Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

The Safeguarding Board for Northern Ireland (Membership, Procedure, Functions and Committee) Regulations (Northern Ireland) 2012

28 March 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy

Witnesses:

Ms Eilís McDaniel	Department of Health, Social Services and Public Safety
Ms Patricia Nicholl	Department of Health, Social Services and Public Safety
Ms Isobel Riddell	Department of Health, Social Services and Public Safety
Mr Hugh Connor	Safeguarding Board for Northern Ireland

The Chairperson: We will now take an evidence session on the draft Safeguarding Board regulations. We have the experts here. I apologise for keeping you waiting so long. There was a suggestion that we could have started earlier to try to deal with some of the stuff, but we will look at that. You are going to take the lead, Eilís, so I will ask you to make the introductory remarks, after which we will open up the session for questions and comments.

Ms Eilís McDaniel (Department of Health, Social Services and Public Safety): Thank you very much, Chairperson. I am here today with Patricia Nicholl, who is from the office of social services in the Department of Health, Social Services and Public Safety (DHSSPS); Isobel Riddell, from the Department's childcare unit; and Hugh Connor, who is the chairman (designate) of the Safeguarding Board for Northern Ireland (SBNI), whom you have invited to the Committee to give evidence in addition to that given by the Department.

I will begin by thanking you for your invitation to give evidence on the draft regulations. Committee members will be aware that the Safeguarding Board Act 2011 became law in February of that year. The Act establishes a new Northern Ireland children's Safeguarding Board and a number of committees of that board. Subject to our having the regulations and guidance in place, it is intended to have the SBNI up and running by July 2012.

The Committee has had sight of the draft regulations, which we issued for targeted consultation between November 2011 and January 2012. The draft regulations make more detailed provision for the operation of the SBNI, the five local safeguarding panels and the case management review (CMR) panel of the board. The consultation sought the views of a range of key stakeholders, many of whom have been involved in reference groups that were set up to advise on the development of the primary and secondary legislation. Regulatory, inspectorate and professional bodies were also consulted, including the Information Commissioner's Office (ICO), the Northern Ireland Human Rights Commission (NIHRC) and the Northern Ireland Commissioner for Children and Young People (NICCY).

The Participation Network, which is funded by the Office of the First Minister and deputy First Minister (OFMDFM), facilitated consultation with children and young people by producing a child-friendly version of the draft regulations and sharing it with a range of children's organisations for comment. The Department received 27 responses from a range of organisations. The analysis report includes a list of all those who responded. In general, it is fair to say that there was overwhelming support for the regulations as drafted. We intend to deal with a number of issues that were raised in the consultation in two ways: first, by amending SBNI guidance, which we are in the process of finalising; and, secondly, by making amendments to the regulations.

A number of issues that were raised in the consultation will not be acted on. The Department has considered each of those issues in detail and has provided a rationale for not taking them on board in the analysis report. For example, there was a request to downgrade the seniority of representation on the SBNI, but that runs contrary to the Department's policy intention to have organisations represented on the SBNI at a very senior, strategic level, and we have discounted that kind of comment on that basis.

Through guidance, we will provide greater clarity on a range of issues raised. For example, it is evident that it needs to be made clear that member agencies of the SBNI will not be permitted to send along a deputy in place of representatives named in the regulations. Clarification is also required of the contents of the SBNI's annual report, the role and function of the case management review panel and the administrative arrangements for the five safeguarding panels. When finalised, the SBNI guidance will be consulted on and published in advance of the board coming into operation this year.

We propose to amend the regulations. To begin with a couple of minor, technical changes, there are two typographical errors in the regulations as drafted, which will be corrected.

We propose to amend draft regulation 3 to provide that a designated nurse for safeguarding — to be defined in regulation 2 — who is an employee of the Public Health Agency (PHA) will be added to the membership of the SBNI. That amendment has been agreed with the Department's acting Chief Nursing Officer, the chairman (designate) of the SBNI and the director of nursing and allied health professions in the PHA. We also intend to add a designated doctor —

The Chairperson: Sorry, for members' information, the stuff that you are highlighting is in their papers.

Ms McDaniel: We provided you with a detailed analysis and report, which I hope will assist members. I am just taking you through changes that we intend to make to the regulations.

As I said, we will have a designated nurse for safeguarding, and we also intend to add a designated doctor for safeguarding.

The Chairperson: It is a tabled item in your papers, Sam.

Ms P Bradley: It is highlighted in red.

The Chairperson: Sorry about that, Eilís.

Ms McDaniel: OK. We will also increase from one to three the minimum number of voluntary and community organisations represented on the SBNI and the safeguarding panels. The maximum will

remain at five. The chairman (designate) may wish to say something more on that, but I am aware that he intends to utilise all five voluntary and community sector places from the outset.

We will amend draft schedules 1, 3 and 5 to reflect that the SBNI and its panels will meet at least four times a year. The draft regulations previously stipulated that the board and panels would meet every two months. Some respondents to consultation considered that frequency of meetings to be impractical, a view supported by the current chairperson of the regional child protection committee and the SBNI chairman (designate). Consequently, the regulations will be amended.

Draft regulation 17 deals with the SBNI's case management review function. In accordance with the draft regulations, the CMRs will be undertaken in circumstances in which a child dies or is significantly harmed and one of a number of other conditions is satisfied; for example, if the child or a sibling was on the child protection register at the time of the child's death. In response to comments from the National Society for the Prevention of Cruelty to Children (NSPCC), the Children's Commissioner, the Health and Social Care Board (HSCB) and one trust, the term "significantly harmed" will be defined in line with the definition that is used in the Children (Northern Ireland) Order 1995.

It is also proposed to amend draft regulation 17 to extend the circumstances in which it is required that a case management review be undertaken. In addition to the circumstances in which a child has died or been significantly harmed, it is proposed that the CMRs be undertaken in cases that demonstrate that member agencies have worked well, either individually or in partnership. Extending the criteria is intended to identify and highlight best practice for the purpose of improving practice across Northern Ireland to safeguard children and promote their welfare. In so doing, the Department intends to shift the balance away from case management review as the mechanism for establishing how and why things go wrong in the management of children's cases towards being a mechanism for identifying and disseminating positive learning.

Draft regulation 37, which deals with the annual report of the CMR panel, will also be amended to complete that shift. References to CMR panel recommendations will be replaced with practice learning points, and we will define "practice learning point" in the regulations. We will also adjust the regulations to better align the arrangements for the appointment, disqualification, period of notice and termination of appointment of the chairpersons of safeguarding panels with those that apply to the chairperson of the Safeguarding Board. Therefore, for example, a safeguarding panel chairperson will be disqualified from appointment on exactly the same grounds as the SBNI chairperson.

Members will be aware that the SBNI has been tasked with promoting communication with children and young people. Those who responded to the consultation queried whether that function should also extend to safeguarding panels. Consequently, we propose to amend draft regulation 31 to include an additional function for safeguarding panels to promote communication between the panels and children and young people, which will mirror the function of the Safeguarding Board. On the basis that the Probation Board for Northern Ireland (PBNI) has been involved in the conduct of case management reviews undertaken by the existing regional child protection committee, it is proposed to amend draft regulation 30 to add the PBNI to the core membership of the SBNI's case management review panel.

It is proposed that schedule 5 to the regulations will be amended to reflect that case management review panel meetings will routinely be closed, given the nature of the CMR panel business. CMR panels will, in the main, deal with highly sensitive cases of child death or serious injury. On that basis, the closure of meetings to the public is considered necessary.

By extension, the Department considers that meetings of safeguarding panels should also be closed. Case management reviews will have their origin in safeguarding panel areas and be subject to discussion prior to, and on completion of, a case management review by the SBNI. Consequently, it is considered appropriate to amend schedule 3 to reflect that meetings of a safeguarding panel, in addition to the case management review panel, will routinely be closed to reflect the confidential nature of the panel's business. We want to ensure that each panel is empowered and enabled to conduct its business openly and frankly. How each panel is performing will be reflected in the SBNI's annual report.

The Department also intends to amend schedules 1, 3 and 5 to the regulations to alter the quorum requirements imposed on meetings of the SBNI and its panels. That follows further consultation with the current chairperson of the regional child protection committee and the chairman (designate) of the SBNI, both of whom indicated that quorum requirements as specified in the draft regulations could present operational difficulties for the board and its committees. As a result, schedules 1, 3 and 5 will be amended to reflect that two thirds of the membership of the SBNI and its panels must be present to enable business to be transacted. That is in place of the three quarters previously stipulated. That includes representation by the chairperson or deputy chairperson of the board and panels.

At this stage, there is no provision in the draft regulations for child death review, which was raised by the Commissioner for Children and Young People. It has always been the Department's intention to make provision in regulations for child death review at a later stage. There are a number of reasons for that. We need to define clearly the relationship between the case management review and child death review processes, given that both have the potential to examine the events surrounding the same child's death. We also wanted additional time to consider the implementation of child death review in other parts of the UK, where there are different approaches to child death review. The jury is still out on the effectiveness and benefits of the child death review process. The chairman (designate) has had discussions with chairpersons of local safeguarding children's boards in England about the merits or otherwise of child death review. The Committee may want to explore that further with Mr Connor.

Different approaches to child death review generate different costs, and those costs can vary significantly. In England, the average cost of an individual child death review is £3,480. In Wales, it is £726. The annual bill in England is £17·4 million and in Wales it is £152,000.

In Northern Ireland, we need to determine which approach is the most appropriate in the context of ongoing financial challenges. At this stage, we are minded to implement a process of child death review incrementally, starting with the establishment of the child death overview panel for the purpose of collecting and reviewing information on all child deaths in Northern Ireland from a range of sources, including information from the General Register Office (GRO) and census collections. That will be similar to the approach taken in Wales and will give us the opportunity to align the SBNI's child death review and case management review functions and to define clearly how it relates to other processes such as the Northern Ireland maternal and child health (NIMACH) process.

It will also give us the opportunity to explore child death review with contributors to an international child protection conference in Belfast next month. Those contributors will have a significant wealth of knowledge and experience of child death review nationally and internationally.

I have taken you through the proposed changes to the SBNI guidance and regulations and, hopefully, provided members with an update on the Department's plans for child death review in Northern Ireland. I am very happy to take questions from members, but, before I do, I will hand you over to the chairman (designate) of the SBNI, who you invited to give evidence.

Mr Hugh Connor (Safeguarding Board for Northern Ireland): I am pleased to have the opportunity to update the Health Committee on the work undertaken to date to establish the Safeguarding Board. The director of operations and the professional adviser have now been appointed and are taking up their respective posts in mid-May. That is the organisation's complement of full-time professional staff. In addition, the board's administrative staff have been appointed, and interviews have taken place for lay members. Names have been forwarded to the Minister in order that he might decide whom he wishes to appoint. The only outstanding appointments are for the posts of part-time safeguarding panel chairperson.

Following consultation with the Department, I have begun a process to bring five members from the voluntary and community sectors on to the board. Twelve organisations have expressed an interest in being considered as members. The selection process now needs to be agreed with the Department and put in place. Since my appointment, I have met most of the people who are to become members of the board. I have also attended meetings of the regional child protection committee and its subcommittees, and I am in the process of attending meetings of the trust child protection panels. I have done so to promote the Safeguarding Board and to manage safely its transition to the board. Additionally, I have been working with other organisations, where appropriate, to develop memoranda of

understanding. I have also been developing a training and induction programme for all staff and members.

The board will immediately become responsible for case management reviews on its establishment, so I have scheduled a workshop with chairpersons of recent reviews to begin to consider how the process can be improved. I believe that the decision of the Northern Ireland Assembly, supported by the Health Committee, to establish the Safeguarding Board was prudent. I believe that the board provides a unique opportunity to keep children and young people safer, without being, in itself, a panacea. The task given to the Safeguarding Board is to ensure and co-ordinate the effectiveness of the activities of the member agencies in safeguarding and promoting the welfare of the children of Northern Ireland. That will involve working along a continuum, from individual case management reviews to targeting vulnerable children and families through to addressing key practice issues and strategic issues.

The key to the success of the SBNI lies in engaging and securing the commitment of the member agencies to collaborate, share information and resources, develop new ways of working or new approaches and deliver on the commitments that they make when signing up to the SBNI strategic and annual business plan. At a time of considerable pressure on public services, every organisation will have its priorities agreed with its parent body. The board's task is to ensure that the issues of safeguarding and child protection continue to receive a high profile, matched by an ongoing commitment from the member agencies to continuous improvement. The Safeguarding Board can facilitate, co-ordinate, challenge and provide leadership, but it is not operationally accountable for the work of the member agencies. It can challenge its members vigorously, but it cannot operationally direct them, as the responsibility to deliver on statutory duties remains with the member agencies. The success of the SBNI is therefore likely in part to be based on learning and implementing the lessons from things that have gone wrong in the past, presenting new ideas, analysing and vigorously debating the strengths and weaknesses of current ways of working and, most importantly, hearing the voices and opinions of children in particular but also those of families and front line staff.

Local safeguarding boards have been established in England and Wales for a number of years. There are some key differences in the Northern Ireland model, not least the level of political accountability. Independent research conducted in England and Wales has flagged the importance of role clarity and of having clear expectations of the Safeguarding Board. That is particularly true in finding the balance between doing on the one hand and monitoring and scrutinising on the other hand. The issue will require ongoing discussion and debate, primarily with the sponsoring Department, but other Departments may also need to be engaged.

A further message from research is that, at a time of change, safeguarding boards must keep their eye on the central issue of child protection. That means that the first strategic plan of the SBNI is likely to focus on some of the key issues of child protection while simultaneously introducing the broader agenda of safeguarding. A key principle that I believe should guide the work of the SBNI is the need for it to be a learning organisation, which seeks to use that learning to change how organisations think, train and work together. Equally, I want the organisation to adopt a children's-right approach. The central question must be this: do our collective efforts keep children safer, and will children and families recognise that? Therefore, listening to the experience of children and families must be central to the board's work. I am keen to explore how measurable and child-focused performance management targets might be developed. The unique selling point of the SBNI is its capacity to tackle issues on a strategic, co-ordinated and multi-agency basis. That aspect needs to be nurtured and developed. The old adage "If you only do what you always did, you will only get what you always got" is magnified here tenfold because of the partnership nature of the body. Mutual trust and confidence takes time. The SBNI must be forward-looking and ambitious; it must build trust and understanding between its members; and it must create a place for strong but safe discussion, where practice is critiqued and views can be openly aired. Although none of that is particularly eye-catching for producing new products or approaches, I argue that it is the very plumbing and electrics that allows the SBNI to function.

In my introductory meetings with a wide range of people, it was very apparent that the board's expectations are wide and diverse. Although I believe that the board provides a unique opportunity to help keep children safer, it is not a silver bullet. I believe that the board's work will be around 90% perspiration and 10% inspiration. The board must be able to demonstrate consistent progress in

keeping children safer. Along this journey, there will be times when tragedies will occur that will bring the child protection system into the public gaze. At those times, it is important to be able to maintain a balanced view and particularly to recognise that the issues of assessing and managing risk in child protection do not and cannot mean that the risk is totally eradicated. Regrettably, as much as we would all want that, it is not possible.

I feel that the Committee should be congratulated for creating the board, and I look forward to our formal establishment, which, I believe, is likely to occur later in the summer. It will provide a unique opportunity for strategic and co-ordinated planning and service delivery. As chairman, I will do all that I can to realise those aspirations.

The Chairperson: Thank you for your presentation and for your patience.

I have a couple of points to make. For my sins, I was part of the previous Health Committee that dealt with this. Therefore, I am well aware of where it came from and the journey that the Committee made at that stage with the Department to get to this point. In saying that, it has to be welcomed, because it has been a long journey to get here. I appreciate, Hugh, that you have done some work as chairman (designate), and fair play on that. However, there is still a lot of work to be done to make the board a reality on the ground and to let people in our communities know that it is there. It is about being proactive.

Although I raised my eyes, I do not think that you were hyping it up when you said that tragedies will occur along this journey. That is key. However, you said that it is about learning, change and listening, and that is important as well. Hopefully, we will never witness tragedies because the Safeguarding Board and other organisations can be proactive and get in early to deal with the issues that can be predicted, based on statistics and analyses. I hope and pray that we never get to that point.

Establishing a Children's Commissioner was a long journey as well. Where does that office fit into this process? If we are being proactive in ensuring that the rights of children at every level, and, indeed, at government level, are central, and if we are ensuring that the UN Convention on the Rights of the Child is central, it seems a bit silly for the Children's Commissioner to be in one place and the organisation that is ensuring that we are safeguarding and protecting children to be in another. Could a link be made for that? I am concerned about how we link those organisations.

A member has just left, and we still have a quorum, but we cannot make decisions, which is a problem. I have another couple of points to make. The annual report is an issue, as it was for the previous Committee. We are now in a new dispensation, and it is important that people are held to account and that everything is open and transparent. My concern is: why would an annual report sit on the Minister's desk but be reported on only when a Minister allowed? We also have a role to play in some of the issues. What is happening now? Will that report be published?

The other point concerns accountability — I commend the Department on this — and ensuring that senior people who can make decisions attend meetings. However, how do we make them accountable for attending the meetings if only a certain number are held every year? We heard about the issue of accountability throughout the Department. Is there a mechanism in that?

Finally, what happens if a child dies in hospital because of misconduct or a lack of care or because someone has not followed procedures? Do you have a role to play in that?

Ms McDaniel: I will start with your first question on the relationship between the SBNI and the Children's Commissioner. We had ongoing dialogue with the Children's Commissioner when bringing forward the legislation to establish the SBNI, and that has continued since the primary legislation was put in place. As chair (designate), Mr Connor has also been engaged in discussions with the Children's Commissioner. In the same way as we need to find a comfortable relationship between the SBNI and the Children and Young People's Strategic Partnership, for example, we need to find a comfortable working relationship between the SBNI and the Children's Commissioner's office. Both have entirely different roles to play in children and young people's issues. Hugh, maybe you want to say something about the agreement that you have arrived at with the Children's Commissioner.

Mr Connor: I have met the Children's Commissioner twice since taking up post, and I am meeting her and her staff next week again to try to agree a memorandum of understanding. Obviously, the Children's Commissioner has the remit to have oversight of what I and the board are doing and to monitor the board's effectiveness. I appreciate and believe that she needs to be played in very closely from the outset. That is one reason for trying to agree the memorandum of understanding.

Ms McDaniel: Your second point was about the SBNI's annual report. There is a requirement in the legislation to lay that before the Assembly. So, it is not just sitting on the Minister's desk, Chair — that will certainly not be the case. I will bring Hugh in on the issue of accountability, because I know that he has been doing some work on the board's objective and on how he ensures that all the board members are acting in the way as we want them to as members of the SBNI.

The Chairperson: I am glad that you cannot substitute. However, we have all probably been at meetings where people do not attend or will not make decisions or where a different person attends every week. So, that is a positive. However, how do you make the members accountable for their attendance?

Mr Connor: Eilís referred to the fact that there was a recommendation to have four meetings a year. I think that the original intention had been that there would probably be six meetings a year. There will still be six meetings a year, Chair, but I think that four of them will be public. The other two are about trying to engage those organisations in a serious debate about what is achievable and about what should be done. They are about looking critically at the developmental work that needs to be put in place, the commitments that need to be entered into and the mechanism for monitoring those commitments. I think that that is pretty important.

I have in my head the beginnings of a framework for measuring how organisations do what they say they will do. I would want to measure at least half of those tasks using a multi- or inter-agency as opposed to a single agency approach. So, in that report, I have the capacity to refer to the promises or commitments that have been entered into, their realisation or the reasons why they have not been realised. The other thing that is available to me is a notice of attendance at those meetings, which sets out very clearly that the organisations have indeed attended.

This is largely about stimulating. It is about having a very open debate and sometimes having strong and challenging words about the quality of what we are doing. It is also about trying to use that mechanism of influencing, negotiating and holding to account as the basis of that process.

The Chairperson: What if, God forbid, a child happens to die in a hospital setting?

Ms McDaniel: If the criteria for a case-management review happened to be satisfied, that review process would come into scope and the review would be undertaken as and when we put the child —

The Chairperson: Sorry, Eilís, I do not want to sensationalise this, but how does that fit? I am aware of serious adverse incidents in our acute sector, and this is a regional board. It has taken a while before either the Health and Social Care Board or the Minister were made aware of some incidents, so how does the possibility of a child dying in the acute sector automatically go through the system directly to you? Does a red light go off? Does the trust know what it has to do in such circumstances?

Ms McDaniel: The trust will be in the safeguarding panel's area. If such a case happens in a hospital and it happens to satisfy the criteria of a case-management review, my expectation would be that the chair of the safeguarding panel will draw that to the attention of the chair of the SBNI, and action would be taken.

Mr Connor: I am not sure, Chair, whether I understand the circumstances that you are suggesting. The case-management review criteria are very clearly set out. They are largely about abuse and harm to a child. I am not sure whether you are raising the sort of context that is ongoing with hyponatraemia, where —

The Chairperson: No; I do not want to get into specifics. It does not necessarily have to be the case that there is physical abuse. In general terms, and we can talk about the definition of abuse, if there is a duty of care on the state and it fails in that duty of care, do you step in if somebody dies in the acute sector?

Mr Connor: Yes, I believe that that would be the case. If the child were in the care of the state or on the child protection register, there would be no ambiguity about it. That would be an issue that the Safeguarding Board would have to consider.

The Chairperson: I will come back to that.

Mr Connor: Is that —

The Chairperson: No, somebody will probably tease out that physical abuse does not necessarily have to be the issue. The issue is more about somebody in the acute sector failing in their duty of care.

Ms Patricia Nicholl (Department of Health, Social Services and Public Safety): It might be important to note that situations can be referred to the Safeguarding Board where there is any concern that agencies or disciplines have failed to work together to safeguard a child where the incident might have been prevented or may even have contributed to the child's serious injury or death. Although the case may not meet the criteria for a case-management review, the Safeguarding Board can deem that a single agency review or other type of review can take place. There is scope under section 3(10) of the Safeguarding Board Act (Northern Ireland) 2011 for the Safeguarding Board to review that case if it deems necessary.

The Chairperson: That is quite useful.

Mr Connor: I want to make one other point about your first comments. I want to say this from the outset. It would be unfair if the criterion that the Committee set was for the Safeguarding Board to avert a tragedy in every instance, because I do not believe that either history or international practice would substantiate that. If you look at our colleagues in England and Wales, you will see that, despite their endeavours, it is unfortunately the case that children experience death or serious harm from time to time. It is important that we recognise from the beginning that we are on a journey to try to ensure that children are safer. However, it is not an absolute that children can be safe all the time.

The Chairperson: I agree with you, Hugh. I have a background in the children and young people sector, but I also have a motto that says that we should reach for the stars. That is the balance that I am seeking. I know that we will be faced with certain situations at different times, but let us reach for the stars on this matter.

Mr Connor: I share your aspiration. I am a member of the board of the Simon Community, which aspires to end homelessness. However, when people become homeless, it does not mean that the aspiration is diminished.

The Chairperson: I appreciate that, and we can have an adult discussion about that.

Mr Dunne: I thank the panel for their contribution. I do not know a lot about the background to this subject, given that I am fairly new to the Committee. What do you see as the main role and business of the board meetings? Will they look at case histories or at the policies of various organisations, for example?

Mr Connor: That gives me an opportunity to explain a little bit about how the board will be structured. Obviously, there will be the board itself, which currently comprises something like 25 or 27 members. So, the operation is of a fairly significant size. Alongside that, there will be five trust safeguarding panels, and I intend to introduce six committees.

Two of the committees are set down in the legislation. Those are the case management review committee and the child death overview panel committee, which Eilís was referring to. The other four

committees that I intend to introduce are a committee that looks at the policy and procedure, and a committee that looks at multi-agency, inter-professional education and training, given the significance of people training and working together. I also intend to establish a committee that looks at communications and raising awareness and that, in particular, has conversations with children and families who are part of this system and front line staff, and finally, a committee that looks at audit ineffectiveness, because, at some stage, I am sure that you will have me back here to ask me how effective I have been.

Mr Dunne: Yes, I wrote "audit role" in my notes. Do you have an audit role to play?

Mr Connor: Most of the board's work will be done through its committees. Those committees will take their guidance and lead from the strategic and business plans that have been set and from the issues that are to be addressed. When I was making my presentation, I chose not to mention individual pieces of work. I did that, because, although I am the chairperson (designate), it is the board's task to agree the priorities collectively.

Speaking hypothetically, clearly one of the first tasks will be to deal with case-management reviews and to try to learn the lessons from things that have gone wrong in the past. A second issue is that, as we all know, there are vulnerable groups of children and vulnerable groups of parents. Again, speaking hypothetically, we know straight away that there are children with, for example, mental health, emotional or psychological problems who, in their teenage years, are involved in very risky behaviours or perhaps attempted suicide. At the other end, you have very young parents who also present a risk, both where the physical and emotional development of their child is concerned and for their longer-term parenting skills.

Other things that we are going to have to look at include some strategic issues. Again, these examples are all hypothetical. For example, a couple of the matters that we will have to discuss and debate include issues such as the sexual exploitation of children. A recent Barnardo's report on that received a lot of publicity last autumn. The other issue that is in my head is something about a new and co-ordinated approach to those families that have multiple problems and multiple agencies working with them. Interestingly enough, there was a little flavour of that in the English context where the riots are concerned. Those are just some ideas.

Last week, Action for Children published up-to-date research on neglect. I honestly believe that it is not critical which issue you tackle, because I have a sense that anywhere can lead everywhere. Wherever you start, if you work on a multi-agency basis and actually change thinking and the way that people work, it will have spin-offs in a whole range of things. I should not say to you today what the board is going to do, because I believe that the board has to agree that and make its commitment to it.

Mr Dunne: OK, thanks very much.

Mr McCarthy: Thanks very much. Sorry for jumping in and out of the room. You may have answered this question, which concerns the make-up of the voluntary sector representatives. Did you say that there was going to be five or 12 organisations involved?

Mr Connor: Five.

Mr McCarthy: Will they get the Department's approval?

Mr Connor: There was a suggestion in the original proposals that there might be one to five. Subsequently, the Department has clarified that there should be three to five. In the discussions that I have had with departmental colleagues, one of the things that I was very conscious of was that this is a very strong professional and organisational body. I wanted to bring in the maximum counterbalance to that, so I have sought to move to the five, as that is at my discretion. I have begun a process and can say that 12 organisations wrote back at the beginning of that process expressing an interest in becoming members of the board. I now need to agree with the Department a process for taking that forward, which I will do. My intention is that we will hopefully have those member organisations in place around the end of May so that I can begin to do some induction training at the beginning of June.

Mr McCarthy: That is five organisations out of twelve. Is that the maximum that you can have?

Mr Connor: Yes.

Mr McCarthy: That is fine.

The Chairperson: OK. You were last in, but the quickest out. That may be because you gave a good presentation. On behalf of the Committee, I thank you very much. Hugh, you should stay in touch with us on some of those issues.

Mr Connor: I appreciate you giving me the opportunity to come and talk a little bit about what I know are very difficult and emotive issues. I believe that the Committee cares deeply about the issue and all its facets. I believe that it is important at the outset that we try to —

The Chairperson: Do not worry about that; we will torture you at every opportunity. Again, apologies for keeping you until this time.