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[13] 'Still Vulnerable – The impact of Early Childhood Experiences on Adolescent Suicide and Accidental Death '(November 2012).

[14] NIMACH (Northern Ireland Maternal and Child Health) – collects and analyses data in support of Clinical Outcomes Review Programmes.

allocation.

6.16 In advance of the establishment of the Child Death Overview Panel, the CDOP Manager worked closely with the lead paediatrician to carry out preparatory work. It was hoped this would enable the CDOP to be established quickly, once the legislation was commenced.

Possible overlap and duplication

6.17 Reporting and learning from child deaths were undergoing change. Following the Donaldson Review, arrangements for reporting deaths through the Serious Adverse Incident process were under review, and Morbidity and Mortality Reviews had been partially implemented by the HSC Trusts.

6.18 Some concerns were expressed about how the enactment of CDOPs would fit with other systems that deal with child deaths, and the risk of duplication. There were also concerns about additional workload for frontline staff.

Capacity

6.19 At the time of writing, the SBNI child death review proposals were over 18 months old. The proposals did not include different options for handling child death reviews, although we understand discussion of various options took place prior to the paper being prepared. The business case included costings but these were not made available to the present Review.

6.20 Perhaps the greatest concern on the part of the present Review was doubt that the SBNI had the capacity to manage the introduction of child death reviews, given that it was already struggling to deliver on its other statutory functions. There is a case to be made for locating child death reviews within Public Health, as in Wales. There may be merit in considering a similar arrangement in Northern Ireland. ****This is a point of note*.***

A phased approach

6.21 The present Review considered that wherever the function is located, it is essential that there is a mechanism to identify and learn from modifiable factors in child deaths. It would be prudent to adopt a phased approach to implementation, starting with themed reviews.

6.22 If located within the SBNI, a move towards individual reviews should be considered only when the SBNI was effectively delivering its existing statutory functions and themed reviews.

6.23 All reviews, whether themed or individual, should be timely, appropriate and sensitive to the needs of bereaved families.

6.24 An initial priority for individual reviews should be the deaths of children and young

people who are looked after. There was currently no multi-agency learning from these deaths if they did not meet the criteria for a CMR. ***This is a point of note*.**

Recommendation 6

Legislation on the Child Death Overview Panel should be commenced, but the arrangements should be phased in, with the emphasis on Themed Reviews in the first instance.

7. Non-Statutory Committees of the SBNI

The SBNI had three non-statutory Committees, dealing with Policy and Procedures, Education and Training, and Communication and Engagement. The Policy and Procedures Committee was on schedule to have revised regional child protection procedures online by April 2016. A learning and development framework had recently been approved and issued. A fourth Committee was established to deal with Effectiveness and Governance but it met only once in May 2013. This was a critical omission. The Board intended to review its Committees, and it must make sure that there are clear arrangements for oversight of finance, audit and performance as well as governance.

There was also an E-Safety Forum, an Inter-Faith sub-group and a Chair's Business Group. There was a Child Sexual Exploitation Strategic Partnership Group, which had been stood down. The Board had still to action several outstanding recommendations from the Marshall Report.

The Policy and Procedures Committee

7.1 The objective of this Committee was to enhance the safety and welfare of children and young people by developing and revising Child Protection and Safeguarding Policies and Procedures, on a multi-agency basis.

7.2 This Committee met five times in 2013, and six times in each of 2014 and 2015. From the evidence of its minutes, it undertook a heavy workload. This included development of an information sharing protocol, which had been out for consultation and was still being finalised.

7.3 A priority for the Committee had been the revision of the regional child protection procedures, last reviewed in 2005. Work on this was well advanced, and we were told that the SBNI was on target to have the procedures available on online by April 2016. Elements of the procedures were being brought forward to the SBNI as they were completed.

The Education and Training Committee

7.4 The objective of this Committee was to develop a strategy for training in child protection and safeguarding which took account of single and multi-agency planning, delivery, monitoring and evaluation.

7.5 This Committee met five times in 2013, six times in 2014, and five times in 2015. Its primary output was a Learning and Development Strategy and Framework 2015 – 2018. This was approved by the SBNI in September 2015. Its purpose was to contribute to the improvement of child protection and safeguarding training and education in Northern Ireland. It set out the key minimum learning outcomes to equip staff and volunteers with the skills, knowledge and competence to promote the safety and well being of children and young people.

The Communications and Engagement Committee

7.6 This Committee had two objectives. One was to develop a communication and engagement strategy to ensure that the work of the SBNI and its member agencies was effectively conveyed to children and young people, the general population and other key sectors of society such as politicians and the media. The second objective was to raise awareness of the need to safeguard children and young people and how this might be done.

7.7 The Committee met six times in 2013, and three times in 2014, after which it was stood down.

7.8 We were advised that a draft Engagement Strategy had now been completed, but there was little evidence of its planned implementation in relation to either of the Committee's two objectives.

The Effectiveness and Governance Committee

7.9 This Committee had two objectives. One was to monitor and evaluate the effectiveness of the Board and its member agencies, individually and collectively, in terms of safeguarding and promoting the welfare of children and young people in Northern Ireland. The second objective was to monitor the governance arrangements of the SBNI and support the Director of Operations in the appropriate discharge of these duties.

7.10 There appeared to be only one meeting of this Committee, held in May 2013. The minute indicated that its role was to evaluate the effectiveness of the work done by the CMR Panel without involvement in the practicalities. It further stated that the terms of reference should be reconsidered, as the proposed role entailed too many additional responsibilities that were beyond their brief. The failure of this Committee was a critical omission.

The E-Safety Forum

7.11 This Forum was set up following a recommendation in a research report commissioned by the Board from the National Children's Bureau of Northern Ireland. This report, published in January 2014, explored e-safety messages to young people, parents and practitioners.

7.12 The Forum was drawn from the main public agencies and voluntary organisations involved in safeguarding. It met five times in 2015 and would meet at two monthly intervals in 2016, or more frequently if the Chair or Forum deemed it necessary. Its initial priorities included an evaluation of current e-safety messages.

7.13 Early in 2015, the SBNI was asked to take forward the cross-Departmental strategy on E-safety. The Forum's work was expected to be complementary and to inform the strategy. This was a piece of work which was being funded on a cross-

departmental basis, involving 7 Departments[15], and needed to be carried forward in the SBNI's 2016/17 Business Plan.

The Inter-Faith Sub-group

7.14 This group had only recently been established. It planned to meet quarterly and more frequently should the Chair or the Committee deem it necessary

The Chair's Business Group

7.15 This group was established in 2015 by the Interim Chair with the purpose of moving forward SBNI business between Board meetings. It replaced a meeting of chairs of Panels and Committees, which was convened by the former Chair. There was broad support within the Board for its establishment.

7.16 The Chair's Business Group was stated explicitly not to be an executive Committee; however some consideration might be given to the need for an Executive Group to take decisions since meetings of the SBNI take place only quarterly.

7.17 At an early stage, the Chair's Business Group took the decision that, in the absence of the Chair, the meeting should be chaired by the Director of Operations. This was not an appropriate arrangement. In the absence of a Vice-Chair, another Board member should be identified to chair it.

Progress Made

7.18 It took the Committees some time from their inception to work out their roles. Evidence from the minutes confirmed that much of the discussion over the first year mirrored the lack of clarity in the Board about remit and authority to direct partner organisations.

7.19 The process for translating some of the work of the Committees into implementation was bureaucratic and lengthy. It was described by the former Chair as 'almost stultifying'. In part, this was because of public sector procedure in Northern Ireland regarding public consultation and Section 75 Equality compliance. With Board meetings four times a year, this process took some time to complete and led to frustration for those who had put time and effort into carrying out the work.

7.20 Despite considerable activity in Committees that continued to operate, it was a major omission that there was no Committee with responsibility for Finance and Audit. The Committee with responsibility for governance met once only. The present Review fully concurred with several comments by Board members that the

[15] Department of Health, Social Services and Public Safety, Office of the First Minister and Deputy First Minister , Department of Culture, Arts and Leisure, Department of Justice, Department of Education Department for Social Development and Department for Employment and Learning.

Board's biggest weakness was the Effectiveness and Governance Committee not working. However no Board members, including the Chair, seemed to have taken any responsibility for challenging the Board's position on this, despite the amount of time and energy spent on governance during the first two years of the Board's existence. The functions of this Committee were poorly specified and it achieved nothing. Had it been operating as it should, many concerns relating to performance and impact on children could have been addressed.

7.21 The Communication and Engagement Committee appeared to struggle with its role - possibly because there are few initiatives in this sphere which are likely to be effective if centrally, rather than locally, driven. Large-scale media campaigns, such as that undertaken on CSE might be one of them, but in general, engagement and some aspects of communications are more likely to work well when in the control of local agencies. They will know the local context and the specific safeguarding and child protection issues which need attention.

7.22 The view of the present Review is that this responsibility should become part of the revised remit of Safeguarding Panels, with an appropriate transfer of budget to the Panels. The function of promoting the work of the SBNI itself could be transferred to another of the Board's Committees.

7.23 The SBNI website gives no indication of the current work of its Committees, merely referring to their objectives and tasks, and does not, for example, make clear that the Effectiveness and Governance Committee no longer exists, or that the Communication and Engagement Committee had stood down in 2014. Communication would be improved by giving information on the website about the work of the Committees and their achievements. More generally, the SBNI's website needed considerable improvement. ***This is a point of note*.**

7.24 Late in the present Review, the Interim Chair advised that a priority would be to review the Committees in 2016 to ensure that the right committees were in place, with appropriate terms of reference, and the right membership and Chairs. She also wanted them to be cost effective and to be able to evidence positive outcomes for children.

Recommendation 7

Regardless of the future structure of the Board, arrangements should be made for Committee oversight of finance, audit and performance as well as governance.

8. Governance

Governance and accountability dominated Board discussions from the beginning, at the expense of focus on children's welfare. The majority of Board members interviewed expressed the view that there was an imbalance between the two. This was crystallised in the handling of the Thematic Review, which appeared to generate argument and ill feeling amongst members over a lengthy period.

The SBNI needed to strengthen its arrangements for scrutinising the performance of its member bodies in relation to multi-agency work on child protection and safeguarding.

Several aspects of governance needed to be resolved. Some of the difficulties for the Board lay in interpretation of the statutory Regulations, which many found to be over-prescriptive, and to create unnecessary bureaucracy. We support the need for a review of some aspects of the Regulations.

8.1 Some fundamental and overlapping governance issues beset the Board since its inception. These are outlined below, along with other governance matters which arose in the course of the present Review. The majority of Board members commented that debate and disagreement about the detail of governance diverted the Board from focusing on children's protection and welfare.

Purpose

8.2 The objective of the Board is to coordinate and ensure the effectiveness of what was done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children.

8.3 The 'ensure' requirement and its interpretation was the source of a vast amount of internal debate within the Board. This has also arisen in the English safeguarding system. The former Chair considered that the time spent in discussing the Board's 'ensure' function was both necessary and inevitable at that stage in the SBNI's development. The present Review did not concur with this view.

8.4 The Act places a statutory duty of cooperation amongst member agencies involved with children and families. The intention underlying the legislation was to broaden approaches to safeguarding by promoting a wider child welfare agenda, whilst ensuring that children are protected.

8.5 The SBNI had no operational responsibility for service delivery by its member bodies. As a consequence, it was heavily reliant on performance reporting and self-evaluation by its member agencies.

8.6 All the bodies represented on the Board had their own governance systems, in addition to their governance role as Board members. In England, a view of some experienced Chairs was that the dual role was almost impossible to deliver, and that there was little evidence of scrutiny of multi-agency working at Board level.

8.7 The former SBNI Chair believed that the Chair and staff of the SBNI were quite

isolated. He made the point that there were few agencies at the Board table who saw the Board's success as being linked to their own agency's success, therefore failing to generate any sense of corporate ownership.

8.8 It appeared to the present Review that preoccupation with governance had prevented the SBNI from developing systems to scrutinise the effectiveness of multi-agency working on child protection and wider safeguarding of children.

8.9 The NI Commissioner for Children and Young People thought that the SBNI should disseminate an assessment of safeguarding arrangements in Northern Ireland on a regular basis 'including gaps, weaknesses and emerging trends'. This is a positive proposal, which the SBNI should consider adopting. ***This is a point of note*.**

8.10 Some Board members recognised the importance of the SBNI finding ways in which to hold members to account for their performance on multi-agency safeguarding. This could partly address their remit to 'ensure', and also verify that the 'duty to cooperate' placed on Board members was being delivered.

8.11 As stated earlier, the Section 12 audit was not effective in holding member bodies to account for multi-agency child protection and safeguarding. A more effective mechanism was required.

Recommendation 8

At a minimum, the SBNI should arrange annual meetings with the most senior operational officers responsible for the Police, Education, Health and Social Services, and Youth Justice for the sole purpose of securing sufficient focus on protecting children in Northern Ireland on a multi-agency basis. Each agency should be required to provide a report on what it had done to improve multi-agency working on child protection. Following scrutiny, the findings should be formally reported to the full Board and should be included in the Annual Report.

8.12 The introduction of annual meetings should be an interim, short-term measure only. In the longer term, the changes proposed in Recommendation 2 should be adopted.

Independence and conflicts of interest

8.13 Whilst there was good evidence of partnership working across several of the agencies concerned, there were tensions for some members between their role on the Board and as a representative of their own agencies. HSC Trust Directors in particular thought they were criticised for speaking too much at meetings on matters which concerned their service, then criticised for not speaking enough on other occasions.

8.14 Conflicting roles were seen by many to be at the heart of the problem of 'independence'. The present Review agreed with that conclusion. The Board needed to have the most knowledgeable and experienced people present, from service delivery in both the public and voluntary sectors, and especially when discussing child protection. Board members had been striving to attain a notion of 'independence' which appeared to be inconsistent with the equally important aim of getting the most from the participation of well-informed operational managers. One idea being considered in England was to designate members as 'Executive' and 'Non-Executive', which has the merit of openly acknowledging the difference in roles.

Recommendation 9

All of the Board's members should view the SBNI as a multi-agency partnership, led by an Independent Chair, rather than as an independent, representative group of people. This would need a shift in attitudes and a willingness to move on from the divisions of the past.

The Thematic Review

8.15 Many difficulties concerning purpose, independence and conflict of interests came to a head over the Board's handling of the Thematic Review.

8.16 In September 2013, the Board received a Ministerial Direction to carry out a Thematic Review of 22 cases of alleged child sexual exploitation in Northern Ireland. Section 3 of the Act provides that the SBNI may publish any matter subject to consultation with the Department, and Section 4 provides that the Department may give directions to the Board as to the exercise of its functions. While it would normally consult the Board in advance, it need not do so on matters of urgency.

8.17 The work was commissioned by the Board and led by a research team from Queen's University, Belfast. Independent scrutiny of the Review was provided by a separate team of specialists in the field, and the report was published in December 2015.

8.18 The former Chair of the Board stated that he received very little advance warning of the information that a Ministerial Direction would be issued for the Board to conduct the Thematic Review. Two of the Board members who were legally trained were of the view that the Direction was 'legally flawed'. The Chair then sought counsel's opinion on the Thematic Review's original Terms of Reference. The Terms of Reference were found to be lawful. However, some Board members persisted in their opposition to the Board carrying out this Direction.

8.19 Every Board member interviewed considered the Thematic Review to have blown the SBNI off course in its development. It consumed a large proportion of the

Board's time, energies and resources. Some of the comments received are given below:

'The Thematic Review had a major impact on the capacity of the Board'

'The Marshall and Thematic Reviews got the Board tied up in knots from which it may only now be recovering'

'It dominated the agendas from September 2013 to September 2014, mostly to do with grievances rather than content.'

'The Thematic Review became like an adversarial court situation'

'It became like a contest to see who had the best interests of children at heart'.

"It was very stressful just being at the meetings."

8.20 The present Review did not consider that it was inappropriate to direct the SBNI to carry out this work. However, its timing was unfortunate. The Board had not long been established.

8.21 The Thematic Review became extremely divisive, and seemed to spill over into other aspects of the Board's work in an irrational fashion. Members became associated with one side or the other. Probably the greatest strain was felt by the Chair, who was still working to establish the Board, and was caught up in trying to reconcile polarised opinion amongst some members.

Child Protection

8.22 It was the intention from the start that the work of the SBNI should begin with child protection and widen out to include safeguarding. In practice, this has not occurred. Over most of its existence, one of the more striking aspects of the outputs of the SBNI and its Committees was the lack of reference to child protection, other than in relation to individual children via the CMR process. An exception to this was work on Infant Deaths, initiated during the time of the first Chair.

8.23 This changed to some extent while the present Review was underway. During 2015, the SBNI received reports on the findings of the Thematic Review, a protocol on bruising in pre-mobile babies[16], and a Review of Infant Deaths (mentioned earlier).

8.24 In 2014, the Board held two workshops in July and September. Child protection was not discussed. Instead, the meetings focused almost exclusively on governance, purpose and the interpretation of 'ensure' and 'coordinate'.

8.25 Meanwhile, the Safeguarding Panels and other forums raised many child

[16] This was an initiative by the Southern Safeguarding Panel that had been developed into a regional protocol.

protection concerns of a systemic multi-agency nature, which one would expect to sit squarely within the remit of the Board. These included problems with attendance at case conferences and reviews; inquorate case conferences, variable understanding of child protection referrals, weaknesses in child protection plans, unallocated caseloads, differential thresholds and shortages of health visitors.

8.26 The former Chair had put in place an escalation policy. Whilst this could deal with individual cases, it could not resolve systems problems.

8.27 We attended the Board Development Day held in May 2015. This included an exercise asking some of the main agencies to speak on 'what kept their people awake at nights'. The focus was almost entirely on important child protection concerns in each of the presentations, leading to child-focused discussions. In later SBNI meetings there were more presentations from individual agencies, which again highlighted issues affecting children.

8.28 Within the SBNI, there were tensions in prioritising activities between child protection and safeguarding. This was a problem in many safeguarding boards. There was a view amongst some Chairs in England that the tendency of safeguarding boards was to focus on the less problematic aspects of their remits, such as training and awareness raising, rather than on matters such as risk, case file audits and quality assurance. Some also believed there was a lack of willingness of statutory agencies to challenge their own organisations and others about ineffective multi-agency practice.

8.29 We concluded that as long as the SBNI continued in its current form, its core role in protecting children needed to be firmly restated and prioritised. In the short term, this could be progressed through a formal structure, such as creating child protection sub-groups of the Safeguarding Panels, with a clear reporting line to the Board. Panels already deal with a significant child protection agenda and a sub-group could take forward specific work around implementation of procedures, audit, and inter-agency working. SBNI meetings could also be organised in two parts, one of which would be reserved for discussion of child protection matters. Consideration should be given to whether Board required to meet more frequently than four times a year, in order to deal with its core business. ****This is a point of note*.**

8.30 The Board should also consider whether some of its wider, preventive remit could be fulfilled by agreement with other partnership arrangements.

Recommendation 10

Child protection must be clearly prioritised in the work of the SBNI.

The Role of the Chair

8.31 The SBNI Chair is a Ministerial Appointment. The Chair is independent of SBNI member agencies and has a line of accountability through the Minister for Health, Social Services and Public Safety to the Northern Ireland Executive and the Northern Ireland Assembly.

8.32 From evidence elsewhere in the UK, skilled chairing of safeguarding board meetings was one of the critical success factors for boards. The SBNI had experienced two different arrangements for the Chair's role.

8.33 Prior to the advertisement of the post of Chair when the Board was set up, there was considerable discussion at the Health Committee about the appropriate rate of remuneration for the role. The rate was set contractually at three days per week. This meant in practice that the first Chair was working much more closely with Board officers than would be the case in Safeguarding Boards elsewhere. The present Review heard that this led to a degree of role confusion between the Chair and the Director of Operations, and raised the question of whether the Chair was an Executive or Non-Executive Chair.

8.34 The first Chair had many complex problems to deal with, especially in relation to governance, independence and the interpretation of the Board's objective. According to several Board members, staffing matters were also played out at Board meetings.

8.35 The Interim Chair was appointed on a contractual basis of 5-8 days per month. She was physically on-site less than her predecessor had been. Nevertheless, demarcation of roles continued to be an issue.

8.36 There was strong support from Board members for the way in which the Interim Chair conducted the SBNI meetings. She was seen to be purposeful and disciplined, and meetings were tightly time-managed.

The Role of the Vice-Chair

8.37 A Lay Member, according to the Regulations, must fill the position of Vice-Chair. This reflected the need to have an independent Vice-Chair in the event that the Chair was unavailable. At the time of writing, the position had been vacant for some time but none of the Lay Members wished to take on the role. The senior Police representative would have been willing to do so, but this would not have met the requirement of independence. The Board needs a Vice-Chair to provide necessary assistance to the Chair. The present Review would suggest that for the future, the specification for Lay Members should include willingness to act as Vice-Chair. ***This is a point of note*.**

Membership

8.38 The membership of the Board was subject to Clause 1(3) of the Act and subsequent Regulations. About twenty representatives were specified, including

those from the voluntary and community sectors. Many additional members were suggested in the course of consultation on the draft legislation. These included the Fire and Ambulance Services and other public agencies. There were 29 members at the end of March 2015.

8.39 Naming the level of representation in the Regulations created some problems for the Board, and the Panels. The scope for greater flexibility would be helpful. The Regulations had been changed to allow SBNI members to send deputies, although it was intended that this should be by exception.

8.40 There were divided views about the level of seniority that the Regulations prescribed. Some believed the right people were not on the SBNI. The intention had been to ensure buy-in at the most senior level in member bodies. But particularly in relation to child protection and CMRs, many expressed the view that Director/Chief Executive level was too far removed from front-line operations.

8.41 The DHSSPS should review whether there is sufficient operational experience of child protection within the prescribed membership of the Board. ***This is a point of note*.**

8.42 According to some members, there were issues related to local council representation on the SBNI and the Panels. Not all Councils were represented, and those in attendance had no mandate to speak on behalf of other Councils.

8.43 There were divided views amongst Board members about the size of the meetings, and whether there were too many members. Most of those interviewed thought that was the case, and examples were given of how difficult it could be to make their voice heard, even to the extent of one contribution at a meeting. Other members thought that numbers were irrelevant, and that skilled chairing and structured meetings were more important.

8.44 The former Chair saw Board diversity of membership as both a strength and a weakness. On the one hand it symbolised the message that safeguarding children was everyone's responsibility. On the other he concluded that the Board's size made it unwieldy and difficult to secure quick action. The Interim Chair thought numbers were irrelevant, and that good chairing was more important.

8.45 There are three Lay members of the Board, appointed for four years through the Public Appointments process. It was not clear that the distinctive contributions of Lay members were fully utilised by the Board. Perhaps the Board should adopt an approach in which Lay members are specifically asked by the Chair at the end of meetings for their views on how the meeting went and whether it was dealing appropriately with the right matters, and record their views in the minutes of meetings.

8.46 The Guidance to the SBNI states that in accordance with Section 1(3)(j) and Section 1(4) of the Act, the SBNI can enrol additional members by writing to the

Department setting out the rationale for extending the membership. Subject to Ministerial and Executive approval the Regulations will be amended accordingly.

8.47 Recruiting additional members was another topic which entailed prolonged discussion within the Board and also in the Panels. We saw references to discussions of possible new members, but there was no clear rationale as to why some were proposed and others rejected.

Recommendation 11

There needs to be a Board statement about criteria for selection of additional members, applied to all of its Panels and Committees, as well as any recommendation made about the appointment of new members to the Board itself.

Attendance and Quoracy

8.48 Continuity of attendance had been difficult to achieve. Departmental Guidance did not initially allow for deputisation. In practice this stance was difficult to maintain and it was later relaxed. It was said that the presence of too many deputies changed the 'dynamic' of the meeting, since they were less likely to challenge. Another consequence of this stated by some members was that it had been hard for the Board, Panels and Committees to get members to undertake work between meetings, causing important matters to remain unresolved. Better attendance than most was reported from the Policy and Procedures Committee and the CMR Panel.

8.49 Quoracy had been a problem for the Board and Panels. Proposed levels of quoracy varied between one-third, one half, and two-thirds for the Board itself and its non-statutory Committees. One member observed that quoracy 'went round the block a thousand times'. Another member related how the Board took a decision to focus on one substantial item for an hour at each meeting. Board members decided the first of these would be the Marshall Report, but in the event, that item took 15 minutes and they spent an hour on quoracy.

8.50 The Regulations regarding quoracy were amended in January 2015, so that the two-thirds quorum would be calculated based on members who did not declare a conflict of interests. In the lead up to the amendment, Departmental advice was to reduce the quorum from two thirds to one third. This was resisted by the SBNI.

8.51 During the present Review, several meetings of the SBNI and the CMR Panel were inquorate when the meeting was due to commence. The start of meetings was then delayed to wait for the arrival of additional members. This was not conducive to getting the business done efficiently. We suggest that the quorum should be reduced to either one third or one half to allow meetings to take place as scheduled, and start on time. ***This is a point of note*.**

8.52 ***More generally, it would be helpful if SBNI procedures were set out in Standing Orders rather than being prescribed in detail in the Regulations. *This is a point of note*.***

9. UK Safeguarding Comparisons

Although safeguarding and child protection systems are different in each of the nations of the United Kingdom, they are all based on similar principles. All are required to ensure coordination and effectiveness of multi-agency working, for example, and all have systems for learning from serious cases. The issues currently facing each country are also similar, with concerns about leadership, focus of the work of safeguarding boards, quality of independent reviews, and a range of governance issues. England, Wales and Scotland are all currently embarking on programmes of change to their safeguarding systems.

9.1 Arrangements in Scotland, England, Wales are briefly described below. Since the SBNI was said to have been drawn primarily from the LSCB system in England, more is included in the commentary about the effectiveness of the English safeguarding system.

9.2 Appendix 3 describes the arrangements for case reviews in the other parts of the UK. In Scotland, reviews are known as Significant Case Reviews (SCR); in England as Serious Case Reviews (SCR); and in Wales as Child Practice Reviews (CPR).

Wales

9.3 The Welsh Government is responsible for child protection in Wales. When the Social Services and Well-being (Wales) Act 2014 comes into force in April 2016, Wales will have its own framework for social services. Child protection concerns which come to the attention of the courts will continue to be treated in the same way as England. The Welsh Government states that the Act introduces 'a strengthened, robust and effective approach to safeguarding'. A National Independent Safeguarding Board is being established to work with the regional safeguarding children boards and the safeguarding adults boards across Wales.

9.4 The Regulations covering the National Board provide for the Board to consist of up to six members, appointed by Welsh Ministers, with one to be appointed as Chair. There are further provisions about the Board's proceedings, the establishment of supplementary groups, consultation, and the completion of an Annual Report.

9.5 The Board's duties will be:

a) to provide support and advice to safeguarding boards with a view to ensuring that they are effective;

b) report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales; and

c) make recommendations to the Welsh Ministers as to how these arrangements could be improved.

9.6 At the local level, regional safeguarding children boards coordinate and ensure the effectiveness of work to protect and promote the welfare of children. Each regional board includes any local authority, chief officer of police, local health board, NHS

Trust and provider of probation services that falls within the safeguarding board area. The regional boards are responsible for local child protection policy and procedures.

9.7 The All Wales child protection procedures provide a common set of child protection procedures for every safeguarding board in Wales. There are very few Independent Chairs in Wales.

Scotland

9.8 The Scottish Government is responsible for child protection in Scotland. It sets out policy, legislation and statutory guidance on how the child protection system should work. The role of Child Protection Committees (CPCs) is to make sure that all the local agencies work together to protect children. Their functions are continuous improvement, strategic planning, public information and communication. Child Protection Committees in Scotland are not set down in legislation, but in guidance.

9.9 The CPCs follow local authority boundaries and work in partnership with the Chief Officers Group, which routinely comprises the Chief Executive of the Council, the senior Police Commander for the local authority area and the senior NHS official. There is no requirement for an Independent Chair of the CPC, though there is encouragement from the Scottish Government to do this. The key guidance is the National Guidance for child protection in Scotland, Scottish Government, 2014. The CPCs design, develop, publish, disseminate, implement and regularly review and evaluate multi-agency policies, procedures, protocols and guidelines.

9.10 The CPCs are administered and supported by WithScotland, based in Stirling University. This supports child protection practice, policy and research. There are several sub-groups which sit beneath the CPC structure, including the Child Protection and Disability Network, the Neglect sub-group and the national CSE sub-group.

England

9.11 The Department for Education is responsible for child protection in England. At the local level, Local Safeguarding Children Boards (LSCBs) coordinate and ensure the effectiveness of work to protect and promote the welfare of children. Each local Board includes local authorities, health bodies, the police and others, including the voluntary and independent sectors. The LSCBs are responsible for local child protection policy, procedures and guidance and all have Independent Chairs. They are also the subject of Ofsted inspection.

9.12 There have been six revisions of the statutory guidance, from 1991 onwards. Working Together to Safeguard Children (2015) introduced two main changes of definition affecting LSCBs:

a) notifiable incidents involving the care of a child. Due to some confusion from local authorities over when they are required to notify child abuse or neglect incidents to Ofsted and the relevant LSCB, the 2015 guidance includes a section on what constitutes a notifiable incident; and

b) the definition of serious harm for the purposes of Serious Case Reviews. This was included following concerns from the National Panel that some LSCBs were not making the right decisions on when to commission a serious case review.

9.13 Other amendments include the specification that LSCBs, local authorities and their partners should commission and provide services for children at risk of sexual exploitation, female genital mutilation and radicalisation.

Findings

9.14 As can be seen above, there are many similarities in the systems of safeguarding and child protection which each of the home nations have put in place. There are also similarities in the issues which have proved problematic. International comparisons show that many countries have some form of multi-agency safeguarding arrangement at local level. The Chair of the Association of Independent LSCB Chairs in England confirmed that research shows they also experience similar problems to the UK boards.

Ofsted Inspections

9.15 A summary of key findings of 19 Ofsted inspections of LSCBs, published by this Association, listed the areas which worked well as:

a) clear lines of accountability and communication between Chief Executive, Director of Children's Services and LSCB Chairs;

b) fit for purpose constitution, appropriate seniority of LSCB members and sub-groups chaired by Board members from partner agencies;

c) Chairs and Boards improving challenge, underpinned by analysis of performance information;

d) completion of S11 audits;

e) key partners contribute to LSCB budget;

f) CSE is a priority area of business for LSCBs;

g) comprehensive multi-agency training;

h) clear pathway for consideration of cases that may meet the SCR threshold and effective CDOP arrangements; and

i) up to date and accessible multi-agency procedures.

9.16 The areas for improvement included:

a) the impact of LSCB's influence at local level;

b) accessibility and application of learning from audits/SCRs;

c) comprehensive, multi-agency dataset which is used by all Board members to hold each other to account;
d) consistent arrangements for engaging young people;
e) effective coordination of CSE/ missing children action plan; and
f) evaluative and analytical LSCB annual report

Recent Research

9.17 The Local Government Association (LGA) commissioned research into the current arrangements for LSCBs, which was published in 2015 (Baginsky and Holmes). The researchers identified four themes related to effectiveness:

a) a lack of clarity on the role and expectations of LSCBs, linked closely to perceived increase in responsibilities;
b) the pressure on LSCB resources, in terms of funding, partner contributions, staffing capacity, the impact of SCRs;
c) the dissonance between the degree to which LSCBs are held accountable and the level of power and authority they have to exercise their responsibilities and in particular hold partners to account; and
d) The pivotal importance of LSCB Chairs and their skills, and the relationship of this to effectiveness.

9.18 LGA's research concluded that if LSCBs were afforded greater certainty and sustainability in their resourcing, alongside clear and proportionate expectations of their remit, they could act as powerful, galvanising forces for good, as was the case in some Boards. But their important caveat to this was if they were to be expected to provide an independent scrutiny mechanism across the whole of children's services 'then the purpose has outgrown the design'.

The ADCS Policy Position

9.19 The Association of Directors of Children's Services published their own Policy Position Paper on LSCBs in October 2015, in which they stated that the messages of LGA's research reflected the concerns of their own members. They make the important point that ensuring that work to protect children is properly coordinated and effective is the principal statutory objective of LSCBs, and go on to say that 'the burgeoning of expectations with regard to the wider preventative remit of Boards is in danger, if it continues apace, of detracting from the achievement of the principal statutory objective of protecting children from harm'.

Independent case reviews

9.20 Analysis of the various review systems in the UK have shown the constant tensions between learning and the allocation of responsibility or blame, as well as completion of these reviews in a timescale which makes the learning relevant. There have been pressures about the mandatory publication in full of these

reviews. In England, this was resisted on the grounds that this would constitute a breach of family confidentiality, and might provoke defensive behaviour amongst professionals whose work was being reviewed. Following considerable media and political pressure, however, publication is now required by guidance, although exceptions are allowed.

Future changes across the UK

9.21 England and Wales are in the process of making important changes to their systems of safeguarding. In Scotland, the Cabinet Secretary for Education and Lifelong Learning has announced that the Scottish Government will develop a programme of action to strengthen support for the protection of vulnerable children in 2016.

9.22 It is of note that the changes to arrangements in Wales followed a joint report by five inspectorates in 2011. Whilst they saw good work by individuals, the Boards were not showing measurable results. They lacked focus and were not fulfilling their legal role, according to the inspectorates. The new National Board will receive information from local Safeguarding Boards and others to assist it to assure the Welsh Ministers that safeguarding and protection are being appropriately led, developed, challenged and promoted in Wales.

9.23 In England, the Prime Minister recently announced an urgent review of LSCBs, to be completed by March 2016. It was also announced that serious case reviews would be centralised. The terms of reference state that the aim of the review is to undertake ' a fundamental review of the role and functions of LSCBs within the context of local strategic multi-agency working, including the child death overview process, and to consider how the intended centralisation of serious case reviews (SCRs) will work effectively at local level.

10. Summary of Recommendations

Recommendation 1 A review of senior staff roles and grades should be undertaken quickly. The role of the Director of Operations, whose appointment is prescribed in the Regulations, should be refocused to one of Business Manager, and the number and grades of Professional Officers and the Business Manager (CDOP) should be revisited. The establishment and grading of posts should require the approval of the Board or one of its Committees. (page 11)

Recommendation 2 In the longer term, consideration should be given to rationalising the various regional bodies concerned with safeguarding, child well-being and child protection, including the creation of a statutory Child Protection Partnership, with an Independent Chair. The wider safeguarding agenda could sit within the revised Children and Young People's Strategic Partnership. (page 13)

Recommendation 3 All agencies must make sure that the SBNI is notified of all deaths and significant harm to looked after children and those on the child protection register, so that these cases can be dealt with through statutory CMR procedures. (page 23)

Recommendation 4 The SBNI, working through the CMR Panel, should act to streamline the CMR process, and introduce some other review options. Reviews must be proportionate and able to be completed within the timescale of about 9 months or less. Learning must be disseminated more quickly. This should be tasked to the CMR Panel, acting in conjunction with the five Safeguarding Panels. (page 30)

Recommendation 5 The SBNI and DHSSPS should discuss possible changes to the Regulations and Guidance, in order to strengthen arrangements for CMR chairing and report authoring, and to delegate authority for CMR decisions. (page 31)

Recommendation 6 Legislation on the Child Death Overview Panel should be commenced, but the arrangements should be phased in, with the emphasis on Themed Reviews in the first instance. (page 39)

Recommendation 7 Regardless of the future structure of the Board, arrangements should be made for Committee oversight of finance, audit and performance as well as governance. (page 43)

Recommendation 8 At a minimum, representatives of the SBNI should convene annual meetings of the most senior operational officers responsible for the Police, Education, Health and Social Services, and Youth Justice for the sole purpose of securing sufficient focus on protecting children in Northern Ireland on a multi-agency basis. Each agency should be required to provide a report on what it had done to improve multi-agency working on child protection. Following scrutiny, the findings should be formally reported to the full Board and should be included in the Annual Report. (page 45)

Recommendation 9 All of the Board's members should view the SBNI as a multi-agency partnership, led by an Independent Chair, rather than as an independent, representative group of people. This would need a shift in attitudes and a willingness to move on from the divisions of the past. (page 46)

Recommendation 10 Child protection must be clearly prioritised in the work of the SBNI. (page 49)

Recommendation 11 There needs to be a Board statement about criteria for selection of additional members, applied to all of its Panels and Committees, as well as any recommendation made about the appointment of new members to the Board itself. (page 51)

Appendix 1

REVIEW OF THE SAFEGUARDING BOARD FOR NORTHERN IRELAND

TERMS OF REFERENCE

To undertake a comprehensive Review of the Safeguarding Board for Northern Ireland to:

- **examine the extent to which the SBNI is meeting its statutory objective, that is, improving inter-agency cooperation and facilitating/contributing to the effectiveness of what is done by member bodies to safeguard children and young people in Northern Ireland and promote their welfare; and**
- **make recommendations on the future arrangements for inter-agency co-operation to safeguard children and young people in Northern Ireland.**

In examining whether the SBNI is meeting its statutory objective, the Review will consider:

- The legislative framework within which the SBNI operates, in particular the statutory functions attributed to it and the statutory duties imposed upon it and how these relate to the statutory functions and duties imposed upon member bodies by other statutes;
- The Committee sub-structure and the relationship between Committees and the wider Board, in particular the CMR Panel and Safeguarding Panels;
- Chairing arrangements;
- Membership;
- Sponsorship arrangements;
- Support arrangements, including business and professional support and hosting by the Public Health Agency;
- Governance and accountability arrangements and how these relate to the governance and accountability arrangements of member bodies;
- Strategic and business planning processes; and
- Resourcing.

In addition, the Review will:

- Compare the operation of the SBNI with other safeguarding partnership arrangements (both statutory and non-statutory) in other parts of the UK; and
- Consider the relationship between the SBNI and other children's and adult partnership arrangements in Northern Ireland and whether there is scope for streamlining, in particular the relationship with the Children and Young People's Strategic Partnership.

Appendix 2

Index of paragraphs containing points of note

Para 2.19 – The level of support to be provided to the SBNI through the hosting arrangement should be clarified at an early stage, to assist the smooth operational running of the SBNI.

Para 3.16 – Improved accountability for procurement decisions was needed, with a clear trail of approval linked to the level of proposed spend.

Para 3.33 – The Board should clarify responsibility for developing and implementing its performance framework.

Para 3.35 – The SBNI should develop effective multi-agency mechanisms for measuring, monitoring and reporting the scale of child sexual exploitation in Northern Ireland, and not rely on verbal reports on this.

Para 4.18 - HSCB procedures must include the statutory duty to notify SBNI of all child deaths and other cases that meet the notification criteria set out in the Regulations.

Para 4.34 - CMR chairs should be given additional support to minute CMR team meetings.

Para 4.42 – The process of commenting on draft CMRs should be improved.

Para 4.54 – The CMR process could be improved if Chairs were assisted by separate report authors.

Para 4.66 - The PPANI system of disseminating learning quickly through web-based practice notes should be introduced by SBNI.

Para 4.72 - The SBNI should give priority to reaching a formal agreement with the PSNI and the Public Prosecution service covering cases that are subject to a CMR.

Para 4.73 – Liaison between the SBNI and RQIA on Case Management Reviews should be strengthened.

Para 5.8 - There would be merit in the Guidance making explicit the requirement for Safeguarding Panels to produce an annual report.

Para 5.25 – The authority of the Panels would be enhanced if the Independent Chairs were members of the SBNI rather than merely in attendance.

Para 6.10 – The need for a regional multi-agency SUDI protocol should be addressed.

Para 6.20 – There may be merit in considering the location of child death reviews in the Public Health Agency, in line with arrangements in Wales.

Para 6.24 – An initial priority for introducing individual child death reviews should be the deaths of children and young people who are looked after, but do not meet the criteria for a CMR.

Para 7.23 – The SBNI's website should be improved and should include information about the work of its Committees.

Para 8.9 – The SBNI should regularly disseminate an assessment of safeguarding arrangements in Northern Ireland, including gaps, weaknesses and emerging trends.

Para 8.29 – For as long as the Board continues in its current form, it should introduce formal structures to progress its core role in protecting children, and consider setting up child protection sub-groups in the Safeguarding Panels. The frequency of SBNI meetings should be reviewed.

Para 8.37 – The specification for Lay Members should include willingness to act as Vice-Chair of the SBNI.

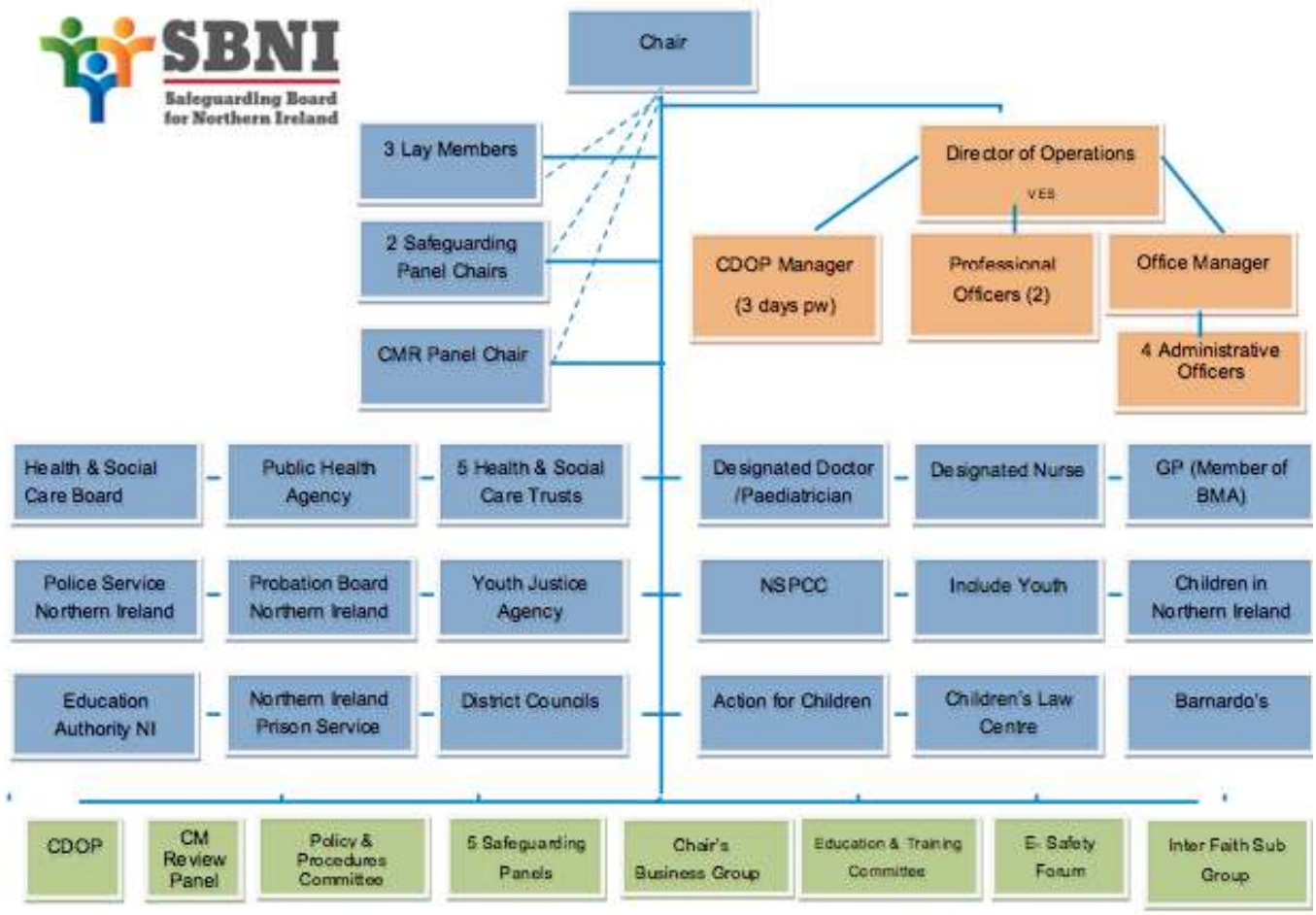
Para 8.41 – The DHSSPS should review whether there is sufficient operational experience of child protection within the prescribed membership of the SBNI.

Para 8.51 - The quorum for meetings of the SBNI and the CMR Panel should be reduced to make sure meetings take place as scheduled, and start on time.

Para 8.52 - It would be helpful if SBNI procedures were set out in Standing Orders rather than being prescribed in detail in the Regulations.

Appendix 3

SBNI Structure



Appendix 4

ARRANGEMENTS FOR CASE REVIEWS IN OTHER PARTS OF THE UK

Wales

Child Practice Reviews (CPR)

1. A CPR should take place if child abuse is known or suspected and a child has:
   e) died
   f) sustained potentially life threatening injury
   g) sustained serious and permanent impairment of health or development.
2. There is statutory guidance to the regional safeguarding boards for conducting a CPR, and there are two types of review.
3. Concise Review - This should take place if the child was not on the child protection register nor in care at any point in the 6 months preceding the incident
4. Extended Review - This must take place if the child was on the child protection register and/or was in care at any point during the six months preceding the incident. Each Child Practice Review is managed by a review panel and a reviewer is appointed to work with the panel.
5. The process should be completed as soon as possible but no more than six months from the date of a referral.

Scotland

Significant Case Reviews (SCRs)

6. A significant case review takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It should take place if a case raises serious concerns about professional or service involvement and EITHER:

   - a child has died AND
     - abuse or neglect is known, or suspected, to be involved
     - the child, or a sibling, was at any point in their life on the child protection register
     - the death is by suicide or accidental death
     - the death is by alleged murder, culpable homicide, reckless conduct, or act of violence
     - the child was in care

OR

- a child has, or could have been, significantly harmed due to abuse or neglect.

7. The local CPC follows national guidance for conducting significant case reviews. When the CPC is made aware of a case that could be 'significant', an Initial Case Review takes place. The Committee uses information provided by agencies who knew the child to decide whether or not to proceed to a SCR. If it decides to proceed, it will next decide whether the review should be internal or external.

8. Internal review - If it appears that the recommendations from a case are likely to have a mainly local impact, an internal review will take place. This means that the investigating and writing of the review can be done by members of the Child Protection Committee.

9. External Review - this may take place if either:

   a) learning from a case will be useful for the whole of Scotland;
   b) recommendations will be useful to a range of different agencies;
   c) the case is high profile or likely to attract media attention; and
   d) there were concerns about services in the area before the incident took place.

10. External reviews are written and investigated by an external team of experts, commissioned by the local CPC.

England

Serious Case Reviews (SCRs)

11. A SCR should take place[17] if abuse or neglect is known, or suspected, to have been involved AND
    - a child has died OR
    - a child has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child OR
    - the child dies in custody OR
    - a child died by suspected suicide.

12. The LSCB follows statutory guidance for conducting a serious case review. The decision to conduct an SCR should be made within one month of the notification of the incident. The LSCB must notify the national panel of independent experts and Ofsted of this decision. Likewise, the LSCB must submit the names of the reviewers to the national panel, and the lead reviewer must be independent of

[17] Source for the above HM Government (2015) working together to safeguard children : a Guide to inter-agency working to safeguard and promote the welfare of children. Department for Education.

the LSCB. The LSCB should aim to complete an SCR within 6 months.

13. The final SCR report and the LSCB response to it must be published on the LSCB website for a minimum of 12 months.

14. The Department for Education (DfE) has taken steps to widen the pool of SCR authors, funding a new training programme. There has also been discussion about the need for a national database of authors and a more formal process for selecting authors than the current informal system of networking. The Association of Independent LSCB Chairs now maintains a database of independent authors, which can be accessed by Board Chairs, but it is not quality assured.

Northern Ireland

15. Please refer to Chapter 4.