Northern Ireland
Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Child Protection in Northern Ireland: Western Health and Social Care Trust

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 Tom Cassidy)
Mr John Doherty) Western Health and Social Care Trust
Mrs Deirdre Mahon)
Mrs Elaine Way)

The Chairperson (Mr Wells):

I welcome the team from the Western Health and Social Care Trust, which is led by the chief executive, Mrs Elaine Way. Also present is Mr John Doherty, who is director of women and children's services and executive director of social services; Mrs Deirdre Mahon, who is assistant director for quality and development; and Mr Tom Cassidy, who is director for family support. I

ask the witnesses to give a presentation of about 10 minutes, after which we will throw open the session for questions, first to the Deputy Chairperson, then to those who represent western areas, and then to all members.

Mrs Elaine Way (Western Health and Social Care Trust):

Thank you very much. I believe that members were given a copy of the presentation in advance. We will report on the two Regulation and Quality Improvement Authority (RQIA) reports, that is, stage 1, which concerned corporate leadership and accountability, and stage 3, which concerned record keeping.

I will start by reflecting on the stage 1 review, about which I wanted to speak, given that it was about corporate leadership and accountability. In July 2008, the Western Health and Social Care Trust first submitted its action plans in response to what is known as the Social Services Inspectorate (SSI) overview report. Those action plans gave details of the measures that we were taking forward to implement the 226 recommendations of the SSI report that apply to the Western Trust.

The stage 1 review started in July 2008 and was completed with the launch of the report in November 2009. The SSI overview report was launched on 15 January 2007. It was completed in December 2006, but it was launched the following January. That was just prior to the establishment of the Western Health and Social Care Trust. When we came together as a new organisation in April 2007, we inherited the 226 recommendations. We were very keen to take those forward and to make improvements in children's services.

Of course, since the review started, two very important reports were published, namely the Boyd report and the Toner report. Those reports were about two awful tragedies, that of Madeleine O'Neill and her daughter, and, of course, the McElhill/McGovern family in Omagh. Those reports also informed the RQIA reports.

The stage 1 review, on which I concentrated, looked at nine recommendations from the SSI report. I am sure that members will have read that the review team assessed us from its perspective and compared that with how we assessed ourselves. The team agreed with our assessment in seven of the nine areas. The two areas where we felt that we were more mature, which was the review team's term, were to do with first, lines of responsibility and accountability

and secondly, the absence of an overarching workforce strategy. The issue with lines of professional accountability was due to the fact that we were not able to produce an auditable trail that showed the training that our staff had undertaken.

I will not go through all the high-level findings; members have those in their papers. However, it is important to look at the issues for which there must be learning. I should also point out that the report gives much credit to the team in the west for some elements of its professional practice that are considered to be really good.

The report's recommendations stated that we should be able to produce auditable information about how our staff are trained. The recommendations also said that we should have a comprehensive risk register. The issue with that was that we did not have a named nurse for child protection on the corporate risk register. That was the issue that concerned the RQIA at that time. The third recommendation was that an overarching workforce strategy should be developed.

I am happy to take questions that probe any of those areas, but I reassure the Committee that significant work is being undertaken in developing a workforce strategy. That is a significant piece of work and not one that we can do very quickly because we have to look at issues such as demand for childcare services in the west and our capacity to provide the best service that we can. That work is being taken forward in conjunction with the Regional Health and Social Care Board.

A database is available to carry out auditable training, but we require resources for administrative staff to feed in information, not just for that training area but for other areas of professional training. I assure the Committee that the governance arrangements for risk management have been significantly enhanced, and the trust's board is paying attention to them.

Mr Tom Cassidy (Western Health and Social Care Trust):

The RQIA audit was undertaken into the trust's newly established gateway service and family intervention teams. The gateway service is the first point of contact for members of the public and for professionals who are concerned about particular families. Family intervention teams sit behind that service and deal mainly with child protection and family support.

The five offices that were visited across the trust area encompass gateway service teams in three geographical areas; that is, Derry, Omagh and Enniskillen. The audit also covered three

family intervention service (FIS) offices, which were Rossdowney House in the Waterside area of Derry and those in Omagh and Enniskillen. During the audits, trust staff were in regular contact with the RQIA team and dealt immediately with any issues that arose. After the review, an interim report was provided to the trust, and, within 48 hours a robust action plan was developed and forwarded to the RQIA team. The action plans outlined specific actions that needed to be taken to address the deficits that had been identified.

The review team also noted areas of good practice in the trust. For instance, the gateway service was deemed to be well established, with a robust service-led structure that is fit for purpose. The review team was also impressed by the functioning of the Rossdowney family intervention team in the Waterside area of Derry. The review team found evidence-based application of the reform implementation team's policies and procedures, specifically relating to file structure and case supervision.

In Enniskillen, the review team found evidence that record keeping by the (FIS) team had improved. However, concerns were identified in the Omagh family intervention service. It is worth pointing out, however, that the RQIA inspection of the Omagh office took place after the terrible McElhill/McGovern family tragedy and the publication of the subsequent Toner report. The McElhill fire had a deep impact on the staff in the Omagh office. Morale was low, and sickness levels were high.

The recommendations to the trust covered seven areas: case file audits, which relate to the management oversight of decisions and files; the implementation of the new regional assessment framework, which is known as understanding the needs of children in Northern Ireland (UNOCINI); file structures and how things are arranged in files; how children are coded in the information system, which is known as the social services client administration and retrieval environment (SOSCARE), whereby each child should have a SOSCARE number; the transfer of summaries between teams; the recording policy; and the implementation of the regional child protection policies and procedures.

I emphasise that the RQIA team found in all the offices that it visited that social workers were committed to their role and were working in a complex and rapidly changing environment in which there was organisational change, a regional policy and service delivery to consider. It is also encouraging to note that throughout the visits, the team encountered staff with a positive

attitude to the audit and experienced real engagement from senior managers. Staff at all levels demonstrated enthusiasm and commitment to making improvements.

Mrs Deirdre Mahon (Western Health and Social Care Trust):

As Tom said, the RQIA report highlighted a number of improvements that needed to be made. I shall inform the Committee about some of those improvements. As our chief executive indicated, since its inception, the Western Health and Social Care Trust has continued to improve services. I shall focus particularly on some of the issues that were raised in the RQIA report.

Tom mentioned case file audits, which we now regularly carry out on social work case files to monitor social work practice and adherence to policies and procedures. Senior managers carry out ongoing random case file audits. Mr Cassidy mentioned the low morale of the social work staff, particularly in the Omagh office. We have invested in team building in the Omagh office, and that helps enable staff to feel valued in their workplace. That has raised morale, as has a comprehensive training programme for staff, which we have focused on, to ensure that they have the necessary skills to carry out their complex and difficult work. We are continuing to train staff and to improve the quality of their work.

We introduced a new file structure into the files, particularly in the Omagh office. That issue was identified by the RQIA team. Those files are in place in the Omagh office. We have strengthened the workforce in the Omagh office, and there are now no vacant posts there. There are also new managers in post, and they are providing strong leadership and direction to staff. We have introduced a new practice model, which is called 'Safety in Partnership: Nothing About Families Without Families'. That is a family focused, strength-based model that includes social and community networks to keep children safe. That is being rolled out at present, and it is having quite an impact on the practice and indicators of good practice in the Omagh office. Among the indicators in the Omagh office in the past number of months is the fact that the number of children on the child protection register has reduced significantly and there are no unallocated cases.

Mr John Doherty (Western Health and Social Care Trust):

As director of social work with professional responsibility for childcare services, I reassure members that since the inception of the Western Trust, my colleagues and I have had a clear focus on improving the quality of service to children and their families. The overview report of

the child protection inspection that was undertaken by the Social Services Inspectorate was launched in January 2007, and the trust was established in April of that year. One of my first actions was to establish the Improving Quality Together project. That was a multidisciplinary and inter-agency project that was designed to ensure that we learned the lessons arising from the inspection and that we implemented all the inspection's recommendations. It has been an important vehicle for us in ensuring that we maintain a focus on this crucial area of work.

The trust approached the RQIA inspection of child protection services in the same way that we approach all inspections. We were completely open to it and looked on it as a learning opportunity. When, during stage 3 of the inspection, we received the highlight report from the RQIA identifying concerns about the quality of service in Omagh, we immediately developed a robust action plan and set about its immediate implementation.

I am satisfied that there has been a transformation of the service in that office. In a recent visit to the office by the chairman, chief executive and myself, we met a highly motivated and enthusiastic group of staff who are committed to improving the service that they provide. Such is our confidence in the transformation that we look forward to the imminent reinspection of the Omagh office. We are preparing for stage 4 of the overall RQIA inspection, and I believe that RQIA will be able to evidence real improvements in our service.

A body of evidence is emerging locally and internationally that shows that the ethos of child protection services is of paramount importance. Those with a family services orientation approach, as opposed to one that is more legalistic and investigative, produce better outcomes for children. Consequently, we have embarked on a family support strategy, which has working in partnership with families at its core. We have redesigned our service to strengthen the support that we provide to families. For instance, we have introduced family group conferencing, and we have rolled it out across the trust. We have established family support panels, which provide tailored support packages for families who are in need of support. In addition to those and to a series of other initiatives, we are building on that progress and are introducing a new model of practice, Safety in Partnership, as described by Mrs Mahon. It emphasises the importance of working with families to identify risks to children and to develop explicit and practical safety plans. We are in the process of training staff and introducing the model across the trusts, and I believe that those service improvements will produce better outcomes for children. I will finish by reiterating our commitment to learning the lessons of all inspections, to taking forward the

recommendations and to continually striving to improve services to children.

The Chairperson:

Elaine, we met on a previous occasion in Altnagelvin, and I was impressed by the work that you are doing up there. To be balanced about it, there are some positive aspects of the report, such as good practice, particularly with the family intervention teams, and that is good news.

I must say that I am not looking forward to the next series of questions that I am going to ask, but I have to ask them, and you will expect me to ask them.

We were unaware that the coroner's report on the McElhill case was going to come out on Tuesday. However, I have dug a little deeper, and it has been absolutely heart-rending to hear what the press could not report. It is a difficult issue, but I feel that I have to ask a question about it. It appears that the McElhill family — I will use that phrase for the seven people involved — seem to have been badly let down by the authorities. I realise that a multi-agency approach is in place, but the Western Trust is included in that. What is your response to the findings in the McElhill case?

Mrs Way:

The Western Trust was not asked to attend the Coroner's Court or to give any evidence. Therefore, we have read only what you have read about the findings of the inquest.

As Tom said, when the awful tragedy happened, it had a devastating impact on our staff and on the wider community in Omagh. The review panel, which was chaired by Henry Toner, investigated thoroughly the Western Trust's role in dealing with the McElhill family. Some 44 individuals gave evidence, and, as you are aware, Chairman, the Toner report made 63 recommendations. The Western Trust was asked to take forward 55 of those recommendations, and we have completed 54. I do not want to pass judgement on others, but one of the issues that has arisen clearly in the past couple of days is the challenge of how to manage and monitor sex offenders in the community. However, that is not an issue for the Western Health and Social Care Trust.

The McElhill family was not a live case for us until their daughter Caroline approached the police through a phone call. I am looking to my colleagues to confirm the detail, but I understand

that the police went to the home on the basis of Caroline having raised concerns. They spoke to her mother, who reassured them that there were no concerns. However, the police then referred the case to the Omagh office for investigation, and that is when it became a live issue for the Western Trust. Is that right?

Mr J Doherty:

That is correct. We accepted all the findings of the Toner report and said that at the time, and we committed to taking forward all its recommendations. However, we accepted that some things could have been done differently. For example, we made the referral, but we have now redesigned our service whereby if a child raises concerns about domestic violence, it is automatically treated as top priority and dealt with immediately. We accept that there are things that could have been done better, but we believe that we have taken all appropriate steps to try to address those concerns.

The Chairperson:

We need to be careful that we do not treat the Committee as a court of law for a specific case. I am asking these questions only because they are relevant to the RQIA report. Two things strike me immediately about the issue. Hypothetically speaking, if someone had been prosecuted twice for serious sexual offences, how could their family not be a live case for any trust?

Mr Cassidy:

It was a live case in the former Sperrin Lakeland Trust until 2000 and for the purposes of the Toner report. However, child protection procedures were followed, and sexual matters were examined in the case of Mr McElhill. It was deemed that he was low risk under the previous multi-agency sex offender risk assessment/management (MASRAM) process, and because of that, it ceased to be a live case for the trust.

As John pointed out, the tragedy was horrendous, and it had a huge impact on staff. I personally have lain awake at night thinking about what the trust could have done differently. People died, and it was horrendous.

The one thing that really stood out with me was the fact that Caroline contacted the police. The police followed that contact up immediately and spoke to Ms McGovern, and although she indicated that things were fine, the trust should have followed up on Caroline's contact.

However, it was a very low-risk referral. If any child makes direct contact with the service about domestic violence or any issue of that nature, the trust now ensures that that is seen as a priority and dealt with in that manner.

It was a live case up until 2000, and it became a live case again only a matter of weeks before the tragedy.

The Chairperson:

The Toner report made 63 recommendations, and the RQIA then carried out its own investigation. It would appear from the RQIA report that either the Toner recommendations had not been implemented or they were in the process of being implemented. You said that part of that was the result of the poor morale of the office staff, who had clearly gone through a dreadful situation. However, given what had happened in Omagh, I would have thought that by the time that the RQIA had finished its review process everything would have been put in place, and things would have been much better managed.

Mrs Way:

The Toner report, which is a very significant and important document that contained many recommendations, was launched on 1 July 2008, and the stage 1 inspection from the RQIA commenced at approximately the same time. At the same time as the recommendations of the Toner report was due to be implemented, there was very low morale among the staff in the Omagh office, leading to a great deal of sick leave being taken. Indeed, the RQIA team visited the office on one occasion, and from a staff complement of 13 members of staff, only two permanent members of staff were present. The rest of the staff were temporary, drawn largely from agencies. It is very difficult to transform things when there is such a heavy reliance on staff on temporary contracts.

However, as Deirdre said, the trust has now filled all its vacancies in that office with permanent staff, and it has a very strong team. It has taken time to get to that stage, but I was hugely encouraged when I visited Omagh just after the launch of the RQIA report. At that time, there was quite a lot of media focus on the service, and several members of the trust had been in the media talking about the implications of the RQIA's findings. I had expected the morale of the staff to be low again, but I instead found that they felt that they are moving into a different era. They have embraced the Toner report, were embracing the RQIA's recommendations and believe

that services are being significantly improved.

Dr Deeny:

Thank you, Mr Chairman, and members of the panel. We meet again Elaine, this time on the opposite side of the Province, having met yesterday in Enniskillen.

This is not a witch-hunt by any means; we are all trying to learn from the awful tragedy in Omagh. I have been listening to you intently, and I have raised the point already that all of us, including those of us who work in primary care, must ensure that children in such situations are listened to.

Are you telling me the right thing here? Examining the circumstances of the McElhill case, the mother said that there was no problem, and Caroline McElhill, who obviously thought that there was a problem, contacted the police when she was 16 years old. Is that correct?

Mrs Mahon:

Caroline was 13.

Dr Deeny:

Was the visit to the mother just a one-off, with no follow up?

Mrs Way:

It was the police who visited.

Dr Deeny:

Was there just one visit?

Mrs Mahon:

Caroline was not actually at home when she made the call. She contacted the PSNI to say that her mum and dad were fighting at home and that she wanted the police to call. The police did call, as far as we understand, and spoke to her mum and dad. The children were in bed. The parents said that it was just Caroline, etc, etc. The police made a referral to social services 11 days later, as they have a duty to do if there is any issue at all in which domestic violence is involved. The case was referred to us, but unfortunately for us it was not marked as urgent, and

we did not treat it as such. That was just a few weeks before the fire.

We have learned from that, and now, if any referral is made — for example, if a child has made a call, contacted a teacher or told anyone of concerns — we treat that as a red alert and respond to it immediately. We do not know what the result would have been had those procedures been in place previously, but we have changed our practice.

Mrs Way:

In response to Dr Deeny, in reflecting on what could have been different and what could have been better, it seems to me that the whole inter-agency element is a big issue in that it involves primary care, social services, education and the police. That issue has arisen before, and we really have to learn from it. In Northern Ireland we are a small community. People generally do not move around, and we ought to be able to get the procedures right. I agree with Dr Deeny; we all have to stop and reflect.

I have no idea whether the Committee is taking evidence from the police or anyone else, but I can confirm that the relationship between social services in Omagh and the police has been strongly and significantly improved. That will help to protect children.

Dr Deeny:

I was going to ask you about the relationship between the trust and the PSNI, so I am glad to hear you say that that relationship has been improved. That point may need to be reinforced when discussing this awful incident.

Tom, you said that the procedure that has been introduced recently that if a child makes contact it will be deemed an emergency and will be urgently dealt with right away. What does that mean?

Both Deirdre and John mentioned the problems in Omagh and the new practice model. When will we see the results of that? I presume that it will be audited. It is also very important that all of us on the front line — whether we are in health, social care, security or education, or anyone who is dealing with the public — are informed of that new model. The model should be sent out to all of us so that we know how we are going to judge it. We have to make sure that it works.

Mr Cassidy:

All child protection referrals are dealt with within 24 hours of receipt, and children are seen as a result.

Dr Deeny:

By whom?

Mr Cassidy:

They are seen by a social worker. A home visit is made, and children are spoken to. In addition, I have told staff that if children make direct contact with our service, irrespective of the content of the referral, it should be treated as a priority and the child should be seen within 24 hours of contact being made.

Dr Deeny:

The RQIA referred to the fact that it had concerns about the length of service, qualifications and experience of social workers and about the fact that they were not being supervised. It referred to appropriate levels of supervision for newly qualified social workers, an over-reliance on inexperienced social care staff and the limited evidence of line managers and senior managers carrying out a quality assurance role. What will it take to ensure that the trust can guarantee that such cases, which can be very difficult and potentially extremely dangerous, will be dealt with by experienced staff? I am not getting at social care staff, because I have said before that their work is very professional.

Mr Cassidy:

We have strengthened our arrangements in the managerial oversight of cases. The Omagh office has three members of staff at senior social work level, which is band seven in the Agenda for Change scheme. A service manager is above them in the Omagh office to directly manage the Omagh family intervention service. The gateway service in Omagh is now different, and it takes all the referrals. We have strengthened the entire service across the trust, specifically in the Omagh office, to ensure managerial oversight. Part of the findings, to which Deirdre referred, state that case file audits should be carried out and checking should be done to ensure managerial oversight. Deirdre will talk about the assessed year in employment (AYE).

Mrs Mahon:

As you can imagine, social workers find child protection to be an area that is more difficult to work in than others, so it has been a challenge to continue to ensure that good, experienced practitioners are in that area of work. As Elaine said, we have to replace social workers who are on sick leave, and the only ones who are available are newly qualified social workers. It is important to point out that newly qualified social workers are professionally qualified and are in their assessed year in employment, which means that they have more competencies to meet. We have a lot of support and supervision to give them, and we are confident that we provide that service to them.

We no longer have the vacancies that we had previously, so experienced staff are now in the offices. We still have some social workers in their assessed year in employment, but they are being supported and supervised appropriately so that they can learn and grow and, hopefully, stay in that area of their work. We are confident that we are compliant with the ratio that the Department of Health, Social Services and Public Safety (DHSSPS) has set down. There is an ongoing challenge in that difficult area of work.

Mr J Doherty:

One of the key issues is to ensure that adequate support is in place and that the ratios are met. As Tom said, there are now three senior social workers in the Omagh office, which is double the number that was in place previously, when there was one senior social worker and one on a job-share. We also have senior practitioners in place to ensure that young people who are in their assessed year in employment are well supported and supervised.

Dr Deeny:

Will Safety in Partnership be rolled out to everyone?

Mr J Doherty:

I assure you that a whole body of evidence exists on the effectiveness of that model. We looked elsewhere before considering rolling it out, we are in the process of piloting it, and we will establish a project to oversee it. Although it is a truism, child protection is everyone's business, but that can be the case only if we act in concert with all the other key professionals, including those in primary care. We will work out a programme to ensure that everyone is fully engaged in awareness and in training opportunities. We are satisfied with our progress, because that is a

practical tool that identifies the real risks that children face and develops the key steps that must be taken to ensure the safety of children. We think that it will be a real positive boon.

Mrs Mahon:

The plan that has been worked out is basic and will involve sitting down with families and extended social networks, which is the part that is a bit different. If wee Johnny is worried about mum and dad fighting, a plan is put in place whereby as soon as there is a raised voice, he rings Auntie Betty, who comes to the house and so on. It is basic but detailed planning process that moves away from some of the more detailed professional procedures on what the family must do. It is about working in partnership with families and the extended wider community to keep children safe.

Dr Deeny:

Is it used elsewhere, Deirdre?

Mrs Mahon:

It has been used in America, Australia and some parts of England. We have been looking models of best practice, and we are gently rolling the model out. We have focused on the Omagh office, and we have already reduced the number of unallocated cases. Anecdotal evidence shows that families in the community say that they feel that there is a difference in how they are being treated and respected by social workers. The courts have said that they feel that there has been a difference. Gradually, we are beginning to see the impact of working in the way that the model suggests.

Mr J Doherty:

Recently, we established a dedicated team to deal with domestic violence, and the people on that team have been trained particularly in that model. They are the first staff to roll it out, and we are already seeing that significant impacts have been made in guaranteeing the safety of children.

Mrs McGill:

You are all welcome. I thank Mr Doherty and Mr Cassidy for taking my telephone calls. You are accessible, and I welcome that.

There has been plenty of comment about social workers during this and the previous evidence

sessions. Are there enough social workers? I heard a comment yesterday about the difficulties that social workers faced, and that has been well articulated today. However, the point was made yesterday that, to some extent, the system lets down social workers. That has been addressed, but I am looking for further reassurance that there are enough social workers and that the system fully supports them.

Does someone have lead responsibility for live cases of child abuse and so on, when there is supposed to be inter-agency working? Who had lead responsibility in the McElhill/McGovern case? Caroline McGovern made that call, which was very difficult for all of you and everyone in the community, particularly the families, to listen to, but at what stage was it reported to social services?

Mrs Way:

I do not believe that any chief executive would ever say that they have enough of anything, because there is more demand for our services than we will ever have capacity for. However, it is well documented that less is spent for each person on family and childcare services in Northern Ireland than anywhere else in the UK. The agreed figure seems to be about 30% underfunding, and you will not be surprised to hear that we will very much make the case for further investment in that area.

The three witnesses who are with me are all qualified social workers who have spent their entire careers in family and childcare work. I am so thankful that I have such strong leaders and experienced social workers committed to improving services in the west. John Doherty has been in this line of work for more than 30 years, and Tom must be doing it for almost 30 years. Deirdre is much younger than the rest of us.

Knowledge, leadership and consistency are important in supporting social workers. Family and childcare social workers have one of the toughest jobs in the trust. It is very tough work. As part of the workforce strategy that I mentioned, the trust, on the back of the Toner and RQIA reports, is working with Fionnuala McAndrew of the Health and Social Care Board to ascertain the demand for family and childcare services in the west and the trust's capacity to meet that demand. I know that that work will show that we do not have enough resources to do all that we want to do or should be doing. We will work with the commissioner to plan for more resources. However, once we get the staff, it is important that they are well supported through supervision

and good, strong leadership.

I do not feel that the Western Health and Social Care Trust has let its front line social workers down. The trust has a responsibility to recognise that because front line social workers are literally on the front line working hard trying to keep children safe, we have to do the strategic work, namely, lobbying for more investment to get more staff and looking at what practices will make a difference. Deirdre and John have taken me through the Safety in Partnership model, and I am absolutely certain that it will make a great difference to managing out risk. However, members will appreciate that we cannot eliminate all risk when it comes to child safety.

I ask Tom to address the matters of live cases on the child protection register, inter-agency work and the question of who takes the lead.

Mr Cassidy:

Our organisation takes the lead in the case of children who are on the child protection register. We follow the regional child protection policies and procedures, which are strongly multidisciplinary and inter-agency in nature. Children are assigned a lead case co-ordinator, who is normally one of our staff.

I have been involved with children in social work for 30-odd years — I started as a social worker, and this is my current job. I am biased, and I believe that it is one of the toughest jobs in the public sector, because we deal daily with risk. Not a day goes by when my staff do not make judgements on risk. They do that in collaboration and in conjunction with other agencies and with other professionals, but their judgements are finely balanced and delicate.

I have said before that life-and-death decisions are not taken only in the acute sector. Such decisions are not only hospital based; community-based decisions are made that affect and have an impact on people's lives long into adulthood. Those decisions can have a major impact, so we need to get them right. We are striving daily to get things right and to work with everyone whom we possibly can to do that.

The McElhill case was a tragedy. The day that I heard about it was the worst of my professional life. The staff who were closer to the tragedy were deeply affected by it. I cannot imagine how the relatives, families and friends were impacted by what happened, but it had a

huge effect on us. We are striving to ensure that such things do not happen again.

We are not the lead agency in the management of sex offenders. We contribute to that management, but the police and the Probation Board take the lead under the MASRAM process.

Mrs McGill:

If Caroline were alive today, would one of you have a telephone number that she could ring? She rang the PSNI, and that is well and good, but is there another telephone contact?

Mr Cassidy:

There is one telephone contact number for our gateway service. Therefore, whether one lives in Lisnaskea or Limavady, there is one telephone number. There are also out-of-hours numbers for the three major hospitals in the trust area. In our area, those are Altnagelvin Area Hospital, Tyrone County Hospital and the Erne Hospital.

Mrs McGill:

It can happen to all of us that, when we call some phone numbers, there is a lot of sifting and so on to go through. God forbid, if something similar to the McElhill case were to happen again and a young girl made a similar phone call, would she get straight through to someone and would there be an immediate response?

Mr Cassidy:

Deirdre and I work in the out-of-hours system. That keeps the likes of me grounded, in the sense of knowing exactly what is happening with our front line staff. For example, God rest Caroline, she would have contacted the local contact person in Omagh at Tyrone County Hospital. A co-ordinator is on duty every night of the year, and he or she would have phoned the likes of me. To reassure you, Mrs McGill, if we receive contact directly from a child, as I said already, that prompts immediate action. If that situation arose again, and the caller had contacted social services out of hours, we would send out a social worker immediately to assess that case.

In contrast to when the McElhill tragedy took place, under the reform-implementation process, we now have a dedicated regional service to take initial contacts, that is, the gateway service. It is attuned and geared up to respond when a child contacts it directly. As I said before, we treat such contact as a child-protection issue, irrespective of what he or she tells us. Immediately, we

go out and visit the child to speak to him or her.

Mrs Way:

You asked about the need for responsibility to be taken for the McElhill/McGovern case. I shall ask John to respond.

Mr J Doherty:

As John described earlier, there were two periods of involvement in the time between Arthur McElhill's convictions and the births of his children, and during that time, child protection processes were initiated. A named social worker was identified at that stage. Unfortunately, a social worker was not allocated to deal with the subsequent incident when a call about domestic violence was made.

In the interests of absolute accuracy, I will explain what happened at that stage. On the night of 14 October, police officers visited the home and spoke to the mum. She said that there had been a disagreement and that Caroline had misinterpreted it. On the basis of that conversation, police officers assessed the situation as low risk.

Subsequently, as they were supposed to, they referred the case to us. Eleven days later, they referred it as low risk among a batch of other concerns. It is important to note that we work very closely with police officers in the handling of domestic violence. Some time ago, police officers used to be able to exercise some discretion in assessments of domestic violence. At that time, a force order was introduced that said that any case of domestic violence had to be referred to social services and that we would be the ones to make an assessment.

Police officers work day and night. The out-of-hours service is available 365 days a year. If they assess an immediate risk to a child, they will draw it to our attention and we will go out and deal with it immediately. Due to the circumstances and the way in which this situation presented itself, it was not assessed to be a major risk at that point. As you have heard, we have described what we have attempted to do since then, which is that if a child raises concern, we deal with it automatically.

Finally, important developments are taking place in public protection arrangements for Northern Ireland. Through that process, there will be a dedicated person in each trust who will

work closely with police officers to assess all cases and determine how we should follow them up.

Ms S Ramsey:

Thank you for your presentation. I will start by agreeing with Tom and Deirdre, who said that social workers have a hard job to do. This discussion should not be seen as a witch-hunt, but I have a responsibility to ask questions. I also believe that we should not lose sight of what Arthur McElhill did. Some of my queries on your presentation have been answered in your responses to members' previous questions. Did you say that all the McElhill kids were on the child protection register?

Mrs Mahon:

No; just Caroline, when she was a baby.

Mr Cassidy:

That was in 2000.

Ms S Ramsey:

Was she still on the register?

Mr Cassidy:

She was on the register in 2000 and was later taken off it. She was not on the register when the terrible tragedy happened, and she had not been on it for approximately seven years.

Ms S Ramsey:

OK. I just wonder, for all the brains and systems that there are in the world, why society and the system failed that family. It is a human tragedy, and that must be taken on board.

Elaine, you said that dealing with sex offenders is not a matter for the trust.

Mrs Way:

We are not the lead agency on the management of sex offenders who live in the community.

Ms S Ramsey:

You said that it is not a matter for the trust. The reason why I want to come back to that is because —

The Chairperson:

Sue, to be fair, she did say that management of sex offenders is not a trust matter.

Ms S Ramsey:

I understand that, Chairperson, and that is why I want to return to it. Is it not a matter for which there is a case management review and in which the trust plays an important part?

I am trying to highlight the fact that, even though all those systems are in place and everyone has an important part to play, if we do not put the correct jigsaw pieces together, we will never see the complete picture. I want to highlight that the trust has an important role to play in the management of sex offenders, whether direct or indirect. That is the issue.

Mrs Way:

I clarify that the Western Health and Social Care Trust has specific statutory child protection responsibilities. We are not the lead statutory agency. I say that partly because, as I listen to some of the media reporting of the incident, I find that the responsibility for the entire failure of the system seems to be resting with health and social services. I agree with you, and Dr Deeny also said, that inter-agency learning must be taken forward.

Ms S Ramsey:

Absolutely.

Mr Cassidy:

My apologies. I talked about MASRAM and the former Policing Authority for Northern Ireland (PANI) and said that we contribute to the process. I am sorry if I was not clear enough.

Ms S Ramsey:

You were clear, Tom. However, everyone is a lead player in the protection of children. I take on board that we cannot get into a lot of the issues that arose in the inquest the other day. The trust was not asked to attend. Did you send anyone to the court? We are talking about learning

lessons.

Mrs Way:

No, we did not.

Ms S Ramsey:

That is an issue. We are all trying to learn lessons and be proactive. If you had the staff levels then that you have now, would the tragedy have occurred?

I also have a sensitive question about corporate responsibility. I agree that children's and young people's services have been underfunded for years and that we need to ensure that we get that right. Would you be proactive and ask the RQIA team to come in now, or in the future, to expose the issue of safety and the legal failings in the statutory duty of a trust on the basis of lack of staff, funds and resources?

Unless that is exposed, society will know nothing of it. If it were announced tomorrow that the Royal Victoria Hospital were to close, 100,000 people would come on to the streets to protest. However, children's and voluntary services are underfunded on a daily basis. As a chief executive, you have a corporate responsibility. Would you become a whistle-blower to expose the failings in your statutory legal duty?

Mrs Way:

Your first question asked whether the tragedy could have been prevented if we had had a settled group in Omagh. It is important that we go back to what the Toner review said. That was a very thorough investigation, and I am sure that you have read it. Despite the fact that that review came up with 63 recommendations, its findings were that it did not believe that any review could have predicted such an awful tragedy.

As to my statutory responsibility for quality, it is my duty to consistently flag up where we do not feel that we have sufficient resources. I assure the Committee that I do that across all aspects of our business, and where we do not have sufficient resource to meet demand, I say so.

Ms S Ramsey:

Yes, but that is internal.

Mrs Way:

It is not internal in that we work with the Health and Social Care Board, which gives us the money to provide the services. We also work closely with departmental officials. When I was chief executive of the former Foyle Community Trust, some of our social workers who felt that there were insufficient resources to meet demand took part in industrial action. We did a fine piece of work at that point along with our front line staff, and we managed to get significant resources for the Foyle team. We relaunched our strategy under the heading 'New Beginings', and I believe that we transformed child protection services in the north-west.

We now have a merged organisation. There have been issues; for example, in the SSI overview report many more recommendations were made for services in Omagh and Fermanagh. We are trying to take that forward, and part of our workforce strategy is to identify the gaps in resources.

Mr J Doherty:

You asked whether we sent someone to the inquest. We made a formal overture. We asked the coroner whether we could contribute, but that was deemed to be inappropriate. Therefore, we had looked at that seriously.

Ms S Ramsey:

Fair enough, but you could have sent someone to sit in the public gallery.

Mr J Doherty:

I know, but it was made clear that we were not invited to be witnesses to the proceedings.

As director of children's services, I think that I have a key responsibility to flag up pressures in the system, and we have been doing a lot of work to improve our capacity. We have been making representations to the new Health and Social Care Board, and I must say that since it has been established, it has been very receptive to our case.

The new director of social care and children's services, Fionnuala McAndrew, is taking the lead in examining what is called "a demand to capacity analysis", which basically looks at all the needs and demands in social services in Northern Ireland and then looks at the services that we

have to meet those demands. That is probably the most objective way to take this forward. If we can prove the facts, I am optimistic that that will lead to subsequent funding.

Ms S Ramsey:

I support Tom's point that tragedies happen not only in the acute sector. The issue is about exposing corporate power and responsibility.

Mrs Way:

I absolutely agree.

Ms S Ramsey:

You must tell us how it is.

Mrs Way:

Finally, I would invite RQIA to carry out an inspection, in addition to its planned inspections, of the Western Trust. When I met the Minister to discuss the RQIA reports, I proposed a reinspection of the stage 1 issues that I referred to. I also suggested and welcomed a reinspection of the stage 3 report, so that everyone in Omagh and the Committee can be assured that things have greatly improved.

Mrs I Robinson:

You said that when the PSNI called to the house on 14 October that the mother — I presume it was the mother — said that there had been a misunderstanding. It should have been quite obvious that the mother said that to deflect any possibility of Caroline being removed from the home or of the family being further scrutinised because of the telephone call. Did the PSNI even speak to Caroline?

Mrs Mahon:

Obviously, we cannot answer for the PSNI because it was its officers who dealt with the call. However, it is my understanding that Caroline was at a friend's home when she phoned the police to say that she had heard her mummy and daddy having an argument while she was on the phone to them and that she was worried.

You are absolutely right: women in domestic violence situations will regularly minimise the

possible risk to them for fear of a number of different things happening. That is why we have a new domestic violence team that is trained specifically to deal with those issues. You might be right in that the mum might have said that to the police so that they would leave the house and leave her alone. That is probably why a police force order is in place to ensure that every incident is referred to social services for further investigation.

Mrs I Robinson:

According to the news, she had been under threat to say what she said. The benefit of hindsight is wonderful. Given the sensitivities that are involved, I certainly sympathise with the staff who have had to deal with this issue very publicly because of the sensitivities that are involved.

Mrs Mahon:

It is difficult to strike a balance between ensuring that all the risks are addressed and not intervening in a family's life too robustly. It is about knowing which way to swing the pendulum, because people fear state intervention in their lives.

Mrs I Robinson:

Given the fact that Mr McElhill had a record and that the trust knew quite a bit about the family's background, it is a pity that other relevant factors were not taken on board at that time. Again, we are all very good at saying that with the benefit of hindsight.

We now need to rally round and support our social workers by ensuring that all the policy guidelines are in place, that they know what to follow and who in seniority to contact.

The Chairperson:

Mrs Way, thank you for giving evidence. Before we conclude this session, we wish to raise one last issue about the very difficult situation in Omagh. The Committee has not taken any stance on whether there should be a public inquiry into that terrible incident, even though some members have strong views on it. How would you feel, as a trust, if an announcement were made that there was the potential for a public inquiry to be held? Do you feel that that would be useful and helpful in focusing on issues that have not been covered? What is the trust's view on that?

Mrs Way:

Obviously, we have heard calls over the past 24 hours for a public inquiry. I have reflected on

that, but I have not discussed it with the trust's board. Therefore, it is more of a personal reaction than an organisational one. My view is that a public inquiry into the trust's actions is unlikely to add any further clarification. Such was the thoroughness of the Toner report that I believe that all knowledge of the trust's contribution is in the public domain, and we are pushing ahead to implement all the recommendations of that report. If Ministers decide that there will be a public inquiry, we will, as we have always done, contribute fully to it. There may be other lessons that could come out, and therefore, we would play our full part in any inquiry.

Going back to Deirdre's point about striking a balance, I am picking up, certainly in the Omagh community, a sense that people want to move on. I would be concerned that a public inquiry could run for years, and I am not sure whether, for us, there would be anything additional to learn from it.

Ms S Ramsey:

I know that that is your personal view, but I think differently, and I am even more convinced of that following your presentation. There is a lack of public confidence. There are a number of instances when state agencies failed because they were not working collectively, or for example, someone on the child protection register in 2000, and then other kids came into that situation. We need to know where that is at. There is a need for a public inquiry, although I agree that that should not drag on. However, there is a need for a time-bound public inquiry to restore confidence internally among your staff, to expose what went wrong and to ensure that the lesson is learned that such an incident does not, cannot, and will not happen again. That would give confidence to the people of Omagh and to people in that area, including your staff. If procedures are put in place, people will be guided by them.

The Chairperson:

Thank you for your view on that. I am sure that the Committee will wish to return to that issue. It is a pity, in a way, that for understandable reasons, we have concentrated very much on one area. However, that was inevitable, given the circumstances.

I thank the trust for its willingness to provide us with information in good time and for the thoroughness of that information. We have not discovered that with every trust, but the Western Trust has always been very forthcoming in giving the Committee its information ahead of hearings and in not hiding behind protocol. I thank you for dealing with what turned out to be

some very difficult questions.