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COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Departmental Response to the Independent Review of Child Protection in Northern Ireland

10 December 2009

NORTHERN IRELAND ASSEMBLY

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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 Dolores Kelly
Mrs Claire McGill
Mrs Iris Robinson

Witnesses:
Mr Sean Holland)
Mr Fergal Bradley) Department of Health, Social Services and Public Safety
Ms Christine Smyth)

The Chairperson (Mr Wells):

I welcome the departmental officials to the meeting. We have had several sessions today on the Regulation and Quality Improvement Authority (RQIA) report on child protection. For this evidence session, the panel consists of Mr Sean Holland, who is the acting chief social services officer, Mr Fergal Bradley, who is head of child policy directorate and Ms Christine Smyth, who is the acting deputy chief social services officer. As usual, I ask the officials to make an initial 10-minute presentation. Did you have the advantage of sitting in on some of this morning's sessions?

Mr Sean Holland (Department of Health, Social Services and Public Safety):
We followed the proceedings.

The Chairperson:
Therefore, you have an idea of what has been said. That is helpful. I am sure that you have the tenor of this morning's sessions. Again, I will give priority to members from the Western Health and Social Care Trust and the South Eastern Health and Social Care Trust areas.

Mr Holland:
On behalf of the Minister and the Department, I want to make it clear that we welcome the RQIA report or, to be precise, the series of RQIA reports. The independent inspection and regulation of services is a cornerstone of delivering high-quality health and social care.

Traditionally, improvements in child protection services have happened following inquiries into high-profile cases that have involved tragic outcomes. Those tragedies have occurred periodically and have normally been followed by detailed recommendations that have driven improvement. However, the reports that the Committee has been considering and discussing today represent the Department's intention to develop a process that does not wait for a tragedy to happen in order to drive improvement. We want to establish a process of periodic review that identifies good practice that needs to be highlighted and replicated. Where there are deficits, we have to understand them and take steps to address them.

The reports have highlighted much good, and even excellent, practice in every single trust area in Northern Ireland. That is especially true of the way in which staff are engaging with children in families in what is an exceptionally difficult area of work. It is a testament to the skill and sensitivity of social workers and staff that even when they are addressing parenting issues and child protection concerns, they are able to take those matters forward in a way that parents and children welcome and value. That was clearly demonstrated by the stage 2 report that members heard about earlier today.

The reports also provide evidence that overall, the trusts have sound governance arrangements in place that demonstrate strong leadership and accountability measures. Indeed, even in the Western Trust, where difficulties were identified in relation to governance, the RQIA assessment found that the trust was performing in the top three scoring categories against seven out of nine

criteria, which is worth noting.

Examples of excellent record keeping were found in all five trusts. I was particularly pleased to see that the report showed significant progress in the roll-out of a new assessment framework, Understanding the Needs of Children in Northern Ireland (UNOCINI), which was developed by the Department specifically to address deficits and inconsistencies in assessments that were highlighted in the Social Services Inspectorate overview report, which members discussed earlier.

Earlier today, a number of Committee members expressed a desire to be reassured that lessons from previous reports are being learned and acted on. The introduction of the new assessment framework is an example of that. Nevertheless, the reports also identified areas for improvement. Generally, they identified a need for greater consistency in record keeping and better supervision arrangements. However, it should be noted that in both areas, the RQIA was inspecting against relatively new standards that were significantly more exacting than the standards that preceded them. The reports also identified two local offices in Omagh and Ards where there were more significant problems. It is important to note that that is exactly what inspections are designed to do, and I welcome the fact that the RQIA identified those issues.

I will not go over those issues again in detail, as I know that members heard about them earlier today and have had the opportunity to question staff from those trusts. Although I am not in any way complacent about those issues, they should be viewed in context, which includes the fact that services for children in Northern Ireland have, historically, been significantly underfunded. Research undertaken by the Office of the First Minister and deputy First Minister, the Department of Finance and Personnel and the Commissioner for Children and Young People identified that such services in Northern Ireland have been adrift by some 30%, compared with similar services in England.

There have also been significant increases in demand and pressure on services. Over the past five years, there has been a 24% increase in the number of referrals and a 46% increase in the number of children on the child protection register. The inspections also followed a period of massive organisational change. There were changes in management structures and a number of trusts were being brought together; for example, three different legacy trusts were merged to form the Western Trust.

The final element is the rise in expectation. We expect considerably more of our services, and quite rightly so. However, that means that inspections are also more rigorous. The expectations of the public, the media and regulators about what social services can do have risen significantly. The Department and Minister McGimpsey regard the protection of children as an absolute priority. That is why, in the current spending round, the Minister has increased spending on those services by 14%. That does not do away with the underfunding that those services experienced historically, but it is an attempt to close the gap. It is also the reason why the Department has been driving forward a number of improvements.

The most significant of those improvements is the reform implementation programme, which members have heard about throughout the course of the presentations from the trusts, the Health and Social Care Board and the RQIA. Under that reform programme, we have introduced a common assessment framework, UNOCINI, across Northern Ireland. We have introduced common structures, with gateway teams dealing with initial referrals in each trust, and each of those gateway teams now uses common processes.

Each trust now has a single contact point or telephone number for the public to use if they have concerns about a child or wish to make a referral. The standards that we are inspected against are common standards. Historically, there was great variation in the approach that different organisations took to recording. We are now working to common standards for recording and, likewise, common supervision standards. We have also introduced principal social work practitioners as a way of ensuring that we retain and appropriately reward expertise in social work practice at the front line.

At the beginning of my statement, I made reference to the fact that we have historically relied on inquiries into catastrophic failings for recommendations to improve services. I am sure that in the course of the afternoon we will discuss such an event. Although the process of inspection and regulation is leading us to continuous improvement, it is nonetheless vital that we continue to learn from incidents where things have gone wrong. That is why Minister McGimpsey instructed Henry Toner QC to undertake an independent review into the tragic events in Lammy Crescent.

I remind the Committee that Henry Toner and his team produced a very detailed report that clearly identified failings on the part of social services in the Western Trust and a number of other agencies. It made many recommendations in relation to those failings. Notwithstanding any

other calls that people may make for a public inquiry, the Minister's priority is to ensure that, where recommendations have been made, they have been implemented. That is why, as a result of the difficulties that were found in the Omagh and Ards offices, the Minister has told the RQIA to revisit both the Western and South Eastern Trusts as a matter of urgency.

I can also announce to the Committee today that the Minister has asked Henry Toner to return to the Western Trust to verify that the 55 recommendations that were made for social services in that trust have now been implemented.

I am happy to take questions.

The Chairperson:

Thank you, Mr Holland. That was a significant announcement at the end of your presentation. I was coming to that point, and you have somewhat pre-empted my question. You have heard calls for a public inquiry, and you have had the benefit of hearing some of the evidence that was given this morning. The Minister has announced that he is asking Henry Toner to go back and check the implementation of the recommendations. Is that his response to the demand for a public inquiry? Is he saying that an inquiry is not required, but that he is sending Mr Toner to check whether things have been sorted out, or will that be done in addition to a public inquiry?

Mr Holland:

Like others who have come before the Committee today, it is not for me to say whether we should or should not have a public inquiry. That is a decision for others to make. Those deciding whether a public inquiry is appropriate have to ask themselves whether it would reveal anything new.

In relation to social services, we have had the Toner report, and in recent days, following the inquest and leading up to the findings of the inquest, I made a point of rereading that report. The Toner report clearly identifies where there were failings. I have heard a lot of people on radio phone-ins and such like saying that the truth has to be found out and that we need to find out what went wrong.

The Toner report clearly identifies a number of things that went wrong in social services practice. Going back over many years, it clearly states that the original decision to remove

Caroline from the child protection register was not undertaken properly; that there were reports that should have been, but were not, considered by the case conference that made that decision; and that there people who should have been in attendance at that meeting were not. It also identified a very serious failing, which was commented on earlier, in relation to how seriously agencies responded to a young girl phoning the police to say that she was scared and frightened because of domestic violence in her house. That was a clear failing.

I believe that the Toner report contains clear evidence that the matter has been investigated, certainly by social services. However, failings are highlighted, and the report did not spare social services. No one can say that the report was a whitewash in respect of social services; indeed, it makes specific recommendations relating to social services. I do not know whether further inquiries could provide more information on the involvement of other agencies. Having found out where mistakes were made, our priority is to ensure that the recommendations have been implemented. That is the Minister's position, and it is why he has asked Henry Toner to revisit the Western Trust.

The Chairperson:

Even if one accepts that all the issues regarding the Western Trust have been covered, the police and the MASRAM system exhibited severe shortcomings in designating Mr McElhill the status of only a grade 1 offender. That seems extraordinary, and it resulted in the children not being protected. What do we do with the issues that were not addressed in the Toner report?

Mr Holland:

You will appreciate that I cannot speak on behalf of the police; it would be improper for me to try to do so. However, the categorisation of Mr McElhill's offending and the decisions about where the children lived and whether they were on the register relate to a broader point. Every day, social workers have to balance risks. The idea that children would live in the same house as a sex offender seems incomprehensible to many people.

The Chairperson:

It does.

Mr Holland:

Many children live in families in which there are serious risks to their well-being. In Northern

Ireland, some 11,000 children live in households where there is domestic violence. Many more children live in households in which one or other parent has a mental-health difficulty. Many children live in households where there is substance abuse. Those children cannot all be brought into care and nor should they; it would not always be in their best interest to bring them into care. The risks have to be balanced. I am not saying that the risks were balanced correctly in the case of the children in the McElhill-McGovern family; clearly, they were not. What I am saying is that it is a very complex area.

The Chairperson:

How many other children live in households in which the father has two convictions for child rape?

Mr Holland:

I am fairly certain that Arthur McElhill did not have a conviction for child rape. He was convicted of indecent assault.

The Chairperson:

OK. How many —

Mr Holland:

I do not know how many children live in a household in which there is an adult who has been convicted of indecent assault.

The Chairperson:

Mr McElhill was sentenced to six years, so it was a serious charge.

Mrs O'Neill:

I want to put on record that we welcome the fact that the RQIA report highlighted good practice. However, we are concerned about certain issues. When will the RQIA go back to the South Eastern Trust?

Mr Holland:

The Minister has asked the RQIA to go back to both the South Eastern Trust and the Western Trust as a matter of priority. As its representatives explained to you this morning, the RQIA is

conducting the final two stages of the inspection. Today, the Committee is discussing the reports that relate to stages 1 to 3. There are two further stages to be reported on, so the RQIA will co-ordinate its activities around the fact that it would have been returning to those trusts anyway. We expect that the RQIA will go back to the trusts shortly after Christmas.

Mrs O'Neill:

Yes; there has to be a follow through. I welcome the fact that the Minister has asked Henry Toner to return to the trusts to see whether the recommendations have been implemented. However, surely that is the role of the Health and Social Care Board. Does the fact that the Minister is sending an independent person back to the trust indicate that he does not have confidence in the board to oversee the performance management arrangements and ensure that the recommendations have been implemented, or is it a public confidence issue?

Mr Holland:

It is partly an issue of public confidence. It is important that people have confidence in services, particularly child protection services. One of the worst possible outcomes of the tragedy in Omagh would be for people to lose confidence in child protection services and, as a result, not contact the police or social services when they have a concern about a child.

The Minister has absolute confidence in the board. The Department works very closely with the board on these matters; for example, we liaise with Fionnuala McAndrew, who met the Committee earlier. It is not a question of not having confidence. Henry Toner did a specific piece of work and made a number of recommendations. We have had assurances from the Western Trust, which I have no reason to doubt, that it has implemented 54 of the 55 recommendations. However, to be absolutely sure and to reassure the public and give them confidence, the Minister is asking Henry Toner to go back again.

Mrs O'Neill:

You talked about the rising demand. In the past year, there has been a 20% increase in the number of children on the child protection register. Can the existing services cope with that?

Mr Holland:

I refer again to the fact that, historically, services here have been underfunded significantly. That is why the Minister has, in a very difficult financial climate, prioritised childcare services. As I

said earlier, in the current spending round, we have seen an additional 14% funding for services. That money is sufficient for us to cope with the situation that we face currently. However, if you are asking whether we could use more money, the answer is absolutely.

Mrs O'Neill:

I talked earlier about lessons being learned, and you referred to it also. I am still really concerned about the fact that 176 recommendations in total were made in the overview report, the Toner report and the O'Neill report, a lot of which are repetitive. Will we meet again in two years' time to discuss another report that also repeats recommendations? I note the good work that has been done, but the reports cover the period from 2005 up to now. Every couple of years, we have another report and another number of recommendations that repeat what should have been done two years ago. That is very frustrating.

Mr Holland:

I fully understand the point that you are making. I know that it baffles people when they look at the situation. You made reference to two or three recent reports, but we could actually go back to 1974 and the inquiry into the death of Maria Caldwell. I know that we have a social worker among our number who is aware of that. That report will have recommendations that sound similar to ones that were made in the reports into the deaths of Jasmine Beckford or Victoria Climbié, or into the cases that we have had here. That does not mean that lessons have not been learned. Standards change and expectations rise.

To use an analogy, if one were to look at an inquiry into an air crash 30 years ago, one would probably find a recommendation that there should be better training for pilots. If one were to look at an inquiry into an air crash a year ago, one may also find that same recommendation. That does not mean that lessons were not learned; it means that standards have changed. So, for example, going back to the Maria Caldwell inquiry, there would have been recommendations about training. In the Toner report, recommendations about training were made also. That does not mean that there was not learning in the many years in between. Expectations have changed dramatically.

Recording is a prime example of changed expectations. When I started out as a social worker there were inquiries into social work services in the Orkney Islands. One of the recommendations that emerged related to recording. At that time, the expectations for records were, more or less,

that a record should exist. The inquiries recommended that records should be improved. The Toner report has also recommended that recording should be improved. However, the expectation and the standard against which Henry Toner assessed practice, and against which the RQIA assesses practice, is a million years away from the type of recording that was used when I became a social worker.

Mrs O'Neill:

Is that what you meant at the start when you talked about RQIA measuring against different standards?

Mr Holland:

That is part of it. The standards against which RQIA measured were newly introduced. I will defer to my colleague, Fergal Bradley, but I think that the supervision and recording standards had only been in place for about a year. They were significantly more exacting than the standards that went before them.

Mr Fergal Bradley (Department of Health, Social Services and Public Safety):

The recording and supervision standards were both issued in February 2008. The gateway team's processes standards were issued in April 2008. When it reported, the RQIA did not expect trusts to be fully compliant yet with all those standards. The Western Trust, for example, had to bring together records from three old organisations.

A key part of the reform programme has been the fact that, three years ago, there were different file structures, file organisations and job descriptions in a trust. There could have been the same job title in two trusts, but the people could have been doing completely different things. You would have had different job titles with people doing the same things. Different types of assessment and record forms would have been used, and there were different information-sharing protocols. That was only three years ago. Since then, we have moved on significantly, and, as Sean said, the standards against which the RQIA was inspecting were issued in February 2008 and the gateway teams' standards came out in April 2008.

The RQIA knew when it went in, and it says so in its report, that it was not expecting that there would be full compliance. We were looking for the RQIA to benchmark how far the trusts had got in moving towards compliance with those standards. Those standards are regional.

Therefore, for the first time in Northern Ireland, we can compare the performance of individual trusts against the same set of standards. Until the past two years, we have not been able to do that. Critically, in the next couple of years, we will be looking for the trusts to be able to demonstrate that have become increasingly compliant with the standards.

Given that the RQIA conducted fieldwork in the Western Health and Social Care Trust and in the South Eastern Health and Social Care Trust in January, we hope that both trusts will have made significant progress by now, because, although the reports were only published a few weeks ago, the two trusts would have had feedback shortly after the RQIA team went in.

Mrs I Robinson:

Thank you for your presentation, although I question your view that holding an inquiry would be an unsatisfactory outcome because most areas have been covered in the recommendations. I disagree on the grounds that, on the mainland, an inquiry is rightly held when a tragedy involves just one child. We are talking about seven human beings. One of them was a sex offender; however, he was a human being.

The size and scale of the tragedy alone merits a public inquiry, which should not be about bashing social workers. It should be about satisfying the wider community that social services are up to doing the work; that they are not hindered; that they have sufficient staff and that they have the necessary backup. Holding an inquiry would send out a very good message. It would be harrowing and very difficult for the relatives of the families concerned, but, at the end of the day, lessons could be learned and the general public could feel that something good has come out of it. That could be proved by showing that all the recommendations are in place. It is the only way to go forward, not as an open-ended inquiry but, most appropriately, as a time-barred one.

The Madeleine O'Neill case was another dreadful incident in which communication was dire. The father of the young girl who tragically lost her life at the hands of her very distressed and distraught mother was not even told by the authorities that his wife had threatened to take her own life and that of her child. If he had known, he could have removed the child from the home. I have dealt with that gentleman and, as you can imagine, he is a broken man. He is haunted by "what if", which is a terrible thing to have hanging over him the rest of his life, because he must go through the times when it would have been her birthday, and he will speculate about whether she would have married and had children. Therefore, although Mr Toner is a highly respected

man, we cannot just walk away and say that his report is sufficient. The scale of the McElhill event and the Madeleine O'Neill case merit us conducting something akin to an inquiry.

Mr Holland:

The inquest into the O'Neill case is ongoing, so I would rather not comment on it in any detail, although no one would disagree that your points about its tragic nature are well made.

In relation to a public inquiry, it is not my decision as to whether one is held. The scale of a tragedy is certainly one aspect that people take into account when considering whether a public inquiry is relevant, but it is not the only factor. You mentioned lessons to be learned, and that is an important factor to consider. As I said with respect to social services, I really do not see what additional lessons could be learnt from a public inquiry. The failings have been identified: no one has been spared having those failings exposed. Those failings have been analysed, and recommendations have been made. Social services are learning lessons, have been learning lessons and will continue to learn lessons. It is an ongoing process.

It was said that public inquiries are held in England when one child dies: that is only sometimes the case. There was a public inquiry following the deaths of Victoria Climbié and Jasmine Beckford. In those cases it was felt that the ordinary process of review that happens following a death, the serious case review, was inadequate and that an additional form of inquiry was required. However, there have been occasions when children have died in England and the learning has been identified through something other than a public inquiry.

Mrs I Robinson:

I take your point that public inquiries are not always held and that certain issues cause public inquiries to be held. However, for the general public, I think that a public inquiry is the only thing that will address the scale of this tragedy. I also think that bringing out this issue in a public inquiry will help all social workers, in the long run, to better understand the pitfalls and black holes that exist, and it will remind them of the dangers of communication breakdown and the importance of note-keeping and interaction between agencies. It can do only good. It is a tragedy and a human story that goes beyond all the bounds. One's imagination cannot grasp it. At the same time, an inquiry would be good, because you are not seen to be saying no to such a large-scale tragedy.

The Chairperson:

Dolores Kelly is not here, so Claire McGill is next.

Mrs McGill:

You are welcome, and thank you for your briefing. Others this morning raised the importance of learning lessons. Lessons are learned, and the recommendations from the various reports help one to learn lessons. In my view, there is one lesson that comes out of this, and it is that whatever the recommendations were, they did not protect the McElhill/McGovern family. A number of members have commended the reports that have been done in the two cases that have been mentioned, but even with those recommendations in place, this tragedy still happened. That is the point. The tragic situation still happened. There is some gap between the learning of the lessons and the reality that happened in Omagh, particularly. I will not prejudge inquiries, and the case for them has been well made.

You made the case that everything that happened in relation to social services has been explored and exposed, and that there are recommendations and that lessons have been learned; but do you accept that not everything has been found out about this case — a point that has just been made?

The Chairperson:

That is the crucial question, and I would like to hear an answer to it before you ask a further question. There is still the view that we have not gotten entirely to the bottom of the case, even from a social services point of view?

Mr Holland:

I am mindful that I can speak on behalf of the Minister, the Department of Heath and Social Services, social workers and other professionals and agencies who were involved. There were two investigations in relation to the matters in Lammy Crescent, and I refer back to a statement from the Toner report:

"The Northern Ireland Sex Offender Strategic Management Committee (NISOSMC) commissioned a Case Management Review in relation to Multi Agency Sex Offender Risk Assessment and Management (MASRAM) arrangements. The Review Panel therefore did not enquire into those matters."

That is referenced at paragraph 2.2.8 of the report. To answer the questions, you would need to address the people who are responsible for those matters in the inquiry.

The Chairperson:

In the absence of devolution of policing and justice powers, that is territory that we, as a Committee, cannot touch.

Mrs McGill:

I have one final point in relation to the RQIA report. I told the RQIA this morning that I had some difficulty with the style, content and form of the report. I was sifting through it, and I had some difficulty understanding what was meant in some cases. That was my position when I read it, and I put it to the RQIA this morning. Therefore, I am keen for that to be noted.

Recommendation 6 in the overview report refers to the lines of responsibility and accountability. This is where the views were matched or not matched. In that recommendation, the Western Trust's view was that it was leading, but the review team thought that it was developing. I am trying to step outside the box here and imagining that someone else was reading the report. Point 2.2 in the high-level findings states:

"There are clear lines of professional accountability and responsibility from front line staff through to the chief executive and the trust board."

I got a response from them and some clarification on that, but it did not clarify it for me, because, when I read that — and I am speaking for myself here — it seems to me to give a clean bill of health on lines of responsibility and accountability. That is my view, and I made that point this morning.

Mr Holland:

I heard you make that point this morning, and it is a point well made. As a civil servant who sometimes writes documents on behalf of the Department, I know what it is like to be accused of using jargon and writing inaccessible documents, and it is something that we should guard against. The specific point being made was that there was a clear policy that identified a clear line of accountability. There is a thing called the scheme of delegation of statutory functions, and it was clear that there was a line of accountability. However, the RQIA had questions about whether it was operating as effectively as it should have been. That led to the difference between a clean bill of health as leading and a categorisation as developing.

I will come back on some of the other points that you raised in your previous question, because I addressed only one of them. You talked about recognising the good work that was

done but that, nonetheless, it did not save those children and adults. It is important to point out that a case such as that of the McElhill and McGovern family quite rightly dominates the headlines. However, the cases of the hundreds of children who are protected, saved and rescued every day by social services do not dominate the headlines, and I understand why that is the case also. Success in this area of work tends to be quiet, private and hidden. Nonetheless, on occasions such as this, it is important to point out that many children's lives are saved and many families are supported by social services.

The vast majority of families who require intervention by social services do not present a risk of that type of harm to their children. Unfortunately, there is no simple diagnostic test that can be performed to separate families who are simply struggling with the difficult task of bringing up children, perhaps because of particular issues in their lives, from those who present a real serious threat and risk to their children's long-term well-being. That is one of the reasons why child protection social work is so difficult. It is also one of the reasons why we can never guarantee the safety of every child. I would love to be able to say that, based on the lessons that we have learned, I promise you that this situation would never happen again. I cannot do that, and, trust me, anyone who says that would not be telling the truth. We can never guarantee the safety of every child, but we can say that we are improving services.

I mentioned the inquiry into child protection that took place in 1974. Since the 1970s, the number of children who have been murdered in the UK has roughly halved. That is a huge success, and it is a trend has not been replicated everywhere. In America, for example, the number of children who have been murdered has increased significantly. The UK figures provide evidence that we do learn and that we do get better, but we will never eliminate that entirely.

Again, I refer to the Toner report. One of the reasons why we cannot give an absolute guarantee can be found in the Toner report. The report found a number of failings in practice, but, nonetheless, said:

"The Review Panel wishes to record that detailed consideration of the extensive oral and written evidence available to us did not reveal any indication to the various agencies under review that the tragic events of the 13 November 2007 were about to occur."

If one cannot predict something, it is difficult to prevent it.

Mrs McGill:

I have to say, Sean, that one could say that nothing can be predicted and one could draw a line

under everything and do nothing.

Mr Holland:

One continually tries to reduce the chances of something happening, but one can never give 100% guarantees.

Mrs McGill:

I finish on this point: questions remain about the tragedy at Lammy Crescent.

The Chairperson:

I have given a lot of latitude to members who represent constituencies in the relevant trust area. I call Dr Deeny.

Dr Deeny:

Thank you, Sean, Christine and Fergal. I have worked with social workers for years. They are highly professional people who do a difficult job. Sean, you are right: 999 things in health and social care work out well, but the one that does not hits the headlines. You referred to a telephone number for kids. What is the number, what is the service called, and is it freely accessible to children?

Mr Holland:

Each trust area has a telephone number that people can ring if they are concerned about the well-being of a child. That telephone number can be used by a health professional, a GP such as you, a member of the public or a teacher. It is not particularly aimed at children, but some telephone numbers are aimed at children. For example, the Department funds Childline, an organisation that is marketed at children. That telephone number is available 24 hours a day, and children can telephone it to report their concerns. Referrals are made from Childline to social services. The NSPCC also runs a helpline for children, and I know from experience as a parent that my daughter has been informed of those telephone numbers at school.

There are also children for whom we have identified specific concerns, and during the meeting this morning, the Committee heard people talking about child protection plans. Sometimes, a child protection plan will be developed that is even more detailed, and it might involve giving a child a telephone number to ring so that they can talk to a social worker. The plan could also

identify people in the child's life to whom they can turn if they feel threatened or scared, or when they believe that their situation is getting worse. That is a common feature of child protection plans.

Mr Bradley:

I will add a couple of points to that. We are doing a lot of work with our counterparts in the South, and some time in the next few months we will jointly issue guidance about what people can do if they have concerns about a child. It will be a simple, short document; a little leaflet that can be made available widely and will give details of different authorities and phone numbers to be contacted.

The Committee is probably aware that the UK internet safety strategy was launched on Tuesday, which is relevant with respect to some of the revelations in the news yesterday. Some of the products that will come out of that over the next year, as well as public awareness campaigns, will be the move towards establishing a one-stop-shop online, so that children and parents who are in social networking sites and other sites will be able to click on an icon when something untoward happens. They will be immediately referred to the Child Exploitation and Online Protection Centre to report what is happening online.

Childline and the NSPCC are also moving in that direction: it is not just about a phone number anymore. They can be contacted by mobile phone and by email. We are trying to keep abreast of the available technology in order to make things easier children and adults. It is worth mentioning the good work that is being done in the education system. A lot of work has been done there to make sure that children are aware of what to do when something happens. Sometimes it works well, and sometimes it works against you. My children have quoted the Childline number to me when I have told them what I did not want them to do. Children are very aware of things like that.

Mr Holland:

I also think it is very important, when we have the opportunity of speaking in public, to make it clear that child protection is everyone's responsibility. I am not just talking about agencies: as a community we have a responsibility. I made that point yesterday during a radio interview, and I can report that, on the back of that interview, the BBC directly received referrals about children who members of the community were concerned about. It is important that whenever we have

the opportunity we reinforce the message that child protection is everyone's responsibility.

Dr Deeny:

People have mentioned a public inquiry. Rather than ask why there should be a public inquiry, my question is this: why not? What are the reasons for not having one? You have heard members here and elsewhere. At the end of the day, we are public representatives, and often reflect what the public thinks. My belief, whether right or wrong, is that for years tragedies and disasters have occurred here, meetings have been held, protocols have been arrived at and, as the Deputy Chairperson has said, recommendations have been made, then we see down the line that nothing happens. If something came out of a public inquiry, those things could be stated in writing and carried out. It is because we really need public confidence; that is the big thing.

Would you clarify for the Committee the whole issue of children at risk? It is a dangerous, difficult and serious area of care for people. We need to have a team approach, involving everyone who deals with children, however that is identified. For example, people such as health visitors, nurses, doctors, the clergy and teachers should be involved, rather than trying to put all the responsibility on the shoulders of social workers, or that social workers take that responsibility. They are the primary professionals involved, but everybody else has something to contribute, and it is very important that that happens.

As the Chairman said, we do not having policing and justice powers here, but I want to tell you about a situation that I have been made aware of in the last couple of weeks, which has changed since then. It is a social worker's dilemma. I have been told, and I met some of my colleagues at lunchtime, that there is concern among many different groups of health workers about a particular group of children. Yet, on the legal advice of a senior legal person — and this matter went to court, I understand — that there was no need to worry, and the child was taken off the at-risk register. Everyone else believes that that should not have happened. I know that this issue is outside the Committee's remit, but if someone makes a legal judgement, surely you, through the Department, can impress on legal advisers that many health professionals do not feel that that such decisions are correct.

I have been told that that particular situation may have changed, but it worried me when I heard about it. I do not know much about the case, but I have heard about it from other health professionals. It could be that people who are not qualified to make such decisions are putting

people at risk and are preventing those who know better, such as social workers and other health professionals, having those children looked after.

We have spoken about the past, and what is done is done. The McElhill case was a terrible tragedy, and it has been mentioned that Mr McElhill was convicted twice in six years for indecent assault and that he had attempted suicide in the past. People ask me how in God's name anyone could have come to the decision and allowed him to look after those children. How many people made that decision? Who were they and what qualifications did they have? Do we, as health professionals, and do you, as social services and the Department, not have the right and the duty to say hold on a second; we must have some input? Was the decision taken by people primarily in the legal profession as opposed to those in health and social care?

Mr Holland:

Kieran, you said that this is one of the dilemmas for social workers, and you are absolutely correct. Social workers must make professional judgements that are based on an assessment of need and risk, and it is on that basis that they will intervene in the lives of families. For the vast majority of families, such intervention is about supporting the family, providing additional assistance and helping them cope with the difficult tasks involved in bringing up children.

Sometimes, social workers must act in accordance with the Children (Northern Ireland) Order 1995 to remove children to a place of safety, but the ultimate judgement whether children stay in care or are returned home is for the judiciary. However, the judiciary also offer a form of quality control and it would not be a good idea for social workers to be able to commit children to care without that scrutiny. Separation of powers and quality control are very important.

However, it is a dilemma, and I know that people sometimes feel frustrated by the decisions of court. That said, the Department works closely with the judiciary and has members on the Children Order Advisory Committee, which is chaired by the head of Family Court division Mr Justice Weir. Very robust and frequent discussions are also held about how best we can work together to protect children.

The Chairperson:

Thank you. There is one issue that I thought would have been covered by members but has not, and it is the issue of the retention of social work staff. In several areas of the RQIA report,

concern is expressed about the number of newly-qualified and inexperienced social workers; in effect, social workers on probation. I know that that is not a phrase used in the profession, but you will be aware of what I am getting at: first-year social workers and the overreliance on them. That is a departmental issue and clearly your responsibility. What is being done to address that problem?

Mr Holland:

It is important to say that problem was not identified by the RQIA in all offices, or across the whole of Northern Ireland. It found the problem in only some areas.

The Chairperson:

Including Omagh?

Mr Holland:

Particularly Omagh: however, such problems are not just encountered in the area of social work. Historically, and I am sure Kieran will confirm this, other professions in the area of health and social care have had difficulty recruiting staff to work in Omagh.

It is important that we are clear that all social workers who work in child protection in Northern Ireland are professionally qualified, including those who are in an assessed year of employment. It is also important that newly qualified social workers get experience working in child protection, much as junior doctors get experience working in some of the most intense environments, such as hospital accident and emergency departments.

However, it is also important that we recognise that an inexperienced social worker needs additional support. That is why we have an assessed year in employment scheme in Northern Ireland. That scheme does not exist in other parts of the UK. We have had it here for about three years, in recognition of the fact that newly qualified social workers need additional support. We issued guidelines on how many of those social workers should be in a team, and the RQIA found that we were not adhering to those guidelines.

The challenge is to retain social workers who work in child protection, including those who are newly qualified. The assessed year in employment scheme is part of that. I will ask my colleague Christine to talk in more detail about that scheme to clarify the point that the RQIA raised.

Ms Christine Smyth (Department of Health, Social Services and Public Safety):

Before I talk about the assessed year in employment scheme, I want to comment on the retention of social workers and the over-reliance on newly qualified social workers in children's services. That needs to be seen in context. More than two-thirds of social workers in our trusts are employed in children's services. It is not unusual, therefore, that that is where most of the vacancies for newly qualified social workers will be. Statistics show that 80% of social work graduates entering the workforce go into family and childcare services.

There are lots of different teams within children's services. Not every newly qualified social worker goes into front line teams that carry out investigations into child protection. Again, statistics show that 14% of new graduates in 2007-08 who joined the trusts to do child protection work went into the front line gateway teams.

The assessed year in employment policy was brought forward in 2005 and implemented in 2006. It aims to provide stronger supports for newly qualified social workers as they enter the workforce after training. Of that training, 50% is done in supervised practice. Therefore, newly qualified social workers are not coming to practice totally raw. They have done assessments and worked with service users by the time they go out into the field.

The assessed year in employment scheme has been running for three years, and we monitor it closely every year. Clearly, there is room for improvement, but we have seen improvement over the past three years. We know that 96% of newly qualified social workers are receiving regular professional supervision. The 4% who are not receiving that supervision work in adult services, and we are looking at that situation. In addition, more than 90% of newly qualified social workers receive specific training during their first year to support them in doing their jobs. The scheme is successful, and, as Sean said, we are the first country in the UK to have introduced such a scheme, and England is now following our example.

Mr Holland:

The vast majority of social workers recruited to work in Northern Ireland have been trained in Northern Ireland. It would be remiss of me if I did not point out that the two social work training providers in Northern Ireland — the University of Ulster and Queen's University, Belfast — are among the very best in the UK. That is not just my opinion, it is demonstrated by the rankings.

Out of 72 providers in the UK, Queen's University is ranked fifth, and the University of Ulster twelfth.

The Chairperson:

Next I will ask the question that has been on everybody's mind but that nobody has yet asked. In GB, directors of social services and senior staff who have been involved in similar cases have been suspended, dismissed or severely reprimanded. That was not mentioned by any of the trusts in all the evidence that the Committee heard today. Has anybody been disciplined as a result of the recent high profile cases that we have heard of in Northern Ireland?

Mr Holland:

The first thing that I would say about the RQIA report is that one of the points that it most consistently makes is to comment on the high quality of staff who do a very difficult job in difficult circumstances. There are quotations from the report that refer to highly motivated staff who work in difficult services. That is worth noting.

Secondly, disciplining any individual member of staff is a matter for employers; it is important to be clear about that. People are disciplined. I will not comment on any specific case, but, as someone who has worked in the service, I can tell you that I have disciplined members of staff, and I have sacked members of staff. It does happen.

Difficulties arise when there is a high-profile case and there are calls for — pardon the expression — a head on a plate. That has an effect on performance, and it ultimately makes it harder to protect children for a number of reasons, some of which we have already mentioned. It also becomes harder to recruit people to the service when that kind of atmosphere has been created after a failing. Furthermore, it becomes more difficult to retain people. Perhaps more importantly, there is a danger of altering the style of practice that people engage in. Again, I look to Kieran Deeny, because there are parallels in medicine, whereby people engage in defensive practice: they stop acting in the best interests of a patient or a child, and instead their actions are determined by looking over their shoulder in fear of being disciplined.

The reality is that child protection work involves balancing risks. If people are to balance risks, it is not a good idea that one of their main considerations is whether they are going to be disciplined if a problem materialises. That is not to say that if people are guilty of gross

misconduct or their performance falls short of what is expected and those issues cannot be addressed through retraining, additional support or by looking at how the system has failed them, they should not be disciplined. In such cases, people should be disciplined.

Indeed, the system goes further, as there is professional regulation for social workers in Northern Ireland. A significant development over the past few years is that social work has become a profession that is subject to protection of title. A few years ago, anyone could have called themselves a social worker. Now they cannot; people must be registered with the Northern Ireland Social Care Council, which has the ability to, in effect, strike people off if their practice is not up to scratch.

I strongly believe that, after any high-profile case, it is much more important for us to focus on how we can make services better than to look for a scapegoat.

The Chairperson:

Are you aware of anybody being suspended, demoted or disciplined? You said that it is not your responsibility, but are you aware of that happening?

Mr Holland:

I am aware of people being referred to the Northern Ireland Social Care Council, but I cannot comment on any detail.

Mr Gardiner:

I have a short question, and you may think that I am going over the top, Chairman. Our country is being bombarded with cases of children being abused, North and South. If I had the knowledge and the wherewithal to do it, I would introduce an injection that offenders would have to have voluntarily once they were detected. That way, they would not interfere with children ever again. I do not think that there is anything of that kind on the market. People can smile at that suggestion, but other cases of abuse of young boys or girls will happen, and we must use every possible means to stamp that out.

Mr Holland:

I would give great thanks if there were a simple solution of that nature.

Mr Gardiner:

It would be a lot cheaper than employing so many additional staff to look after children. Children would be protected.

Mr Holland:

Unfortunately, this is a very complex area of work, and there are no simple solutions. It would be wonderful if there were, but there are not.

Mr F Bradley:

To be clear, child protection cases overwhelmingly involves families in which there is domestic violence, mental-health problems, or substance abuse. Overwhelmingly, abuse is about what happens within families. Sexual abuse happens within and outside of families, but it is not the experience of the vast majority of children who are on the child protection register or who are in care.

Mr Holland:

I would like to reinforce that very important point. There is an image of a stranger who poses a threat to children, both sexually and physically. We hear about child murders and child sexual abuse, and we all probably grew up with the message — I certainly heard it from my mother — not to talk to strangers or get into strange cars. Although that is a serious threat, unfortunately, Fergal is right: the biggest danger to children normally comes from inside the circle of people whom they know and, indeed, their own families.

Mr Gardiner:

Yes; however, when a child comes forward to confide in a doctor or another health care professional, action should be taken. Either the guilty person should go to jail for a long time, or he or she should receive the injection.

Mr F Bradley:

All parts of the UK are pretty much at the forefront worldwide in having systems and arrangements in place to prevent abuse. Even then, look at what happened in day nurseries in England, which are regulated and whose staff are vetted. There are people out there who pose a risk to children and who will use every means possible to evade all the measures that we have put in place to try to protect children. At the end of the day, you cannot offer absolute guarantees.

What we can do is put in place arrangements to try to minimise the chances of abuse.

The Chairperson:

This morning, we heard about a 92% increase in cases in one unit of the South Eastern Trust. When you hear such a statistic, you become extremely worried about where we are going as a society.

Mr F Bradley:

One reason for that increase is that it is now much easier to contact social services. There are many agencies, and many members of the public are now much more willing to come forward than would have been the case a few years ago. As we discussed earlier, fifty years ago, many of the issues that we deal with in families today, such as domestic violence, sexual violence, substance abuse, and so on, would have been considered to be private family matters, even when there were children involved, rather than matters in which the state should become involved. There is a quantum difference between the situation now and where we used to be.

Mr Holland:

As Fergal suggested, the rise in cases can almost, in a strange way, be seen as a sign of our success in that we are identifying problems and uncovering need that was previously hidden. People are coming forward and working more closely with the police and social services. We are identifying children who are in need who, previously, we would not necessarily have identified.

Mr F Bradley:

An example of that is cases of domestic violence. A great deal of good partnership work is being done with the police. The amount of information flowing from the police in cases involving children is increasing. For example, the Western Trust has put in place a specialist domestic violence unit within its family intervention teams. The volume of referrals has increased significantly. It is almost the case that if you build it, they will come. The more services are put in place, the more hidden demand will come forward.

The Chairperson:

I want to make a final point. This morning, you may have heard us discuss with a couple of the trusts the hall-to-the-kitchen approach; that is, statistics make it look as though improvements are being made when, in fact, the problem is simply being moved from gateway teams to family

intervention teams. Child referrals are not being solved more quickly, they are just being moved along the system.

Mr Holland:

It is important to recognise that gateway teams have been a huge success. Gateway teams were introduced to ensure that we had experienced people at the front end of the service who could make good judgements, assess need and risk, and be a single, identifiable, point of contact. For those teams to work, it is important that they do not get backlogged and that there is throughput of cases to the family intervention teams.

Yes; pressure on the family intervention teams is building. Certainly, if we had additional resources, we would invest in those teams. However, it is not a case of simply moving the problem along. I would be very worried if gateway teams were characterised not as a success but as merely a way to hide problems. That is certainly not the case. The RQIA inspection report bears out the fact that gateway teams have been a huge success. They have greatly improved the quality of analysis and assessment of new referrals. However, there are significant pressures in the system and on the family intervention teams.

Mr F Bradley:

Our strategy during the past number of years has been to try to put resources into the whole system; not just the gateway and family intervention teams but services for looked-after children and for people leaving care. We need to invest in the whole system. If not, the danger is that the problem will simply be displaced from one part of the system to another.

The Chairperson:

Lady and gentlemen, thank you very much for your evidence. You have a challenging role in the Department, to put it mildly. To listen to the problems that are faced by your team and by those on the ground has been draining for us all. Thank you for your presentation and for the way that you have dealt with questions. Members will be glad to know that that was the final evidence session. We have probably broken a few records today.