

Child Care Policy Directorate  
DHSSPS  
Room D1 Castle Buildings  
Stormont Estate  
Belfast  
BT4 3SQ

10 August 2012

Our ref: 12/PD/PLM/077

Dear Sir/Madam

## **Consultation on Guidance to the Safeguarding Board for Northern Ireland (SBNI)**

The Northern Ireland office of the Commissioner for Children and Young People (NICCY) was created in accordance with 'The Commissioner for Children and Young People (Northern Ireland) Order' (2003) to safeguard and promote the rights and best interests of children and young people. The UK Government, including Northern Ireland, is a signatory to the United Nations Convention on the Rights of the Child (UNCRC) and the Department should ensure that the guidance takes full account of the Convention. NICCY therefore welcomes the acknowledgment in the document that SBNI is bound by commitments made under international law such as the UNCRC. We also welcome the work undertaken by the Department with the Participation Network and other stakeholders to ensure the consultation seeks the views of children and young people.

NICCY has sought to engage extensively in legislative and policy debates concerning the development and establishment of SBNI. This response is not intended to be comprehensive but instead highlights key concerns and should be considered in conjunction with our previous evidence papers and responses which have been enclosed.

### **Comments on the draft Guidance**

#### Introduction

As previously noted, the Department should ensure that membership of SBNI is reviewed to assess if representation is appropriate and that where there are gaps, effective communication mechanisms have been developed to address this. Examples



of this include the judiciary and courts, guardian ad litem service and border authorities, such as the UK Border Agency. The Department should also ensure the SBNI panels and committees have appropriate non governmental representation (NGO) which is also kept under review. In considering strategic partnerships that SBNI should develop links with we note that this must include the Children and Young People's Strategic Partnership.

#### Objective, duties and functions of SBNI

The description of safeguarding set out in the Guidance should include promoting the physical and psychological recovery of children who have experienced abuse and neglect as outlined in article 39 of the UNCRC. It is important that the Department ensures that in discharging its statutory functions SBNI takes account of the particular vulnerabilities of some groups of children to abuse and neglect, such as those with disabilities, separated children, and care experienced young people. NICCY would also highlight that SBNI should maintain a focus on its 'core business' of child protection before expanding into its wider safeguarding remit which has been identified as an important factor in the effectiveness of Local Safeguarding Children Boards (LSCBs) in England.<sup>1</sup>

We request that the Department outlines any legal or practical implications of SBNI duties and functions being discussed in the guidance but not prescribed in secondary legislation, such as the duties to cooperate and to keep under review the effectiveness of what is done by each member. NICCY recognises that the operation of the duty to cooperate will be central to the success of the Board and further consideration of the implementation and monitoring of this should be detailed in both the guidance and SBNI membership agreements. The guidance on keeping under review the effectiveness of what is done by each member should include reference to assessing the effectiveness of services and support provided to children, young people and families including early help, as part of reporting and monitoring arrangements.

NICCY welcomes the requirement that the duties to cooperate, to review the effectiveness of members and to make arrangements to safeguard and promote the welfare of children should be assessed in SBNI's annual report and note this should be highlighted in the governance section of the guidance. We also welcome the reinforcement that this latter duty requires members to both discharge their functions in accordance with this and ensure services contracted to other bodies or persons have regard to the duty. More detailed consideration should be given to arrangements

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<sup>1</sup> France A., Munro E.R. and Waring A. (2010) The Evaluation of Arrangements for Effective Operation of the New Local Safeguarding Children Boards in England, (London: Department of Education).

whereby concerns identified by SBNI would be reflected in the activities of regulatory and inspectorate bodies.

#### Communication between the SBNI and children and young persons

NICCY is supportive of the principles outlined and the reference made to the Ask First Standards and other documents. We would note that direct engagement with children and young people and ensuring that their voices shape the work and priorities of SBNI should be given greater prominence. The guidance should reflect the importance of engagement with children and young people who have experience of child protection and safeguarding arrangements and ensure that there is thematic or specialist engagement with particular groups, such as children with disabilities. It is important that the document recognises that ethical considerations apply to all work with children and not just those identified as vulnerable or marginalised. We welcome the direction in the guidance that consistent standards in relation to this duty should operate across all panels and committees and note that SBNI should report on this.

#### Other functions

It is of concern that minimal detail is given in regard to other functions of SBNI and NICCY requests clarification on the direction that these will only be used exceptionally. In relation to SBNI's 3(9) function, the guidance should reflect that the requirement for the Board to consult with the Department in relation to the publication of information, advice or other matters should be for purposes such as ensuring factual accuracy rather than requiring Departmental approval. We would also note that SBNI's 3(10) function to engage in any other activity conducive to its objective may allow the Board to conduct thematic, overview or other forms of review that do not fall within the scope of Case Management Reviews (CMRs).

#### Structures

NICCY would point to the importance of ensuring that SBNI, including its panels and committees, is adequately resourced, including in relation to staffing, as documented in evaluations of LSCBs.<sup>2</sup> The Department should ensure that a mechanism is in place to review the structure and resourcing of the Board, including the in-kind contribution of member agencies and resourcing of CMR and child death review functions.

It is helpful that the guidance permits the inclusion of time bound members to SBNI. NICCY acknowledges the importance of membership agreements specifying the particular roles of those representing professions and groups of organisations. In

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<sup>2</sup> op cit.

relation to closed meetings of SBNI, the guidance should highlight that where only specified items of an agenda are not appropriate for discussion in public only these sections of sessions should be closed.

#### Governance and accountability

It is important that robust monitoring and evaluation processes are in place across all areas of SBNI's statutory remit. NICCY is supportive of the inclusion of feedback from children and young people in the criteria identified to measure SBNI's effectiveness. Further consideration should be given to how external reviews or inspections, including reports undertaken by NICCY, will be used as a means of assessing the Board's effectiveness.

The guidance should ensure that a mechanism for matters to be escalated to or indeed by the Department is clearly established, for example, in cases regarding the effectiveness of members who have not responded satisfactorily to concerns raised by SBNI. The document should also specify the processes that will be in place to notify the Department in relation to matters such as child deaths and CMRs and should clarify the oversight role of the Department.

As highlighted in previous submissions, SBNI's annual report should provide an analysis of safeguarding arrangements and services including assessment of weaknesses, challenges and emerging concerns. We request clarification that the report should list reports that have been submitted to the Department for publication when the primary legislation affords SBNI the function of publishing any matter (subject to consultation with the Department). The guidance should reflect that the annual reports of SBNI committees and panels should also be published.

#### Guidance in regard to the review of information relating to child deaths

NICCY must again express concern at the delay in the commencement of the child death review duty and requests that the Department and/or SBNI ensures early and ongoing engagement with the office during the development and establishment of this function. We would highlight the importance of ensuring effective links are developed across SBNI's CMR and child death review duties.

#### Guidance in regard to CMRs

The guidance relating to CMRs should ensure that these are conducted where a child has died, including death by suicide or accidental death, or been significantly harmed and abuse or neglect is known or suspected as a factor. In such cases a CMR should be carried out without the additional requirement of the child or a sibling being or

having been on the child protection register or looked after. It is important that the guidance does not present a restricted threshold for CMRs and recognises that concerns relating to the effectiveness of member agencies may only be clearly evidenced during the course of a CMR. NICCY also observes that the guidance should be prefaced with the requirement that SBNI ensures steps are taken to safeguard all other children who may be at risk of harm in cases which are considered for a CMR.

In considering the membership of the CMR Panel we highlight the importance of agreeing detailed membership agreements and note that there is no representation from a designated doctor or mental health services. NICCY would also raise concern that only statutory agencies are identified as core members and points to the need to draw on the expertise and knowledge of NGOs such as voluntary sector agencies and academics.

In relation to CMRs and other linked processes, the guidance should make reference to the interface with serious adverse incidents, public inquiries and the SBNI Child Death Overview Panel. NICCY welcomes the requirement for SBNI to establish memoranda of understanding (MoU) with agencies such as the Coroner's Office and inspectorate bodies. NICCY does not develop MoUs with bodies who are designated relevant authorities for the purposes of our legislation but we are establishing a Protocol with SBNI. This dialogue is ongoing and, as the Department is aware, NICCY is of the view that SBNI should provide the Commissioner with the equivalent access to CMR information as has been afforded through our Protocol with the Health and Social Care Board.

NICCY remains of the view that the CMR Panel should be vested with the statutory function to monitor and review the implementation of learning from CMRs. It is particularly important that this duty is specified given the significant changes proposed to the CMR process, such as the removal of the requirement to produce action plans and update reports or to conduct individual agency reviews. Indeed, we note our disappointment that given the nature of these changes the Department has not engaged in substantive discussion with NICCY in relation to the proposals.

NICCY would highlight the importance of ensuring that a consistent, robust and transparent process for implementing and reporting on local and regional learning from CMRs is developed. SBNI should conduct regular analysis of CMRs beyond an annual bulletin of learning, including undertaking overview and thematic analysis. This may for example consider sub groups of cases, seen for instance in NICCY's commissioned research on cases relating to adolescent suicide and accidental death

and trend analysis tracking the distribution of variables such as age, geography, disability, mental health difficulties, domestic violence and so on across cases. SBNI's monitoring role should be further clarified to ensure that an over-reliance of agency self audit does not develop in relation to this or any other function of the Board.

We also draw attention to concerns that the move away from CMR recommendations to practice learning points may restrict the scope and findings of reviews which should, where appropriate, identify issues beyond professional practice that have contributed to poor safeguarding outcomes for children and young people. Examples of this may include weaknesses in legal arrangements, policy provision or resourcing. Indeed, the purpose of the CMR process should reflect the aim of improving safeguarding arrangements as a whole, rather than focusing only on practice or service delivery. In instances where barriers to effective safeguarding are identified and not within the remit of SBNI or its members a mechanism for escalating findings to other bodies or the Northern Ireland Executive should be outlined.

NICCY must state our serious concern in relation to the direction that CMR reports should be published in full. While much of the draft guidance replicates that developed for LSCBs in England, the document should take account of the context and arrangements that operate in Northern Ireland. NICCY recognises the importance of ensuring transparency in the CMR process and supports moves, in the public interest, to strengthen this. However we recommend that the Department requires SBNI to publish CMR Executive Summaries (which has not been a requirement or practice to date) having agreed a consistent format, typology and content of summary reports which will protect the identity of children and families. These new arrangements should be implemented for a period of time and then reviewed further before consideration is given to the publication in full of CMRs.

In addition to this, NICCY requests clarification on the reference in the guidance to the expressed view of the Information Commissioner's Office which has, of course, recently issued a positive decision notice on the decision of the Health and Social Care Board not to release CMR Executive Summaries. It would be helpful for the Department to provide further detail on how comments in the document noting the need for case by case consideration of publication and the final decision resting with the Chair of SBNI are reconciled with direction for the full publication of reports. NICCY is further concerned that where full reports may be published this could severely limit the potential for effective analysis or review as reports may lack any significant context or depth in order to ensure that identity of children and families is properly protected. We would also question whether it is the role of the CMR Team, rather than the Panel, to

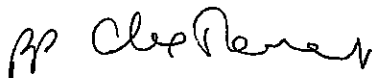
report on action taken in response to the case and how practical this is given the timeframe in which reviews must be completed.

NICCY requests that the Department clarifies whether the reference to systems approaches to case review is specific to the Social Care Institute of Excellence model. Whilst we recognise that this is a developing area, along with other commentators, we note that systems methodology is yet to be proven as an effective approach in child protection or case review work.<sup>3</sup> We are particularly concerned that a change to this approach does not lessen the review focus on the voices or experiences of children and young people. NICCY recommends that the Department requires SBNI to pilot this approach and ensures that a proper evaluation of the methodology is completed before it is further rolled out. NICCY welcomes the reference made in the guidance to the involvement of and support for children and families throughout the CMR process and notes this should take account of the research commissioned by the British Association for the Study and Prevention of Child Abuse and Neglect on this topic.

Finally, in the transition to SBNI it is important that the Department ensures the Board properly takes account of legacy CMRs and recommendations from Area Child Protection Committees and the Regional Child Protection Committee and we request further detail on the repository of previous learning which is referenced. NICCY would note that SBNI must also consider and implement learning from the findings of the QUB/NSPCC Overview Report and NICCY's forthcoming commissioned research on cases in relation to adolescent suicide and accidental death.

Please do not hesitate to contact my office if you would like any further information.

Yours sincerely



Patricia Lewsley-Mooney  
Commissioner for Children and Young People

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<sup>3</sup> NSPCC (June 2011) Parliamentary briefing on the Munro Report and its implications for child protection. Available at:  
[http://www.nspcc.org.uk/Inform/policyandpublicaffairs/westminster/briefings/munro\\_report\\_wdf82966.pdf](http://www.nspcc.org.uk/Inform/policyandpublicaffairs/westminster/briefings/munro_report_wdf82966.pdf)