Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Child Protection in Northern Ireland: Regulation and Quality Improvement Authority

10 December 2009

NORTHERN IRELAND ASSEMBLY

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COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mrs Claire McGill
Mrs Iris Robinson

Witnesses:
Ms Fiona Goodman)
Mr Glenn Houston)
Ms Theresa Nixon) Regulation and Quality Improvement Authority
Mr Phelim Quinn)

The Chairperson (Mr Wells):

I welcome Glenn Houston, the chief executive of the Regulation and Quality Improvement Authority (RQIA), who has been with us before; Phelim Quinn, the director of operations and chief nurse adviser; Fiona Goodman, who is head of children's services; and Theresa Nixon, the director of quality assurance and chief social work adviser. As you will notice, only four Committee members are present, but we expect other members to arrive soon. There are traffic problems this morning.

Some of you are experienced veterans of the Committee and will know how we operate. I invite you to make a 10-minute presentation, and I will then start the questions and throw the meeting open to members.

Mr Glenn Houston (Regulation and Quality Improvement Authority):
We will begin with a 10-minute presentation. I will lead off, and then I will hand over to my colleague Mr Quinn, who will take the Committee through the rest of the presentation. I thank the Committee for the opportunity to address it on the RQIA's child protection review.

In January 2007, the Social Services Inspectorate (SSI) published a major report on child protection, 'Our Children and Young People — Our Shared Responsibility', which is referred to as the SSI overview report. The detailed report contains 77 recommendations for organisations with child protection responsibilities and is aimed at improving arrangements for safeguarding children and young people; increasing public awareness of that important issue; enhancing professional practice, including multidisciplinary and inter-agency working; and informing policy development with regard to safeguarding children and young people.

Since the publication of the overview report in January 2007, there have been a number of significant events. On 1 April 2007, under the review of public administration, five new health and social care trusts were established. They have statutory responsibility for child protection and replace the previous trust structures. The Department of Health, Social Services and Public Safety (DHSSPS) initiated a regional reform of children's services to improve and strengthen child protection. Those reforms are being taken forward by the multi-agency reform implementation team.

Undoubtedly, Committee members will be particularly aware of two separate independent reports of investigations into the tragic deaths of children in Northern Ireland. In March 2008, the O'Neill report on the tragic deaths of Madeleine and Lauren O'Neill was published by the independent inquiry panel to the Western and Eastern Health and Social Services Boards. In June 2008, the Toner report was published following an independent review of agency involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their five children.

In September 2008, work began on planning the RQIA's review of child protection services.

The RQIA review's terms of reference were: to evaluate the implementation of selected recommendations from the SSI overview report; to report on progress by the five health and social care trusts in implementing the relevant reform-policy directives and guidance documents; to evaluate the implementation of the key recommendations in the SSI overview report that were particularly relevant to specific child protection recommendations set out in the O'Neill and Toner reports; and to review the actions that are being taken by the health and social services boards — now the new Health and Social Care Board — with regard to the transitional arrangements that are in place to ensure the continuity of child protection services.

In undertaking that work, the RQIA was assisted by expert reviewers from peer organisations, which included the Care and Social Services Inspectorate Wales and the Health Information and Quality Authority from the Republic of Ireland. The RQIA was also assisted by independent childcare experts from throughout the United Kingdom, which included the child protection adviser for the Royal College of Paediatrics and Child Health; an independent children's social services adviser and lead in the Children's Workforce Development Council; and a nurse consultant who specialises in child protection and vulnerable children. In seeking the views of service users, we also involved an organisation known as VOYPIC, which stands for the Voice of Young People in Care. It is a charitable organisation that represents the views of children and young people who are, or have been, in care.

The 11 reports that the RQIA published in November 2009 made a total of 53 recommendations for trusts. Stage 1 reports concentrated on corporate leadership and accountability of organisations, workforce planning and escalation arrangements. There were 12 recommendations in stage 1. The stage 2 report concentrated on the views of service users and made four recommendations. Stage 3 reports examined the quality of record keeping and made 37 recommendations.

I will now hand over to Phelim Quinn to provide an overview of our findings.

Mr Phelim Quinn (Regulation and Quality Improvement Authority):

The safeguarding of children who are at risk of harm is a challenging and, at times, complex and difficult job. We acknowledge that child protection is one of the most challenging areas of social work. The RQIA also recognises that parents and members of the extended family, as well as other professionals, who include doctors, nurses, teachers and police officers, have an important

role to play in protecting children who are at risk of harm.

Although good progress has been made in certain areas, consistent performance in implementing recommendations from the overview report, which was published in 2007, was not evidenced throughout all parts of the service.

The stage 1 reports dealt with corporate leadership and accountability, and, as Glenn pointed out, examined the lead roles and responsibilities for corporate accountability, workforce strategy and escalation issues. The trusts' executive and non-executive directors had a clear understanding of the corporate parenting role. There was good provision of training to all board members, both executive and non-executive, in that important statutory responsibility. Good practice in visiting programmes for board members to children's residential homes was also noted as part of the review's findings. At corporate level, trusts indicated that policies, procedures and governance arrangements were in place.

However, the inconsistencies in service delivery and professional practice that were observed in stage 3 challenged some of the assertions that had been made by the trusts' senior executives at stage 1. Some difficulties were also identified in the recruitment and retention of staff, and the RQIA made specific recommendations on those areas to two of the five trusts: the South Eastern Trust and the Western Trust.

Each trust should have a named doctor and a named nurse for child protection. In some trusts, however, there was some ambiguity between the role of the doctors who are named and designated by the boards and the trust-named paediatrician. The nurse specialist on the review team commended the way in which the safeguarding role of nurses had been developed in all five trusts across the Province.

As Glenn said, the views of service users were surveyed by VOYPIC. Parents were generally positive about their experiences of using the services provided by trusts and identified several areas of good practices. They commented favourably on family centres and the quality of support that they offered. Parents also spoke positively about the courteous and professional manner of social workers and other members of support staff. Parents were generally satisfied with the response time from social work services when they contacted their social worker. However, they expressed concern about the difficulties of taking part in child protection case conferences. In

some instances, the conferences were regarded as being overly bureaucratic and formal, and they were often perceived as focusing on the failings of parents, rather than on the best interests of the child or young person at the centre of the discussion.

In stage 3, which examined the quality of record keeping, we audited 430 files across Northern Ireland. Stage 3 resulted in the greatest number of recommendations for trusts. A total of 37 recommendations were made and covered issues that include: file structures, recording, training in the use of the new single-assessment tool called UNOCINI, risk assessment of new referrals and unallocated cases, and compliance with child protection policies and procedures.

The audit of child protection files showed that, in some offices, a proportion of new referrals was not screened and appropriately risk-assessed by gateway teams. The RQIA also found that some referrals had not been allocated for appropriate intervention within the recommended timescales. In some offices, there were delays in transferring cases from gateway teams to family support and family intervention teams in accordance with the required protocols. The review teams reported that some case records were incomplete and, in certain cases, an examination of records also showed poor child protection practice and non-compliance with child protection policies and procedures.

Where reviewers found evidence that risks had not been adequately and appropriately identified or managed, the RQIA's escalation policy was brought into play, and the trust's chief executive was immediately informed.

In some offices, inspectors reported an over-reliance on, and inappropriate use of, inexperienced social work staff who were still in their assessed year of employment. In certain offices, inspectors also identified a concern about the lack of appropriate levels of supervision for newly qualified social workers, and there was also limited evidence of quality assurance of the file records by line managers and senior managers. Those processes and practices need to be improved.

Good practice was also noted across the offices in Northern Ireland. Examples of good practice identified in each trust area included: good local management structures at individual office level; good case-file auditing by first line and senior management; and good file structures in which the child's story was easy to follow. In one office, local training initiatives were

observed for all social workers including those in their assessed year of employment. In one trust, there was an ongoing system of multidisciplinary management meetings that had been established to monitor the effectiveness of child protection processes.

The review is not yet complete. The RQIA has been instructed by the Minister to carry out follow-up inspections of the Western and South Eastern Trusts to ensure that the issues identified in stages 1 and 3 of the review have now been fully addressed and the recommendations fully implemented. Dates have now been set for the inspections, which will be carried out as soon as possible. In addition, the second phase of the RQIA review is currently under way. It examines inter-agency working and involves visiting the sites of front-line services to examine public access to services and the quality of staff supervision and appraisal systems. It is hoped that that work will be completed by the middle of next year.

The Chairperson:

Thank you for your presentation. As you know, child protection is a topical issue, and the public are deeply concerned about it. You mentioned the particularly poor standards in two offices, one in Newtownards and one in Omagh. After the Deputy Chairperson has asked her question, I will give priority to members who represent the areas covered by the Western and South Eastern Trusts.

The number of unallocated cases still seems to be an issue. The Minister has provided some extra funding to address that, but we hear anecdotal evidence that the pressure on numbers has shifted from the gateway teams to the intervention teams. Did you see any evidence of that?

Mr Houston:

As part of our visit to each office, we examined the number of new referrals coming through the front door to the gateway team. As part of our remit, we studied the processes that the teams followed in their initial risk assessment of referrals and how quickly a case was allocated to a social worker in the gateway team. In general, we found that cases were being allocated quite well within the gateway teams. However, in some offices, we found delays in undertaking risk assessment and allocating cases. Through our escalation policy, we immediately brought those matters to the attention of the trusts' chief executives.

The Chairperson:

Anecdotal evidence suggests that the threshold that must be reached before a case can be passed to a family intervention team has increased over the past two years. Have you any evidence to suggest that that is correct?

Mr Houston:

An important aspect of our review work was to consider the risk threshold to determine whether initial referrals were being appropriately risk assessed and allocated. As always, work must be prioritised to ensure that the referrals that are in greatest need of a response are seen immediately. That is why the new arrangements under the gateway system were brought in.

The Chairperson:

The Toner report made 63 recommendations. The Minister said that 61 of those have been progressed and that two are outstanding. Are you satisfied that all those recommendations have been properly implemented?

Mr Houston:

We focused on three particular areas of the Toner report. First, recommendation 50 deals with record keeping and formed part of our review under stage 3. Recommendation 45 deals with the supervision of staff. Recommendations were also made on workforce planning. We undertook a mapping exercise of the recommendations that were set out in the Toner report and examined how those related to the overview report that was published in 2007. That formed part of our approach to the fieldwork in the review. Mr Quinn, do you wish to add to that?

Mr Quinn:

As Glenn pointed out, we carried out an extensive mapping exercise of the recommendations of the Toner report, the O'Neill report and the SSI overview report. As members might be aware, some of the recommendations from a number of different incidents were continually being reiterated, and there was considerable overlap. Therefore, we combined the recommendations and asked questions based on those. We will continue to examine the range of recommendations in stages 4 and 5, and, if necessary, we will carry on beyond that.

The Chairperson:

Given that the report highlights two specific trusts and two local offices, I will, after the Deputy

Chairperson has spoken, give priority to Dr Deeny and Mrs McGill, who represent the area covered by the Western Trust, and to Mrs Robinson and Alex Easton, who represent the area covered by the South Eastern Trust.

Mrs O'Neill:

The report identifies gaps in the robust governance arrangements within children's services in the Western Trust. Will you give us a bit more information and explain exactly what you mean by that?

Mr Houston:

As part of our process, stage 1 examined the accountability and governance arrangements within the organisations. The board of a trust has an important role as the corporate parent and as the body responsible for overseeing the implementation of delegated statutory functions. Those functions are described in the Children (Northern Ireland) Order 1995 and primarily relate to child protection.

Part of the approach at the beginning of the review was to meet senior representatives from the trusts, and the panel of independent experts assisted in that process. Initially, we asked the trust to undertake a self-assessment across a complex matrix to tell us how it thought it was performing. We then asked the independent assessors to evaluate that. That formed part of stage 1.

When the inspection team visited the local offices, it identified evidence of good practice and evidence of areas in which there were concerns. When those concerns were identified, we raised them with the trusts through our escalation arrangements. The trusts then responded appropriately. One issue that we raised was the importance of ensuring a good audit trail and a good arrangement whereby first-line managers and senior managers could make sure that case records were robust. We found, in some instances, that that was not the case.

Mrs O'Neill:

As the Chairperson said, there have been many high-profile cases, and no one wants it to take a high-profile case for people to learn lessons. Some of the issues that you identified in the report are the same as those that were highlighted in the Baby P and Victoria Climbié cases. Have any lessons been learned?

Mr Quinn:

In several offices and trusts, we found evidence of good practice in the way in which the reform implementation team's guidelines had started to become embedded. However, that good practice was patchy. In certain local offices, we found evidence that former practices had remained within those trusts. Therefore, I believe that lessons are being learned, but, our view was that this particular review would be proactive in its examination of the way in which all the recommendations had been implemented.

Halfway through the preparation and conduct of the report, the report on the Baby P case was published, and we also took account of that. We started to map the recommendations of the Laming report into our review to ensure that we were not missing anything. They will also be incorporated into stages 4 and 5.

Mrs O'Neill:

You said that you will carry out follow-up inspections of the two trusts. We cannot waste time, so those must happen quickly to prevent any gaps in services. We must ensure that the entire system is robust and that everyone is accountable. Perhaps you will report back to the Committee after the inspections.

Mr Houston:

I want to pick up on that important point. Where there are lessons to be learned from any review — of a case in Northern Ireland, England or elsewhere — it is important that those lessons are learned.

Soon we will make return visits to the two offices that the Chairman mentioned, and we will provide reports of our findings to the trusts' chief executives and to the Minister. The Minister asked that the visits be undertaken immediately, and, as Mr Quinn said, those arrangements are in hand. Subsequently, we will follow up again through the next phase of the review. Part of that work will involve the children's services team returning to the trusts to examine the systems and processes that are in operation in front-line offices, in particular those that provide for the support and supervision of social work staff. One of the critical issues in good child protection practice is that robust arrangements exist for the support and supervision of front-line social workers. Social workers do a difficult job in demanding circumstances, and it is essential that they have good

support.

The Chairperson:

Alderman Gardiner has to leave now, but there is not enough time to slip in his question because I must give Dr Deeny a chance to speak. However, I will try to ask his question for him.

Mrs I Robinson:

He may go ahead of me.

The Chairperson:

That is very generous.

Mr Gardiner:

Thank you. We must bear in mind that the issue is one of quality improvement. Mr Quinn referred to two reports that the Minister sent back for further investigation because he was not satisfied with the standard. Is that correct?

Mr Quinn:

On the back of the file audit and stage 1 reviews of the Western Trust and the South Eastern Trust, the Minister requested a further review to ensure that our recommendations have been implemented.

Mr Gardiner:

Have the recommendations been implemented?

Mr Quinn:

We will conduct a further review in the near future to determine that.

Mr Gardiner:

Therefore, you could say that the Minister is on top of the matter. He studied the results, decided that they were not up to the standard that he expects and asked for further investigation.

Mr Houston:

That is absolutely correct, Mr Gardiner. The Minister has given me precise instructions to ensure

that we follow up with further visits to particular offices in the trusts that I mentioned. We have already indentified dates on which to do that and will take that work forward quickly.

Mr Gardiner:

I welcome that, because the issue is one of quality improvement. We will not get it all right in one go; it is a continuing process. I am glad to hear that the Minister has studied the results, decided that they are not up to the standard that he expects and asked for further investigation.

The Chairperson:

I have just been informed that Sue Ramsey also represents the South Eastern Trust, so she is also coming up to the top of the queue. The problem is that everyone is now at the top of the queue.

Ms S Ramsey:

I am representing two areas at the moment.

The Chairperson:

Omagh was mentioned, and we have, or had, two members who represent that area. I will let Dr Deeny ask a question.

Dr Deeny:

If you do not mind, I will leave my question until later.

The Chairperson:

Until Mrs McGill returns, we will move on to questions about the South Eastern Trust.

Mr Easton:

I am not out to knock social workers, because they do an extremely good job under difficult circumstances. However, there are flaws in the system. One of the flaws in the South Eastern Trust seems to be with its paperwork and keeping records up to date, and I am greatly concerned about that. A great deal of overtime is being done to address that. Are there enough social workers? If not, why not? Why is the trust so badly behind with its paperwork? Has it always operated like that?

Given that social workers have to deal with some horrendous issues, what support do you

provide to ensure their good mental health?

Mr Houston:

We visited several offices in the South Eastern Trust. The concerns that we identified related to one particular office. We found evidence of good practice in other parts of the South Eastern Trust, and it is important to place that on record.

Paperwork is vital to child protection services. It is important to keep a clear and comprehensive record of social work involvement with children and their families. When a child is placed on the child protection register, social services must closely follow certain mandatory reporting arrangements. Other healthcare professionals, such as doctors and nurses also contribute to those records.

The introduction of a new, single-assessment protocol across Northern Ireland was part of the drive to improve services. That was introduced in 2007, following the publication of the overview report. Throughout our inspection process, we saw a high level of compliance with the new multidisciplinary single-assessment protocol. That protocol is known as UNOCINI, which stands for Understanding the Needs of Children in Northern Ireland. We found a compliance rate of over 90% with the UNOCINI single-assessment protocol. However, we also found that, in some cases, case records were not presented in accordance with the recommendations. In some cases, it was difficult to follow the child's story because of the absence of summary sheets. We also discovered that, in some offices, there were delays in the issuing of minutes from child protection case conferences. That is a critical aspect of child protection work. We concentrated on driving improvement in those areas.

The question about support for social workers is important. Social workers deal with difficult situations, and we mentioned the need for robust arrangements for their supervision at local office level. Moreover, social workers are now required to register with the Northern Ireland Social Care Council and to maintain their professional registration. They must undertake several days of training every year to demonstrate their compliance with the registration standards. Support networks are available to social services, and most trusts provide support networks to all staff who endure difficult times at home or at work.

Mrs I Robinson:

The mental health of social workers is vital to their performance in the job. Therefore, I am glad that checks and balances are in place. Social workers probably feel undervalued because of the high-profile cases, which occur mostly on the mainland, although some similar cases have arisen in Northern Ireland. Therefore, it is important not to engage in a witch-hunt in any sense. Politicians are the first to criticise shortfalls in services. However, we must recognise the difficult sphere of work that social workers undertake. None of us would want to do their job.

I pay tribute to social workers' hard work. I have encountered many cases in Newtownards through which I dealt with social workers and directors. They are dedicated people and have been helpful to me down the years. How do you guide social workers to ensure that they do not feel the need to take too much action in response to minor issues that require them merely to talk to people?

Mr Houston:

One of the biggest challenges that a social work team faces is that it must be able to analyse the information that comes through the front door. When a new referral is presented, the information is sometimes limited. The decision on whether the matter needs an immediate response or can be dealt with through normal processes must be made on the basis of that information. Social workers work with other healthcare professionals and, as part of the process of risk assessment, try to build up a comprehensive picture of a child and his or her family situation.

The new single-assessment protocol is designed to gather the information that is needed to facilitate such a decision. Social workers often rely on the support of their team leader and colleagues when discussing particular cases. In some cases, they are involved in strategy meetings or child protection case conferences. At any point in time, there may be more than 2,000 children on the child protection register in Northern Ireland. Those 2,000 children need regular visits from social workers. The children's needs must be assessed and clear care plans should be put in place. It is important to note that the majority of those children will reach the age of majority without having endured significant harm.

Ms Theresa Nixon (Regulation and Quality Improvement Authority):

I echo Glenn's comments. The provision for case conferences enables a range of professionals to meet around a table to consider evidence and make skilled judgements on what should happen in

particular situations. That is a daily occurrence in the trusts. Issues of concern that require further management advice can be escalated up the line to the director. Standards of staff supervision are also a valuable resource for social workers, because they know that they can discuss those issues with their line managers.

Mrs I Robinson:

The PSNI, for example, does not always interview in connection with cases of alleged abuse. How much effort is made, and what procedures exist, to ensure that the police follow up quickly on such allegations?

Mr Houston:

Usually, a strategy meeting would be required. Initially, that involves the social worker talking to other professions, after which those professions come together to consider what the appropriate next steps might be. Some cases may require progression to a child protection case conference. In fact, if the information is such that a child protection case conference must be called immediately, that might be the first and most appropriate decision.

The police co-operate with social services through the area child protection committees and the trusts' child protection panels. Much good work is being done to develop working relationships between various agencies, including the PSNI, education bodies and schools. All those organisations have important information that can help social services to make an informed decision about the degree of risk, or the degree of need, in a particular situation.

Mrs I Robinson:

I noticed that the level of note taking was questioned in one of the offices. It is important that shorthand and abbreviations are not used. It will be interesting, when you make your follow-up visits, to see how much of that has been taken on board. I wish you well.

The Chairperson:

Indeed, according to your report, some of the note taking could not be read at all, which is a bit worrying. I will quickly move on to the Western Trust, after which Sue Ramsey may ask the first question of the South Eastern Trust to make up for her not getting a question in earlier.

Mrs McGill:

Thank you, Chairperson. I apologise for my late arrival and for having to leave the meeting briefly.

I thank the witnesses for their briefing and their papers. As was said, we in the west have had to bear the tragic circumstances of the McElhill and McGovern deaths. The Deputy Chairperson began by asking about lessons being learned, and you gave some assurances on that. However, I read your report and then went back to the SSI overview report. When I read the final paragraph of Paul Goggins's foreword to the overview report, I realised that it could be transposed and made relevant now.

Work on the overview report began in 2005, and it was published in early 2007, yet the McElhill and McGovern tragedy happened in November 2007. The RQIA is revisiting the recommendations of the overview report. To return to the point that was made by the Deputy Chairperson, learning the lessons from such events is part of the process. I am not particularly confident that lessons will be learned. Having read both reports, it seems, as Phelim said, that reports are reiterating the same findings.

I want to address the issue of the lines of responsibility and accountability in the Western Trust. On the matrix, the trust's assessment was that it was "leading" in that regard, but the review team's assessment was that it was "developing". I would like some clarification on section 2.2 of the review:

"There are clear lines of professional accountability and responsibility from front line staff through to the Chief Executive and the Trust Board."

Is it the review team's assessment that the trust is "developing" in respect of recommendation 6? Does the statement in section 2.2 not contradict that?

The Chairperson:

We should deal with that point before asking any further questions.

Mr Houston:

Thank you for the question; it is both important and relevant. As I said earlier, each of the five trusts was asked to provide us with an assessment of its level of performance against a number of indicators. The indicator to which Mrs McGill refers is on the lines of responsibility and

accountability. In its self-assessment, the trust thought that it was "leading". However, the review team felt that it was not that far progressed and came to the conclusion that the Western Trust was at the stage of "developing" its systems and processes. Section 2.2 of the report details several higher-level findings on that matter. Some refer to the lines of accountability; for example, the second bullet point of section 2.2:

"There are clear lines of professional accountability and responsibility from front line staff through to the Chief Executive and the Trust Board."

However, when we visited one of the offices, we found some issues that needed to be raised with the trust's chief executive. That caused us to consider whether the trust's assessment was appropriate. That probably bears out the fact that the review team's assessment was much more accurate. The trust was not "leading" against that aspect of the matrix at that time, but was at the stage of "developing" its lines of reporting and accountability.

Mrs McGill:

Whose high-level findings are detailed in the review?

Mr Houston:

It is an RQIA review, so it reflects the RQIA's findings.

Mrs McGill:

OK, but the main findings seem to be different. The review team's assessment is that it is "developing", but the RQIA describes "clear lines of professional accountability" in the Western Trust. That seems ambiguous to me, and I cannot reconcile the two, but I am willing to listen to your explanation.

Mr Quinn:

I appreciate where you are coming from. In one instance, the review team, which was the expert panel, considered that there was a line of responsibility and accountability, as described by the trust, from front-line staff to the chief executive. The problem that we uncovered through questioning the review team and based on our knowledge of what was going on at stage 3 — because those stages of the review were happening in parallel — was that, although that line of accountability existed, it was not working well in all instances.

Mr Houston:

A particular reference on page 8 of the report helps to explain:

"The Trust was able to outline unbroken lines of accountability between front line staff through the organisation to the Chief Executive and the Trust Board. However, the review team had queries relating to legacy Trust issues and consistency of performance across the new Trust."

The review team highlighted the issues of legacy trusts and consistency. We must bear in mind that the Western Trust was a new organisation bringing together three legacy organisations, two of which had lead responsibility for child protection. Thus it had to put in place arrangements that were consistent throughout the new organisation.

Mrs McGill:

I read that excerpt too. However, from sifting through your report, it is difficult to ascertain what the problems are. I mean no disrespect by that. From listening to the media and the views of local people, one wonders how someone did not spot what was happening. The Toner report takes account of the McElhill and McGovern case. Stage 1 of the RQIA's 'Child Protection Review Report' refers to "legacy Trust issues", and so forth on page 8. Even with the further explanation that you have just given, I cannot see how that relates to the direct line of responsibility that should exist within the trust. How does it relate to what happened in Omagh?

Mr Houston:

It is important to be clear that the Western Health and Social Care Trust was already an established entity when the RQIA review began. The review examined the systems and processes that the Western Trust had in place for the delivery of the protection and safeguarding of children. The report identifies a concern about the workings of the line of accountability down through the system to the front line. The report states that issues were identified in one office specifically. We visited six offices in the Western Trust and found that arrangements were working well in a number of them. We found a particular problem in one office, which we identified to the Western Trust's chief executive at that time.

Mrs McGill:

May I ask a further question?

The Chairperson:

Yes; it is a serious issue, and your questions are pertinent.

Mrs McGill:

Page 15 of stage 3 of your report refers to the family intervention team at office B. Despite reading that page, I cannot work out how many vacancies there were in that team. An elected MLA or any member of the public may want to read the report, but I, for one, cannot ascertain the number of vacancies from the language that is used.

Mr Houston:

I see the section to which you are referring, Mrs McGill

"At the time of the audit, a number of these posts were vacant, including the senior practitioner post. In addition, three agency social workers were employed to cover full time vacancies."

Mrs McGill:

Does that mean that there were four vacancies at that stage?

Mr Houston:

Yes; one would expect that agency staff would be required for only a short time and that arrangements would be in place to recruit permanent staff to those vacancies.

Mrs McGill:

Did that team have a total of four vacancies?

Mr Houston:

That would seem to be the case. Four vacancies are mentioned in that paragraph. A senior practitioner post was vacant, and three agency social workers were being employed to cover full-time vacancies.

Mrs McGill:

What was the role of the gateway team in ensuring that offices did not have to rely on agency staff? I read that the gateway team is the contact point for all childcare referrals, and so forth.

Mr Houston:

The concept of the gateway team is relatively new. It was one of the reforms that was introduced on the back of the reform implementation process. Across Northern Ireland, each of the five health and social care trusts now has a gateway team in place. They are the front door for all new

child protection referrals that come into the system. The purpose of a gateway team is to undertake the initial risk assessment. After that, and when decisions have been made about how to manage a case, a decision is taken on whether the case needs to be transferred to one of the family intervention or family support teams. It is important that the gateway teams are robust and have the numbers of staff that they require to deal with the volume of work that comes through the front door.

Mrs McGill:

For me and others who want to read your report, the information must be presented in a form that enables us easily to identify the issues, such as the four vacancies. I found that difficult as I was reading your report.

Finally, Chairperson, I greatly much appreciate your allowing me to —

The Chairperson:

Ask your next question quickly, please.

Mrs McGill:

This is my final question: has the RQIA existed since 2003?

Mr Quinn:

It has existed since 2005.

Mrs McGill:

The Order that established it was made in 2003. From 2005, the Western Health and Social Care Trust, for example, will have submitted monthly reports. Did I read somewhere that the RQIA asked for monthly reports, and was that a recommendation of the overview report?

Mr Quinn:

No. There is a statutory responsibility under regulations for residential care homes in the Western Health and Social Care Trust to supply us with monthly reports on activity in the homes, etc.

Mrs McGill:

The recommendation refers only to residential homes. Thank you.

Dr Deeny:

I apologise for being late. I left home at 8.05 am, but the fog on the motorway was dreadful. Thank you for coming. Is it correct that the RQIA did not examine the McElhill/McGovern tragedy?

Mr Houston:

In preparing our approach to the review, we studied the recommendations that were set out in the Toner report. However, that report was the result of an independent inquiry that was established at the time to examine the circumstances of the fire and subsequent tragedy.

Dr Deeny:

Now that the coroner's report is in the public domain, it is clear that it is the most appalling tragedy that I have ever come across. In my professional life, I have never encountered anything like it before. You should examine that case. I agree that this is not the time, by any means, for a witch-hunt. However, there is no point in all of us sitting here and talking about what happened; we must act to ensure that it never happens again. The very least that should come out of that awful, appalling tragedy is that every carer, whether they work in health, security or social services, must learn from it. Indeed, we as a society must also learn from it. Were the same fate to befall five, six or seven animals, there would be a public outcry, but human beings were involved. What has the RQIA learned from it?

I know that this is a general point about the trust, but it concerned me, as a GP, when I first heard about the over-reliance on newly qualified staff. As a health professional, I am deeply concerned by that. I work with social workers, and I have done so for many years. It is a difficult and responsible job. It is worrying that people who take on such difficult jobs are so inexperienced.

You reported on the inappropriate use of inexperienced social work staff, appropriate levels of supervision for newly qualified social workers and limited evidence of line managers and senior managers' quality assuring child protection processes and practice. As tragic and dreadful as it was, the case in Omagh has happened. Would it not be a good idea for all of us, whether we are involved in primary care, social services, the RQIA or the Department, to write down, in one year's time, what we have learned from that tragedy? Rather that just talking about it and the

whole thing blowing over in two or three months' time, we should put in writing what we have learned from the tragedy and outline the steps that we will take to ensure that it does not happen again.

Mr Houston:

Dr Deeny makes an extremely important point. It was a tragedy of huge proportions, which, to my knowledge, is unprecedented. All the agencies that were involved with the McElhill/McGovern family want to learn lessons from the events surrounding the fire, and the Toner report highlights several important issues. Earlier, I referred to several of those issues on which we focused when we were framing various aspects of our review.

In the next phase of our review, the first part of which is already under way, we will return to examine, amongst other issues, the level of inter-agency co-operation on the delivery of good and robust child protection services. That deliberation will be an important aspect of the overall process, and our findings will add vital knowledge and learning about what has happened.

The Chairperson:

When will your report on that stage of the review be published?

Mr Houston:

It will be published in April 2010 after we have completed the further round of visits.

Ms Nixon:

The report will also include our findings on the supervision of social work staff.

Dr Deeny:

This week, I became aware of the media focus on a particular aspect of the case. I cannot remember whether it was on the radio or television, but a senior departmental official commented — perhaps you heard this too — on the lack of importance that was placed on having discussions with children. The person being interviewed may have been referring to the poor 16-year-old girl who died. I cannot recall; however, he said that, no matter what children said, there was far too much reliance on discussions with adults. If a 16-year-old were to come in to my practice, I would like to think that my colleagues and I would take what he or she had to say extremely seriously.

I missed most of your submission, but what clout do you have in that area? What happens after the RQIA publishes its report? I have asked this sort of question before, but whose duty is it to ensure that such a case never happens again? Part of the solution must be to address such matters. Kids are very mature these days, so, when a 14-year-old child says something relevant, we must listen, rather than glossing over and dismissing what has been said because the words are those of a youngster. We should bear in mind what would have happened in the Omagh case had only one parent been involved in discussions: the full picture would not have been gleaned. This week, it was highly disturbing to hear the revelation that other young people were implicated in that dreadful scenario.

Mr Houston:

I shall respond by making a couple of points. Dr Deeny is absolutely right to say that children must be heard. In the context of child protection, the voice of the child is vital. Yesterday, you heard a departmental official commenting publicly on the case. I also heard that interview, and it was, in fact, the chief social services officer who made the point that, if a 16-year-old goes to the trouble of telephoning the police to express concerns about what is happening at home, that message is extremely important and must be heard.

The RQIA's work, following on from the publication of the overview report and taking account of the recommendations in both the Toner and O'Neill reports, is important. It is vital that we are here today discussing the recommendations of this report and thinking about how lessons from it can be taken forward. Many other discussions will take place at trust level and between the trust, the Health and Social Care Board and various other organisations that have a shared responsibility for child protection to ensure that everything possible is done to tighten procedures and reduce the risk of anything similar happening again.

Dr Deeny:

By next year, will the Department and all of us who are involved in health and social care have, as a result of the action that you will undertake, official written guidelines incorporating the lessons that have been learnt and telling us what we should do? From my experience in health, I fear that talks and meetings about meetings lead to nothing, and that, in a year's time, the matter will have blown over, and the attitude will be that the McElhill deaths were a terrible tragedy, but nothing will have been done.

Mr Houston:

You will be aware, Dr Deeny, of the proposals to establish a new safeguarding board for Northern Ireland. That board will have a vital responsibility in ensuring that the McElhill tragedy is not forgotten and that the lessons of the Toner report and of the further work of the RQIA will be fully considered in the analysis of child protection services across Northern Ireland.

Ms S Ramsey:

I join other members in welcoming the witnesses to the Committee. Unfortunately, you are becoming a permanent fixture at our meetings. I mean nothing personal by that. Nevertheless, your repeated appearances before the Committee demonstrate that there are problems in the health and social care sector.

Before I ask a question, I should say that we have a duty not merely to read but to scrutinise the reports and to ask probing questions to ensure that we learn lessons from them. You quote from the summary of the key findings of 'Our Children and Young People – Our Shared Responsibility':

"This inspection has identified many areas of good practice and good quality work undertaken by highly motivated staff who are working in extremely pressurised and high risk situations".

I agree with that. In common with other members, I have worked closely with social workers and social services over the years, and we should not lose sight of their good work.

You may have hoped that, as I am last to speak, I would have few questions because most questions would have already been asked. However, the discussion has prompted me to ask further questions. Stage 5 of the RQIA's review focuses on "inter-agency working", yet, according to the media, one of the main criticisms to emerge from the inquest was the lack of inter-agency working in the McElhill case. Claire outlined some of the other issues.

Two years after the tragedy, which occurred in November 2007, the charge of a lack of inter-agency working — by which I mean all agencies — can still be levelled. Kieran Deeny is right: we are not discussing the deaths of animals; we are discussing the tragic deaths of adults and children. The final stage of the RQIA report will not be completed until 2010. That does not send out a clear message that we are serious about improving child protection standards.

You said that issues were identified in residential homes in the Sperrin Lakeland Health and Social Care Trust and in the South and East Belfast Health and Social Services Trust. Who identified those issues? I am aware that you may not be able to go into some of the details.

The Chairperson:

Sue, some of your questions do not relate to the RQIA, although you may ask them of the trusts or the Department later.

Ms S Ramsey:

OK, I will. I wish to ask the RQIA about inter-agency working. Glenn, you said that you believe that the board and its executive and non-executive directors had a clear understanding of their corporate responsibility. You also mentioned the changes proposed by the review of public administration. I made a note to the effect that, although it may be regarded as a new organisation, it is staffed largely by the same people; we have to be clear about that.

Did you, or would you, recommend disciplinary proceedings? Were the gateway teams set up on the back of the deaths of the two young lads in Lurgan and Portadown? Have we learnt lessons from that? According to the findings of the report, I am not sure that we have. Individual organisations might have learnt lessons, but have we learnt lessons collectively?

The Chairperson:

That question, too, would be better asked of the Department, and I will allow you to ask it of the Department as a priority.

Ms S Ramsey:

Chair, the RQIA investigates procedures, and questions are being asked about who is being held to account on various issues are being asked. Likewise, questions are being asked about who is being held to account for a lack of policy in senior management. It does not seem that anyone is being held to account.

Mr Houston:

Sue is talking about the case involving the Briggs children. Sadly, one of those children died, and the other child was injured. That case was the subject of a separate independent investigation,

which made a number of recommendations to the particular trust. The issue related to adoption from overseas. The gateway teams were not established as a direct consequence of the outworkings of that investigation but as part of the reform implementation team protocol. That was a drive to ensure a clear streamlined system across Northern Ireland for receiving new referrals of a child protection nature and making sure that they were risk assessed and responded to appropriately. The Department might comment further on that when it gives evidence.

You raised the issue of accountability and the sequencing of the various stages of our review. I agree that multi-agency working is hugely important in child protection. I do not want the Committee to think that, because we will address multi-agency working as part of the next phase, we consider it to be any less important than any of the other areas. In putting the review process together, we thought that it was important to begin by examining corporate accountability and the arrangements that the trusts had in place for the management and delivery of safe and effective child protection services. We will be equally diligent in our examination of inter-agency working, and we will bring our findings into the public domain.

The issue of accountability and personal accountability comes up often with any regulator, including the RQIA. Our primary responsibility is to identify good practice and failings and to refer those back to the organisations that have responsibility for the delivery of those services. It is a matter for those organisations to consider whether individual officers should be held to account in relation to specific professional accountability. That is not part of the remit of the review, nor is it part of the responsibility of the RQIA.

Our determination is to develop a learning culture in which we can reflect on practice and consider ways of improving practice and performance. As Dr Deeny said, this is not a witch-hunt; it is a question of considering the lessons that have been learnt, applying them and ensuring that we improve performance as a result.

The Chairperson:

We have come to the end of our time with the RQIA. Some desperately serious issues have been raised. Iris Robinson wants to speak, and the Deputy Chairperson has asked to come in again. If they ask their questions, we will have to chop 15 minutes off the lunch break, thereby reducing it to 45 minutes.

Mrs I Robinson:

I want to highlight the fact that the most important group is the children. How can we get across to children, particularly young children, that they will be listened to? I am not picking on the Catholic Church, because, sadly, children are abused across all denominations. However, the Ryan report informs us that young people went to the highest authorities and were ignored. Of course, the abuse also has an impact in Northern Ireland. How do we convince children that they will be listened to and that their cries for help will be taken on board?

Ms Nixon:

Our expectation is that children will be listened to and that anyone who assesses a child will listen carefully to how he or she describes what is happening. In its inspection of children's residential homes, the RQIA is starting to consider methods of encouraging young people who have experience of care homes to accompany inspectors. That will give our inspectors an opportunity to try to get at the issues that are important for children. That is an added bonus, because it gives us a better picture of what is happening from the perspective of a child who is in a home.

Better communication with children has been achieved through staff training. Different methods of how to interpret information have been explained to staff, and children may have had several opportunities to communicate with staff at different levels. When a child is distressed, the pacing of communication is important, and the increased training has proved helpful. Trusts also report to their boards every six months on the training afforded to staff, and the issue of communication with children has been raised in some of these reports. Communication is an important issue, and the trusts must continue to work at it.

Mrs I Robinson:

Is there any encouragement of whistle-blowers, such as neighbours who are able to assess a situation and see that something is untoward?

Ms Nixon:

Referrals received by trusts through their gateway teams often come from neighbours, friends or concerned relatives. All of those referrals are screened and processed, and any accompanying intelligence is examined when deciding what the next steps should be. That could lead to a multidisciplinary case conference or further decisions being made.

Mr Houston:

One element of the outworking of the review that encouraged me was the finding at stage 2, during which the RQIA worked closely with an organisation known as the Voice of Young People in Care. Families particularly highlighted the excellent work that some family centres do to support parents. Often, those who are referred to family centres require extra support and find the support provided by the centres valuable and worthwhile. That process also helps social services to understand the family dynamic, rather than simply having a formal discussion with professionals and parents. It is a much more thorough process.

Mrs O'Neill:

I am particularly interested in what can be learnt from experience. Glenn, you spoke about a learning culture in the RQIA and the fact that it reflects on lessons and applies the learning to future work. However, 77 recommendations were made in the overview report, 36 in the O'Neill report and 63 in the Toner report. Has the RQIA examined how many of those recommendations were repetitive?

Furthermore, the Toner recommendations demonstrate that inter-agency working, which was a major focus of the overview, has failed. I am frustrated that, despite what Glenn and Phelim said today, lessons seem not to have been learned.

Many of the issues are repetitive, and every time that there is an investigation because a child has lost his or her life, a report is published that contains the same recommendations that were published years before, but the lessons have not been learned.

Mr Quinn:

I agree with you, Michelle. When the RQIA carried out a mapping exercise across all of the reviews, some overlap was discovered between the recommendations of the various reports. However, that was not specifically highlighted in the report, because it related more to the review process itself.

When I said that lessons have been learned, I meant that, even in trusts with underperforming offices, we found other offices that were exemplars of good practice. It appeared that the lessons had been learned in those offices, because they were using good practice in safeguarding and protecting children. Lessons are being learned, but we must ensure that they are learned across

the system.

Mr Houston:

The consistent application of the message is the important factor, and therein lies the challenge that we all face. It is a matter of ensuring that every office practice is at the optimum level and that all staff are supported in following the policies, procedures and protocols.

The Chairperson:

This Committee is nothing if not current. As you will be aware, the OFSTED assessment on child services was published yesterday, although I do not expect the witnesses to be aware of its content. Do we use similar tools, and is there a way of comparing standards of service in Northern Ireland with the rest of the UK, particularly England? Is there any assessment tool to enable that to happen?

Mr Houston:

I have not read the OFSTED report, but I will make a point of doing so. One way in which we try to gain a wider perspective on our work is to ensure that our review processes draw in expertise from outside Northern Ireland. On this occasion, we drew quite heavily on expert support from people who work in other health and social care networks and are, therefore, able to bring a degree of independent scrutiny to bear. Their scrutiny, along with that of our teams and officers, enables us to gauge how Northern Ireland performs against other childcare organisations across the rest of the UK.

The Chairperson:

Thank you for the information that you provided on what is a terribly difficult and emotive issue. We appreciate the time that you have given to the Committee. I reiterate the comments of Mrs Robinson in saying that, to some extent, we hope that you do not have to come back to us on such serious issues, because some of the detail associated with those cases is quite distressing. Thank you once again. I notice that Ms Goodman got away scot free today. I am sure that you are disappointed, Ms Goodman, but no doubt we will get a chance to question you the next time around. Thank you.