Looking Back to Look Forward in Child Protection and Safeguarding

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“Children are the living messages we send to a time we will not see.”

Neil Postman, 1994: xi
United Nations Convention on the Rights of the Child

- **Article 6 (1)** States Parties recognise that every child has the inherent right to life.

- **Article 6 (2)** States Parties shall ensure to the maximum extent possible the survival and development of the child.

- **Article 39** States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.
Objectives of the Child Protection System

- To reduce the prevalence and incidence of child abuse and neglect through preventative approaches;
- To reduce the child mortality rate as a consequence of having a system for identifying and protecting children at risk of significant harm;
- To prevent children identified as being in need of protection from experiencing repeated harm;
- To address the effects of the harm experienced by children on their development, and promoting their welfare resulting in improved psychological and social functioning and improved educational attainment;
- To address the needs of other family members so that they are in a better position to provide for the care and future protection of the child.
Number of deaths of 0-19yr olds from all causes in Northern Ireland 1980-2011
The Child Protection Success Story

An improving situation regarding non-accidental child deaths

Children known to the child protection system are less likely to die from non-accidental causes

Three quarters of children subject to a child protection plan have a positive outcome
And yet............

**Risk still drives the system rather than support**

**Practitioners struggle to make a difference with families with certain types of problems**

**The focus on outcomes is still underdeveloped**

**The focus is still on childhood rather than lifecourse**
Windows into Practice

- Feedback from service users
- Feedback from practitioners
- Administrative data
- Audits and evaluations
- Research
- Reviews and inquiries
“The death of any child for whatever reason is a personal tragedy for the family and a loss to the wider community. Where that death is the result of abuse or neglect, the sense of both grief mixed with outrage is more palpable. There is therefore a natural tendency within the policy making sphere to respond to these public and professional reactions by being seen to do something, even if it is unclear what this should be.”

Devaney, Lazenbatt & Bunting, 2011
Purpose of Reviewing Incidents of Child Death and Serious Injury

To better ensure that all children are kept safe and their well being promoted through identifying:

• what aspects of the system have worked as intended, and therefore can be built upon;

• what aspects of the system have not worked as intended and need reconsidered; and,

• whether any new processes or systems need to be developed as a result of our improving understanding about children’s needs.

A focus on learning and quality assurance
Criteria for a Case Management Review

A review should always be undertaken when:
• A child dies, including by suicide, and abuse or neglect is known or suspected to be a factor in the child’s death

A review should always be considered when:
• A child has sustained potentially life-threatening injury through abuse (including sexual abuse) or neglect
• A child has sustained serious and permanent impairment of health or development through abuse or neglect
• The case gives rise to concerns about the way in which local professionals and services worked together to safeguard children
Northern Ireland Overview: Translating Learning into Action

- 24 case management reviews completed between 2003-2008 on 45 children

- All the children white, Northern Irish

- 18 of the reports dealt with the death of children:
  - 3 reports on children who were murdered
  - 6 reports on younger children who died from undetermined causes
  - 1 young person who died from a suspected sexual assault
  - 8 young people who died accidentally or by suicide
Indicators of Current and Historic Concern
Within Family

- Family history of child neglect
- Family history of child emotional abuse
- Family history of child physical abuse
- Family history of child sexual abuse
- Low family income
- Adult learning disability
- Adult mental illness
- Adult substance misuse
- Domestic violence ever
- Domestic violence in previous 12 months
- Death of previous child in family
- Death of parent
Childhood Adversity of Index Child

- Domestic violence: 14 (No), 10 (Yes)
- Parental substance misuse: 9 (No), 15 (Yes)
- Parental imprisonment: 1 (No), 23 (Yes)
- Parental mental ill health: 6 (No), 18 (Yes)
- Child sexual abuse: 9 (No), 15 (Yes)
- Child physical abuse: 7 (No), 17 (Yes)
- Child emotional abuse: 5 (No), 19 (Yes)
- Child neglect: 12 (No), 12 (Yes)
Numbers of Indicators of Concern

[Bar graph showing the number of indicators of concern for various cases, labeled Case 1 to Case 24. The x-axis represents the cases, and the y-axis represents the number of adversities recorded, ranging from 0 to 10.]
Keeping the Focus on the Child

Hearing Their Voice

Understanding Their Experience
Early and Sustained Intervention

“In one case the commencement of appropriate therapeutic work with one young person was seriously delayed, and in the interim the young person’s emotional life became more complex and complicated by the death of a parent, and the increasing negative influence of a peer group.”
“In spite of a history of poor parental mental health and substance misuse, and evidence of poor supervision, underage babysitters, regular crisis, incidents of domestic violence and frequent house moves and poor school attendance, the behaviour of the ten year old child was diagnosed as ADHD, and she was commenced on Ritalin.”
“In one review report dealing with the death by suicide of a young person, the author identified that professionals had been alerted by older siblings and other relatives to various incidents of physical abuse of the child and their siblings over a four year period. Professionals had dealt with each incident in isolation, not appreciating the cumulative importance of the multiple incidents.”
Communication and Information Sharing between Professionals

“One consequence, which regularly shone through the review, was an unjustified optimism held by different disciplines about the work that others may be doing with the child and family.”

“Critically, for two social workers visiting the same family (from child care and adult mental health), there was no evidence of collaborative working.”
Compliance with Established Policies and Procedures

“The focus of the recommendations was surprising. The conclusions had dwelt on lessons to be learned about work with children and families and with other agencies to improve safeguarding practice. These conclusions were generally related to information about the case and to its analysis. The solution to enable these lessons to be learned, however, was not on improving practice by increasing knowledge and skills but on creating more procedures. The focus of the recommendations was predominantly on reviewing existing procedures or calling for new procedures…..”

(Rose and Barnes, 2005: 45)
Supervision, Staff Support and Training

“The inexperienced social worker was carrying cases across three teams in two different offices without proper line management arrangements in place to ensure appropriate support and supervision.”
Organisational and Staffing Context

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

• High quality work with families and children was often evident, even when the outcome was poor
• Children in the child protection system are safer
• Increasing evidence of multi-disciplinary working
• Professionals keen to participate in processes which focus on learning to keep other children safe
Turning Learning into Action

• Introduction of UNOCINI
• Improvements in the receipt and management of referrals to children’s social services
• ‘Think Child, Think Parent, Think Family’ initiative
• ‘Thresholds of Intervention’ guidance
• Improvements in the arrangements for staff supervision
• Review of the Joint Protocol
Conclusion

The cases subject to a review are very similar to lots of cases known to professionals – therefore trying to spot the child who might die is futile. Rather, providing the larger pool of vulnerable children and families with earlier, sustained and better co-ordinated services will reduce the likelihood of children suffering unnecessarily.
Looking into the Future

• Refining the process of how we review such cases
• Sharing anonymised data between countries
• Continuing to focus on translating the learning into action
• Engaging with the media, public representatives and the public about the reality of some children’s lives
A Final Thought........

“There are children alive today because of what we have learned and what we have done as a result of that learning.”
A Final Thought.......  

“There is arguably a moral as well as a legal responsibility to try to understand more about the circumstances which might lead to the occurrences of a child’s death or their serious injury. However, there must though be a greater recognition that child deaths from maltreatment are not entirely avoidable.”
Resources


https://www.nspcc.org.uk/Infor m/policyandpublicaffairs/norther nireland/evaluation_of_case_ma nagement_review_process_ni_w da76707.html


http://www.niccy.org/artic le.aspx?menuId=16030